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System Reform: Progress Report

Consumer Perspectives on Change: for Better or for Worse

By Barbara, Charles, and Emily
Clients Served by Services for the UnderServed (SUS)

We were asked to consider whether changes in the way we receive and respond to behavioral health services has been for better or for worse, now that Medicaid Managed Care is the order of the day. It was a tough conversation because at the beginning, some of us really felt like we hadn't even known that much of a change had happened, but as we got into things, we realized things have changed - and sometimes not for the better.

Another SUS focus group wrote about Adapting to System Reform in the 2016 summer issue of *Behavioral Health News*, and back at that time the writers made some very important points: that health reform was confusing, that decisions made by government and policymakers without us are never okay, that communications about changes need to be understandable and clear and that housing and supported housing is absolutely key. Those points are just as important today as they were when they were written, and even though it's been over a year since Managed Care officially appeared on the scene, we're still struggling with lots of issues.

Our group wound up coming back to a number of the points that were raised by the earlier consumer group, but now we began to get even more clarity about some specifics.

First, there is still a big problem around how changes are communicated. All of us agreed that the letters we get, when we get letters, are very confusing and written using language that seems to be much more for professional administrators than for people who are receiving services. It's very hard to tell what our various health plans writing to us are trying to convey, except that usually it's not good news. The prior peer group that wrote about this had the same experience and what happens is that either we just toss the letter in the can, which may not be such a good idea, or we bring them to a case worker to interpret. There has to be a better way - and we wonder whether the Managed Care companies have ever considered asking one of us peers to review

see Change on page 29

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System Transformation in Substance Use Disorder Care: New York State Progress and Priorities

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

Arlene González-Sánchez, MS, LMSW

The Surgeon General's Report on Alcohol, Drugs, and Health (https://addiction.surgeongeneral.gov), issued in November 2016, is a landmark report for the substance use disorder (SUD) care system. This report makes clear the importance of identifying and treating substance use disorders and places emphasis on integration of treatment with physical health, prevention efforts, early intervention and the reduction of stigma. Only 1 in 14 people who have a substance use disorder access care. There are many reasons[2] for this including: not knowing where to get care, not being sure that care is needed, worry about employer finding out and not being able to pay for care. The New York State Office of Alcoholism and Substance Abuse Services (NYS OASAS) has been working with providers, plans, recovering individuals and family members affected by substance use disorder to ensure that Substance Use services are able to meet the challenges of the current opioid crisis and that we use this crisis to strengthen SUD services to meet challenges beyond the current crisis for all substances including alcohol. With all of this in mind OASAS will focus efforts in the coming year to consolidate gains made through Medicaid Re-design to improve access, better integrate substance use services and improve quality to ensure a welcoming environment for all individuals seeking help.

Physical health providers must improve identification of substance use which will improve health care outcomes, reduce costs and most importantly improve quality of life. In order to achieve that promise, we must all come together to recognize the problem, speak about it, intervene when someone is in trouble, and follow-through by getting help. Treatment options must be accessible and which means that they are available when people are ready to reach out, and responsive and engaging regardless of where people are in recognition of substance use as a problem. Together physical health, mental health and specialty provides must ask questions about substance use and must have the confidence and competence to intervene.

We must build bridges from the community providers to primary care, emergency and specialty care providers so that the expertise of the SUD specialty system is available to other settings and that relationships are established to ensure bi-directional linkages to care. Providers must respond to the demands that greater identification and early intervention will create and they need to build the capacity to respond to urgent and emergency patient need at off-hours, in the community and with peers who can share experience and help to connect individuals to the right care. OASAS has been encouraging providers to join together to break down silos between treatment settings. We need everyone involved to solve problems with gaps in care in order to make a difference.

We need a continuum of care with easy access to the best place for care after a professional assessment. It is too hard for an individual who has made a decision to enter treatment to wait for that care for an extended time. OASAS has developed the treatment availability tool, at FindAddictionTreatment.ny.gov (https://findaddictiontreatment.ny.gov/pub/ctrldocs/oasastaw/www/index.html#/app/search), so that individuals and family members can find treatment that is right for them. It is hard to know without professional advice what care is best for the person and that kind of professional assessment and consultation should be available 24 hours a day 7 days per week, regionally, and as locally as possible. People in an urgent situation, whether they are experiencing withdrawal or an event that has lead them to acknowledge a need for change, are still, too often, seen in emergency room settings where they will be stabilized but may never have an assessment or treatment. Most SUD concerns can be met in community settings, whether a person needs medication, group individual and family counseling, or an admission to an inpatient or residential setting. We know is that it is best to deliver that care as soon as possible.

We also need to better integrate the SUD continuum of care so prevention and recovery services are a part of the SUD system of care well and that the silos of treatment, recovery and prevention are broken down. Everyone is impacted by substance use, whether as a community member, family member or friend, a person needing help or a person in recovery. We see the large and integrated community of people within other health conditions working together to prevent, promote health and early intervention, treatment and support. We need this same community around substance use disorder.

Together, we need to change the narrative about substance use. The Surgeon General very directly identifies that stigma reduces access and marginalizes treatment and those impacted by the disorder. The way we talk about addiction and respond to it matters and we can encourage people to acknowledge problems with substances, seek treatment and continue to work towards long term recovery by discouraging the behavior of substance misuse but not ostracizing the person with the disorder. Addiction can happen to anyone who uses substances, including alcohol. Although we know that individuals who have genetic predisposition, a history of trauma or mental health disorder at higher risk. We must welcome people who are seeking help into care, not scare them away. Addiction shares a lot of similarities with diabetes in that behaviors impact the development of the disorder and difficult behavioral changes are required to attain remission and long term recovery. We do not shame individuals with diabetes or other chronic health conditions, and we should not shame those who have a Substance Use Disorder.

Individuals with SUD need access to high quality care. In order to identify quality we must develop measures of quality including system level metrics of access and identification, individual metrics of engagement, linkage to next levels of care following detox and inpatient care, medications treatment when an FDA approved medication is available, connection to recovery support, and positive response to treatment. OASAS is working with providers, payers, state partners and other stakeholders together with the National Center on Alcohol and Substance Abuse to develop meaningful measures. These measures of quality should be reflective of standards of care and reflect the best evidence available for successful treatment.

Individuals need to be able to be welcomed to care and have information provided in terms they understand in a way that is respectful and supportive. Like diabetes and other chronic health conditions, not everyone is ready to commit to treatment fully, others are in need of a structured and abstinence-based approach. Quality treatment is able to meet the needs of all individuals presenting for treatment, regardless of current commitment to change. Individuals seeking care should expect to be treated by qualified staff with treatments that are based on the best evidence available.

The NYSPA Report: Taking Stock and Taking Leave

By Barry B. Perlman, MD, Chairman, Committee on Legislation, New York State Psychiatric Association

Advocacy must be unending, ongoing work because there is always more to accomplish and always the danger that hard won gains may be undone. For the past 14 years I have either written or edited the work of guest columnists for the quarterly NYSPA Report in *Behavioral Health News (BHN)* or in *Mental Health News* as the publication was previously known. Mostly a labor of love, it nevertheless has meant a great deal of labor. Now retired, this column will be the last regular NYSPA Report for which I shall be responsible.

It has been my hope and that of NYSPA's members that the Reports served to inform readers about a wide array issues confronting those with an interest the field. Columns over the years have addressed issues as diverse as NYS's sexual offender law and its implication for the mental health system, the need for passage of Timothy's law and the federal Parity law and how the complementary provisions benefit New Yorkers, the benefits of Electro Convulsive Therapy and why its continuing availability is important, controversies about prescribing psychotropic medications for children and youth, the opioid epidemic, and many, many others. BHN readers are drawn from an assortment of interested persons including family members of those suffering from mental illness and/ or substance use disorders (MH/SU), consumers/ patients, professionals, policy makers, and advocates. While their viewpoints may not always coincide, I believe that all stakeholders sincerely desire improvements in the delivery system through which care is provided and research advanced with the goal of improving the lives of those diagnosed MH/SU.

My final column is written at a fraught time for those concerned about the future for those with MH/SU. We worry about whether the gains achieved in recent years will survive the transition to a new administration which, although not antithetic to access to quality mental health services, does intend to undue many of the relevant statutory and regulatory gains of the Obama years and before. As advocates for sound mental health policy we know of areas which are in danger of suffering collateral damage as a consequence of Republican attacks directed at the Patient Protection and Affordable Care Act

Barry B. Perlman, MD

(PPACA) and its mandates along with their efforts to radically alter the way funds are distributed to Medicaid. Medicare too may become a target.

There is irony in what is likely to unfold. The PPACA required that essential health benefits, including those for MH/SU treatment, be explicitly defined and included in the plans sold. The ACA also expanded Medicaid coverage in states which opted to participate. Both of these vastly expanded Americans' access to MH/SU care and that care was to be available on a nondiscriminatory "parity" basis with physical health care. The expansion of access to MH/SU services resulted in large measure from the requirement that such benefits, when covered, be provided at parity with physical health benefits because of the Mental Health Parity and Addictions Equity Act (federal Parity law) signed into law by President George W. Bush in 2008.

As I write this column The 21st Century Cures Act has been signed into law; an important goal of it is the improvement of the nation's mental health system. Many of its provisions, such as moving to improve the integration of mental health care within primary care services, train new behavioral care workers with a priority given to psychiatric residencies, establish a federal Coordinating Committee to study the effect federal programs related to serious mental illness have on public health as well as a policy laboratory to study and promote evidence-based practices and service delivery models to mention but a few are likely to be undercut by the repeal of the PPACA including its expansion of Medicaid, increased reliance on Health Savings Accounts (HSAs) and switching Medicaid to a block grant scheme. For the goals of the 21st Century Cures Act to be realized Americans must be insured! Given Republican's antipathy to "mandates" and their assertion that individuals should be allowed to buy health coverage which best suits their needs, it is possible that plans entirely lacking MH/SU coverage will emerge on the market. Their stated goal of reshaping Medicaid into a block grant program is intended to hold federal expenditures flat. Mental health advocates must bear in mind that 60% of mental health services in the country are paid for by Medicaid and limiting its funds will have an adverse impact on access to as well as the scope of mental health services. The increased push for HSAs would be unlikely to benefit those with serious MH/SU given their low earning capacity and frequent inability to manage their budgets and lives.

Speaker Paul Ryan was recently quoted in The Milwaukee Journal saying that as a result of the transition from the ACA "no one (will be) worse off" than they currently are. That promise, while being viewed skeptically, should remain the Holy Grail of advocacy work in the years to come.

Recently rereading Albert Deutsch's "The Mentally Ill in America" reminded me that the words used by concerned citizens, professional and lay, to critique the public system of care for persons with serious mental illness, especially the poor, has little changed since Colonial times. The system has always been described as broken and gaining support for funding needed for improvement has always been a fight. Nevertheless, we who know the history of the field and who have worked or been involved with it over recent decades know true gains in the lives of persons suffering with serious MH/SU have been achieved.

Unfortunately, progress does not always advance in a straight, unbroken line. The period we are entering may be one during which advocates will need to expend their energies sustaining achievements realized. The American Psychiatric Association and NYSPA can be counted on to remain steadfast actors in the struggle collaborating with other advocacy organizations whose missions align around improving the care available for and lives of those with serious mental illness and substance use disorders.

On Behalf of our Board of Directors and the readership of *Behavioral Health News*
we wish to thank Dr. Barry B. Perlman for his many years of dedication and tireless efforts
in writing, organizing and editing "The NYSPA Report" in this Publication.

Through his efforts, the behavioral health community has gained an increased understanding of the role of psychiatry in the ever-changing landscape of healthcare services delivery and mental health supportive care.

Driving System Success During Times of Change

**By Andrew Cleek, PsyD,
Boris Vilgorin, MPA,
Caitlin Cronin, BA,
Dan Ferris, MPA,
and Meaghan Baier, LMSW**

The adult New York State Behavioral Health System recently transitioned to Medicaid Managed Care. While everyone would acknowledge initial challenges and ongoing issues to be resolved, overall, the transition has been successful. This article will highlight the positive aspects of the transition and key challenges that remain with an emphasis on applying lessons learned to bolster additional system transformations.

More than a year after the Managed Care transition for New York City and six months for the rest of the state, the service system has remained largely intact. Consumers are receiving care, providers have not closed their doors en masse, and the foundation has been laid for a value-based payment environment.

Still, as with any system or policy change, New York's adult behavioral health system transition was not challenge-free. Adult behavioral health Home and Community Based Services, designed to meet the challenges faced by consumers with the most severe behavioral health needs, have encountered significant start up difficulties; there have been varying levels of success around consumer education across services; providers are managing an increased administrative burden; and billing issues emerged early-on and, while largely resolved, persist for some services.

As stakeholders at all levels work to remedy these issues, it is important to take a step back and consider how New York's adult behavioral health system made it through this remarkable period of transition and transformation largely intact. Other states have seen choppier waters during their respective health system transitions, specifically when shifting Medicaid behavioral health services into Managed Care. Learning from those who have gone before, New York State layered in robust policy and support efforts.

It is the authors' opinion that the following things led to the successful adult behavioral health system transition to Managed Care: stakeholder collaboration, government protections, open channels of communication, information dissemination, training and education, and starting early and proactive problem-solving.

Andrew Cleek, PsyD

Boris Vilgorin, MPA

Caitlin Cronin, BA

Dan Ferris, MPA

Stakeholder Collaboration

Stakeholders worked together during each step of the transition process to ensure widespread coordination and thorough consideration of details. Regular meetings occurred between the NYS Office of Mental Health, Office of Alcoholism and Substance Abuse Services, Department of Health (OMH, OASAS, and DOH, respectively), and Managed Care plans. OMH and OASAS solicited input while working out service logistics, even releasing the draft adult Mainstream and HARP Provider manual for feedback. Providers, as well as advocacy and training groups, contributed valuable perspectives throughout the process.

Government Efforts

Local and state officials worked determinedly in conjunction with CMS to shape regulations that would help, not hinder, while protecting providers and consumers alike. Specifically, New York State established consumer and provider protections including setting guaranteed rates for some services for two years, defined and required plans to contract with essential community behavioral health providers including Opioid Treatment Programs, required the use of state approved level of care criteria including the OASAS LOCADTR 3.0, and established a Medical Loss Ratio of 89%. Where possible, officials worked to minimize unnecessary or overwhelming regulatory work for providers. To this end, uniform billing and a 90-day transitional grace period for authorization for existing consumers were established. In addition to existing organizations and groups that support providers, the state recognized the need for specific Managed Care focused training and technical assistance and created the Managed Care Technical Assistance Center (MCTAC) to serve as a training and educational resource for all behavioral health agencies navigating system transformation.

Open Channels of Communication

Throughout the transition, providers and plans knew where to turn with their questions. State agencies created managed care teams and mailboxes which fielded and addressed concerns in a timely matter. MCTAC answered thousands of questions submitted to mctac.info@nyu.edu and several hundred more at or following up from training events. Regional Planning Consortiums (RPCs) led by Conference Local Mental Hygiene Directors (CLMHD) provided another resource and forum for questions and problem-solving.

Information Dissemination

Participants were kept informed through regular policy updates including what had been finalized as well as what decisions required further discussion or approval. MCTAC worked with stakeholders to disseminate a weekly clearinghouse with information about regulations, trainings, and resources. Managed Care plans worked with and shared information with MCTAC and directly with providers, including making representatives available at numerous public forums and training events. Finally, through tool and resource development, critical information was distributed widely, including tips for contract negotiation, utilization management requirements, submitting clean claims, and Medicaid Managed Care plan contact information. This prevented duplication of work so that provider resources and time could be more valuably allocated.

Training and Education

Education efforts helped people understand the influx of information being provided to them. Based on provider feedback and need, MCTAC worked with government officials and Managed Care plans to create tools, trainings, and other educational resources including a Managed Care readiness assessment. The readiness assessment allowed providers to benchmark their internal strengths and needs while in-person and web-based trainings helped them understand the transition and how best to adapt.

Starting Early and Proactive Problem-Solving

Last but certainly not least, success hinged on the incredible efforts of providers and managed care plans. As encouraged by the state, getting an early start proved to be a critical component for individual agencies and plans alike. Many who opened channels of communication early found that the contracting process went more smoothly. Agencies that participated in claims testing identified and worked out some common problems before Managed Care went live. Organizations that created integrated transition specific teams to spearhead organizational and clinical changes improved internal efficiency and knowledge. Overall, the providers that believed the transition was closer than it appeared and who acted on that belief better understood and adapted to the changes.

In closing, while substantial work remains, behavioral health providers, managed care plans, government officials, and consumers can look with cautious optimism toward further system changes on the horizon. The lessons learned and commitment to a strong behavioral health system through collaboration, communication, and education give great hope as future transitions including the Children's Behavioral Health System and Value Based Payment, get underway.

Credits: Andrew Cleek, PsyD, is the Executive Officer; Boris Vilgorin, MPA, is the Health Care Strategy Officer; Caitlin Cronin, BA, is a Project Associate; Dan Ferris, MPA, is the Assistant Director, Policy and External Affairs; and Meaghan Baier, LMSW, is a Research Scientist. All authors are affiliated with the McSilver Institute for Poverty Policy and Research at NYU Silver School of Social Work. Our apologies that a photo of Meaghan Baier was not available by the press date of this issue.

The New Normal: How We Learned to Love and Understand Data

By Elisa Chow, PhD, and Chris Copeland, MSW ICL

Data. The world today is all about data. With the transformation of the Medicaid payment system into a more value-based approach, the need for understanding data has taken a higher priority at many agencies, including ICL. Managed Care Organizations (MCOs) are making arrangements with agencies that can prove that their models of care result in improved health outcomes for clients. This value-based payment formula moves away from the more traditional fee-for-service models toward more financially risk-based arrangements. Outcome data will help transform agencies from a system in which the volume of services provided was prioritized to a system in which the outcomes from the services are foremost. Since ICL claims People Get Better With Us, how do we prove to the world that statement is correct? The answer lies in our data and the outcomes we can interpret from the information contained therein.

Improving the U.S. health care system requires simultaneous pursuit of three aims: improving the experience of care, improving the health of populations, and reducing per capita costs of health care. With that in mind, Managed Care Organizations and Behavioral Health Agencies must work together to achieve true system reform. How does data play into that? Quality outcomes can only be demonstrated with data—reliable data, aggregated from the client level.

Agencies have always collected data; however, this data was often locked in paper records and couldn't be used in the aggregate, meaning for example, it couldn't be gathered and then broken down according to gender, borough of residence, which managed care they use, or some other criterion. As Electronic Health Records (EHRs) grew, the power to collect data grew along with them. But much of the information was still not available beyond the client level—it couldn't be easily presented in a way that had meaning and was useful to staff to enable them to make program-wide decisions. Furthermore, the information was often incomplete and therefore considered too unreliable to be useful beyond its function as an individual's medical record.

So the question then became: How do traditional agencies use existing technology to produce data that can be trusted and used to demonstrate outcomes? The traditional use of EHRs allowed for individual client health records and for billing. Any aggregate data was usually only available to specialist users—such as finance and data analysts. System reform created the need for all staff to be able to use and understand the information being recorded. One crucial strategic step was to democratize the data, making it meaningful and useful to the staff who are working with program participants and can put those numbers to their best use.

Elisa Chow, PhD

ICL recognized the need for a data revolution a number of years ago when it implemented an EHR in a way that could gather data specific to outcomes that would be needed to demonstrate value, such as emergency room visits and quality-of-life indicators. This proactive approach led to the creation of today's Live Data Dashboard, which is changing the way data is used and understood, and aiding in the agency's goal of working with MCOs to demonstrate the outcomes of our work. The Dashboard is updated daily and staff can access it from their desktops. The data provides an understanding of services provided—whether it's program-wide or specific to an individual.

Chris Copeland, MSW

The ICL Dashboards help staff, from Supervisors and Program Directors to the Executive Team, track program goals and understand treatment patterns, noting correlations between services and health outcomes. The data can be isolated to show patterns for the agency, a particular program, or an individual client. Additionally, clinicians can begin to set benchmarks for their program participants and track their recovery. These benchmarks become crucial as both clinical and management-level tools in that they can be used to make sure each person who's part of, say, an ACT Team is getting all their required services or they can be used so that clinicians can track and monitor an individual's progress toward achieving his/her goals.

So how does the data accessible in these Dashboards help individual program participants? How is the data that's presented responding to the needs of system reform? Let's take a look at one individual named Kevin. Kevin is a 20-year-old African American male with a diagnosis of schizophrenia. He resides with his mother in a shelter. Kevin has had multiple psychiatric admissions due to not taking his medication as prescribed, has difficulties accessing the proper healthcare, did not graduat`e high school, admits to recreational marijuana use, and often isolates himself from contemporaries.

Kevin came to the ICL ACT Team in 2015. His team, comprising a psychiatrist, nurses, family specialist, vocational specialist, peer specialist and substance specialists, recorded the services he was initially receiving, which concentrated on mastering daily living activities, medication management, school and employment training, and problem solving. As his treatment progressed, staff added substance use, wellness and relapse prevention, and empowerment and self-help services. At the same time, staff entered into the EHR any incidents of ER and hospital use, as well as Kevin's quality-of-life indicators.

Therefore, in addition to the pattern of changing services, we are able to see an increase in his quality-of-life responses over this time on the Dashboard. When first questioned in April 2015, Kevin felt he wasn't connected to family or friends, he didn't engage with mental health treatment, and he wasn't pursuing any primary care doctors either. A year later, after being able to track and appropriately enhance the services he was receiving, Kevin now responds that he is well connected to family and friends, is following the advice of his mental health practitioner, and has started seeing a primary care doctor. Over the course of that same year, Kevin's hospital admission and emergency room visits for mental health reason decreased substantially. Being able to demonstrate both the service pattern and the associated outcomes on the Data Dashboard allows ICL to demonstrate the quality of its treatment.

So with an eye to the future of healthcare, ICL has harnessed the data within its EHR into an interactive Data Dashboard that gives staff the ability to understand all the nuances of the information it stores. The data elements range from census and individual life details through services and specific outcomes measures. This enables ICL to measure much more than what we have done—it enables us to understand the relationship between services and outcomes. The data is now accessed nearly every day by the people working directly with program participants as well those who help to create macro changes within the agency so that we can continue our mission and prove that People Get Better With Us.

Quality of life questions	22-Apr-15	20-Oct-15	18-Apr-16
Deal effectively with problems	Neutral	Neutral	**Agree/Strongly Agree**
Have Control of their life	Agree/Strongly Agree	Agree/Strongly Agree	**Agree/Strongly Agree**
Improved Quality of Life	Neutral	Neutral	**Agree/Strongly Agree**

The data from ICL's Dashboards effectively shows a decrease in a program participant's hospitalizations and an increase in his quality of life outcomes.

Credits: Elisa Chow, PhD, is Director, Innovations, Outcomes and Evaluations; and Chris Copeland, MSW, is Chief Operating Officer, at ICL.

WellLife Network – A New Name and Strategy Reflects New Priorities and Directions for Leading Health & Human Services Agency

By Staff Writer
Behavioral Health News

It's a time of change, challenge and an opportunity for accomplishment. For individuals and families coping with a wide range of mental health, intellectual disabilities and drug addiction issues, human service agencies continue to seek viable solutions while facing new scrutiny from government and other funding sources on how to measure results, maintain efficiency and improve service delivery. Reflecting these new priorities is WellLife Network.

"The WellLife Network," formerly known as PSCH/Pederson-Krag, has announced the launch of a rebranding campaign, beginning with the introduction of a new name and logo – the first of a number of exciting new initiatives that are intended to broaden public awareness about the agency's mission and work, expand its fundraising base of support, and strengthen relationships with existing partners in government, business and the voluntary sector.

"For some 80 years, WellLife Network has been an integral part of the New York and Long Island community, providing vital services to those who are among our most vulnerable citizens," said Alan M. Weinstock, CEO, WellLife Network. "Our new name and logo more clearly convey the vitality, purpose and essence of the WellLife Network mission - *to empower individuals and families to realize their full potential for achieving meaningful goals, guided by principles of independence, health, wellness, safety and recovery*."

WellLife Network provides life skills opportunities to its group home residents

Cooking for the House Family Gives Farah Fulfillment

We see the results of our efforts every day, often in small, simple ways: Farah, one of our more than 1,100 residents with an intellectual/developmental disability or mental health challenge, enjoys cooking in her residence kitchen each morning. From scrambling eggs to baking chocolate chip cookies, Farah is the lead cook to four of her "sisters" – the residents in the Queens home they share. "I learned to cook for everyone in the house. I like that people really like my food, it makes me happy." Each day they gather around the dining room table to exchange stories and prepare to begin a new day of experiences. They are family, five active participants of the more than 1,400 individuals with a developmental disability for whom the WellLife Network provides a warm, nurturing and safe living environment. The home direct service professionals who manage the house are central to the family and bring the caring and loving services that transform a house to a home.

A Network of Programs Serving New York and Long Island

WellLife Network operates its programs in over 300 locations across New York City and Long Island. A dedicated and skilled workforce of over 1,800 staff, volunteers, interns and consultants assists it in delivering high quality and highly-accountable services. "The agency's multidisciplinary approach and centralized referral process helps to ensure that each person served receives the appropriate range of services and level of care," said Shavone Hamilton, Chief Operating Officer. "Each person receives a mutually agreed upon individual treatment plan, coordinated by highly competent and supportive case management professionals."

"The need for WellLife Network services has never been greater," said Hamilton, "As New York State embraces technology to redesign its vast and costly health care system to integrate and manage care, government at all levels faces reduced revenues and an aging and more chronically disabled population. We are implementing a data warehouse that will deliver information that combines clinical, financial, quality, cost and patient experience data and which highlights our organizational performance relative to peers and national benchmarks."

The work of WellLife Network is reflected in our vision: To create and provide necessary services that allow and encourage individuals with a mental illness, developmental disability or substance abuse issue live full, active lives within the community.

Triumph from Adversity

Jonathan, 36, was a man who faced many challenges. He fought mental illness almost all of his adult life. He was depressed and had little hope for a better future when he first came to WellLife Network. He still did not have any direction after being released from a state psychiatric hospital. With the assistance of caring case managers and counselors, Jonathan started talking to his doctors and attending his day program. Although he was nervous, he started getting accustomed to attending groups; and he also started expressing himself, and this made him feel better. Jonathan took control of his life, went to community college and trained to become a peer to help others who have been facing mental health issues. Jonathan has more goals to accomplish. He has his driving permit and will soon be taking his road test. He is saving money to buy a car so he can take his roommates shopping, go to his program, and socialize, instead of staying home all day. Jonathan has also been actively looking for employment, which is his present goal.

He is taking control of his life with the help of his clinical team, the supervision of WellLife Network and just the will to do better – and he is living a good life, once again. Jonathan said, "I am so grateful for the opportunity to have a good place to live and the help I get is wonderful. Thank-You WellLife Network."

Partnerships that Make A Difference

WellLife Network has been inspired by a committed board of directors, dedicated staff, caring volunteers, respected collaborations with partners, the many individuals who support our work, and most importantly by the 5,500 people who each day seek our assistance.

WellLife Network is proud of its services to 25,500 New Yorkers each year and its leadership role in the development of new models of care. Our broad network of high quality, outcome-based health, disabilities, youth, family, housing, addiction recovery and community education services are supported by a robust infrastructure and sophisticated technology platforms. WellLife Network will increase our scale and capabilities to thrive and grow in a changing health care environment and will allow us to compete more effectively and with sustainability in the health and human services arena. WellLife Network's vision of the future is based on the following tenets:

• *Compassion/Caring* – the understanding, support, guidance and dedication of an outstanding staff, whose expertise and experience is augmented by a cadre of generous and devoted volunteers;

• *Partnerships* – comprehensive, integrated programs built upon the deep and long standing partnerships WellLife Network has developed with the public, private and voluntary sectors;

• *Fiscal Responsibility* – WellLife Network will have a break-even budget for 2016 and has completed a long-term debt restructure that will provide a strong basis for implementing a five-year strategic reduction of administrative cost.

Sherry Tucker, CFO, WellLife Network, stated, "This is a time of rapid change and transformation in the health and social services sectors, as New York State and other funders, both public and private, transition to new service models. WellLife Network's realigned service areas – which include Health, Disabilities, Youth & Families, Housing, Addiction Recovery and Care Coordination – position the agency to maintain its leadership role as a dynamic partner and solutions provider to our funders, and to continue to make a difference for all New Yorkers in assisting them to *be well for life*."

For more information visit WellLife Network at: www.WellLifeNetwork.org or call 866.727.Well

Transforming Behavioral Health Systems of Care to Improve Outcomes and Promote Value

By Richard Elorreaga, Vice President of Optum Behavioral Direct Sites Optum

Many state and county Medicaid programs are considering the implementation of managed care models in their behavioral health care systems in order to ensure consistent quality outcomes for their residents with a mental health condition or substance use disorder. As a national leader in managed behavioral health care services, Optum has helped states and counties transform their behavioral health service systems to provide clinically effective, and cost-effective, evidence-based and person-centered care for their populations.

Transitioning to a managed system of care requires coordinated efforts among all local stakeholders, and Optum recommends a four-step framework for supporting this transformation. This includes: 1) ensuring clinical excellence; 2) establishing partnerships with covered members, families, and communities; 3) collaborating with providers; and 4) enhancing and expanding programs and services. This approach has helped states and counties improve the quality of care, as well as increased the satisfaction among those who receive and provide clinical services.

In order to ensure clinical excellence, it is important to promote the use of evidence-based best practices that have demonstrated positive outcomes. Multiple states, including Utah and Idaho, have implemented managed care solutions and partnered with Optum to promote evidence-based guidelines across their programs and services. This approach is fostered though consultation and education to assist behavioral health and primary care providers on the implementation and adoption of these guidelines.

As an example of improving clinical services, Optum has implemented effective outreach and access resources through crisis lines that provide clinician availability 24/7 in select areas. These services help facilitate the referral of people in mental health crisis to effective treatments that promote evidence-based care and support recovery. In San Diego County, California, Optum's management of the access and crisis line has been commended by Michael Reading, Board Chair of CONTACT USA, a leading organization that accredits crisis line services.

Clinical excellence is also achieved through partnerships with covered members, their families, and communities. Optum has recognized the need for empowering people to play a key and decisive role in their behavioral health. Engagement in care is promoted through the involvement of members and their families in the development of resources and strategies to foster recovery and resiliency. For example, Optum has conducted trainings across the state of Idaho with covered members and their families on the key role they have in effective care planning. Furthermore, in both urban and rural communities across the state, Optum has conducted Mental Health First Aid training to help community members learn how to recognize and better understand someone who is experiencing a mental health crisis. This training also enables community stakeholders—including those working in social services, law enforcement and first responders, school faculty, and others—to help people in crisis access the appropriate behavioral services they need.

Transforming systems to managed care models also requires effective provider collaborations. One way Optum achieves this is by working with local provider organizations to develop joint advisory committees that are actively involved in the identification and implementation of evidence-based and person-centered services in the community. When gaps in services are found, Optum works with providers in these identified locations, to provide the necessary training and education, as well as the design and implementation of new service programs, in order to fill the need.

Optum has found that such partnerships are greatly valued by the providers themselves, as they are able to actively participate in improving their services and outcomes. In Idaho, Kim Dopson, former Clinical Director of Proactive Advantage Behavioral Health (a community-based network provider), has reported that "Optum Idaho has been an excellent proponent and accessible partner in supporting the transformation of our practice, our providers and our profession. Transforming the mental health care system in Idaho has meant applying national best practices that are grounded in recovery-focused, evidenced-based treatment."

Enhancing programs and services involves the expansion of resources for covered members, including peer support services, level-of-care transition programs, and community-based supports, among others. As an example, peer support services have been recognized by the Substance Abuse and Mental Health Services Administration (SAMHSA) for increasing a person's likelihood of mental health and substance use recovery. These services are provided by individuals who have personal experiences with mental health or substance use conditions, and are trained and generally certified to use their experiences to engage and support

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Final Registration Deadline - May 30, 2017

Proceeds from this event will go towards expanding and developing the nonprofit educational mission of Mental Health News Education, Inc., publisher of Autism Spectrum News and Behavioral Health News, via print and online media to reduce stigma, promote awareness and disseminate evidence-based information that will serve to improve the lives of individuals with mental illness, substance use disorders and autism spectrum disorders, their families, and the provider community that serves them.

For more information contact Ira Minot, Executive Director, at (570) 629-5960 or iraminot@mhnews.org

Beacon's Unique Staffing to Facilitate System Reform in New York State

By Jorge R. Petit, MD
NYS Regional Senior Vice President
Beacon Health Options

Since 1997, Beacon been a valued partner and thought leader for managed care plans, local and state agencies, and provider and consumer stakeholder groups in New York State, enabling Beacon to execute programming that achieves the intended goals of New York's Medicaid Redesign Team.

Our partnership and development efforts in preparation for Qualified Medicaid Plans (QMP) and Health and Recovery Plans (HARP) began when Beacon partnered with Hudson Health Plan to develop the Westchester Cares Action Program (WCAP), a New York State Department of Health (DOH) funded Chronic Illness Demonstration Project beginning in 2009. This project focused on Medicaid FFS recipients having 2 or more chronic illnesses, both medical and Behavioral Health in nature, who had demonstrated poor engagement in preventive treatment and relied on the Emergency Department for Primary Care. WCAP was the only health plan based demonstration project, and it used an innovative, field based case management model featuring an interdisciplinary team comprised of nurses, Social Workers, and Peers. WCAP helped more than 250 recipients manage their chronic medical and

Jorge R. Petit, MD

Behavioral Health conditions; furthermore, WCAP promoted recovery goals by securing permanent housing, clothes, furnishings, employment and vocational training. In its first two years of operation, WCAP reduces inpatient hospitalizations by 55 percent for individuals who remained enrolled in the program. WCAP remains operational today as a Case Management Agency (CMA) for Health Homes. In 2011, Beacon participated in a Regional Behavioral Health Organization (RBHO) in Western New York. The purpose of the RBHO was to conduct Managed Care preparedness activities for Medicaid Fee-For-Service (FFS) providers. These activities included utilization review and care coordination initiatives designed to promote better treatment quality, comprehensive discharge planning, and improved outcomes through preventive, community based treatment.

Beacon's extensive collaboration through the years with the New York State DOH, Office of Mental Health (OMH), Office of Alcohol and Substance Abuse Services (OASAS), and Local Departments of Social Services (LDSS) on innovative initiatives like the RBHO and WCAP has sharpened our understanding of the critical components for success working with complex populations in New York's fragmented service delivery system. As a result, Beacon has been successful in operating as the fully delegated behavioral health partner for ten (10) health plans who serve HARP members. Eight of these plans operate HARP and QMP plans, and the remaining two are HIV SNP plans with HARP eligible members. Beacon currently serves approximately 30% of the eligible Medicaid adults statewide and has been instrumental in ensuring the provision of Home and Community-Based Services (HCBS), designed to provide an individual with a specialized scope of recovery-oriented, person-centered support services not previously covered under the State Plan Medicaid services. These HCBS are designed to allow individuals to gain the motivation, functional skills, and personal improvement to be fully integrated into his or her community.

During the Medicaid redesign and transformation process and since QMP/HARP inception, Beacon has contributed thought leadership and close collaboration with our State partners and the many stakeholder and provider groups to design, operationalize, and implement the complex behavioral health service delivery system transformation as envisioned by NYS. Accordingly, since the implementation of and as a response to the creation of HARP, Beacon has created several unique staff positions that work with the provider community and assist/facilitate in these transformation activities; these positions include the Provider Clinical Liaison Specialists (PCLS) and the Manager, Provider Partnerships (MPP).

Provider Clinical Liaison Specialists (PCLS)

Beacon's PCLS outreach, train, and support newly designated Home and Community-Based Services (HCBS) providers and work to support and oversee Health Home Care Coordinators in referring members to HCBS. In this role,

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Mary Pender Greene, LCSW-R, CGP, is the President & CEO of MPG Consulting. She is a psychotherapist, career & executive coach, trainer and consultant with a private practice in Midtown Manhattan. She isa thought leader in the social services industry, recognized by her peers for her novel ideas on coaching, training and mentoring. She has 20+ years of experience helping individuals, couples, companies and non-profit organizations. MPG Consulting provides culturally competent and anti-oppressive (anti-racist, LGBTQ affirming, non-sexist) coaching and professional development to individuals at all levels, and specializes in working with senior management and executive leaders.

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Fight Against Threats to Behavioral Heath Funding

By Michael B. Friedman, LMSW
Adjunct Associate Professor, Columbia University School of Social Work

The Trump presidency and Republican control of the Congress may do great damage to the already inadequate American mental health system by repealing the Affordable Care Act, eliminating Medicaid as an entitlement, privatizing Medicare, and limiting the authority of the states to regulate health insurance.

The Affordable Care Act

The Affordable Care Act (ACA) has provided important benefits for people with mental and substance use disorders who previously were unable to pay for treatment. Through expansion of Medicaid and the creation of health care exchanges designed for small businesses and individuals to be able to purchase health insurance at more reasonable prices than previously possible, 20 million people now have health insurance coverage who did not have it before the ACA. Their insurance is mandated to include coverage of mental and substance use disorders, coverage that was not previously required.

Although prior to the ACA, most employer-based health plans covered some behavioral health services, only 61% of private individual health plans had any

Michael B. Friedman, LMSW

mental health coverage and only 54% had coverage for addictions. And mental and substance use disorders were among the pre-existing conditions for which health coverage could be denied or sold at very high prices. Because of this new requirement, about 12 million people who had health insurance but without behavioral health coverage before the ACA now have it.

In total, roughly 32 million people have behavioral health coverage now who did not have it prior to the ACA.

In addition, the ACA spelled out, and required coverage of, a range of benefits, such as rehabilitation, that are essential for positive outcomes. And it included efforts to close the cracks in the American health system by integrating physical and behavioral health care. And more.

Medicaid

Medicaid is the single largest source of funding for behavioral health services, paying $54 billion of $220 billion spent on mental health and substance abuse services in 2014 (Private insurance covered a tad less, $53 billion). And it has grown considerably over the years from 16% to 25% of behavioral health funding. Medicaid is now the lifeline for almost everyone with a long-term behavioral health condition and for many others with less severe disorders who otherwise would have no coverage.

What would happen if the Republicans succeed at turning Medicaid into a block grant program? It is arguable whether state Medicaid programs would be better or worse with fewer federal controls. But it is not arguable that it would become far more difficult to make inroads in the vast unmet need for behavioral health services if Medicaid is no longer an entitlement. Keep in mind that currently 60% of people with behavioral health conditions do not get treatment. Constraints on federal funding for Medicaid would at best stop the growth of funding for behavioral health services and at worst would allow states to roll back Medicaid funding altogether.

Hospitals and other organizations that provide behavioral health services to people without adequate coverage would be particularly at risk. Medicaid has not only provided coverage for many of their patients; it has also provided mechanisms such as "disproportionate share" to help them deal with deficits due to non-payment of fees. Loss of mechanisms of this kind threaten the survival of hospitals and community behavioral health organizations if expanded coverage under the ACA is eliminated.

Medicare

Medicare has grown as a funder of behavioral health services from about 7% in 2004 to 14% in 2014, so that it now is close to reflecting the proportion of the population that has Medicare. As the older population doubles over the next couple of decades, Medicare will become a more and more significant payer—unless, of course, the program is gutted in the way that Speaker Ryan has proposed. Providing funds to individuals to choose among competing Medicare plans would effectively end Medicare as an entitlement, and if, as is likely, federal vouchers or tax

see Funding on page 28

MHA of New York City Names Kimberly Williams New President

By Staff Writer
Behavioral Health News

The Mental Health Association of New York City, a national leader in mental health services, advocacy and education, recently announced that Kimberly Williams, MSSW, has been named the new President of the organization. The appointment is effective January 1, 2017. Williams takes over from Giselle Stolper, the President and CEO of MHA-NYC who shared with the board her desire to retire at the end of the year.

"We are thrilled that Kim is taking the reins at MHA-NYC," said Chairman of the Board Kevin Danehy. "We had big shoes to fill following Giselle's tenure during which MHA-NYC experienced years of unprecedented growth and success. After an extensive and extremely thorough search process we found that the best person to move us forward was right here on our team."

"Kim's vision, knowledge and commitment are just what MHA-NYC needs for its next generation of leadership," Stolper, who is retiring after serving for almost 27 years said. "As the health and behavioral health care systems continue their rapid transformation I am thrilled that our organization has the perfect person at the helm to manage that change and continue our outstanding track record as an innovator in the field."

Kimberly Williams, MSSW

Williams first joined MHA-NYC in 2004 working on the Geriatric Mental Health Alliance of New York (GMHA) of which she then became director. She has since become one of New York State's and the nation's foremost leaders in mental health advocacy. She is the chair of the National Coalition on Mental Health and Aging, a member of the New York State Interagency Geriatric Mental Health and Chemical Dependence Planning Council, and is a member of the Board of Mental Health News Education, Inc., currently serving as Treasurer. At MHA-NYC Williams has most recently served as Vice President of the Center for Policy, Advocacy and Education and then as Executive Vice President of Integrated Policy and Program Services. Williams has been recognized for her talent and leadership by being named one of the 40 under 40 Rising Stars by NYN Media in 2015 and in receiving the Staff Leadership Award from the Mental Health Association in New York State in 2013.

Williams, who received her Master of Science in Social Work from the Columbia University School of Social Work, has been an adjunct lecturer at the NYU Silver School of Social Work, the Silberman School of Social Work at Hunter College and at Columbia University on mental health policy. She resides in Brooklyn with her husband Dan and son Jackson.

"It is an honor to be elected President by the Board of Directors of MHA-NYC and I thank them for their trust and confidence in me," Williams said. "I have always been so proud of the work we do every single day and I am excited about the tremendous possibilities that exist to build and expand on that work to meet the new challenges ahead and continue to provide help and hope to the millions of people in this City and across the nation who need us."

MHA-NYC is a non-profit organization with local roots and a national reach that for over 50 years has been leading the way in mental health with our three-part mission of service, advocacy and education. Our mission is to identify unmet needs and develop culturally sensitive programs to improve the lives of individuals and families impacted by mental illness while promoting the importance of mental health. We break down barriers by providing care directly to those who need it, with state of the art telephone, text and web based technologies to respond to community needs where and when that help is needed. We work every single day to save lives and assist those in crisis while providing millions more with the help they need before a crisis can occur. www.mhaofnyc.org

Systems Transformation in Progress: Promise and Pitfalls

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

A couple of months ago I attended a conference in Albany in order to learn of the latest developments in the state's movement toward a "value based" healthcare delivery system. Monica Oss, Chief Executive Officer of Open Minds, a publication that explores the intricacies of behavioral healthcare, was on hand to deliver the keynote address and to field questions concerning transformational initiatives presently unfolding throughout the country. When asked what, if anything, is unique about New York's approach to behavioral healthcare reform she offered a succinct assessment that validated the anxieties many of us have carried for some time. "New York," she said, "is trying to do everything at once." Whereas other states have adopted more incremental approaches to reforming their publicly-funded healthcare systems, the Empire State has embarked on an ambitious (some might suggest grandiose) plan through numerous concurrent initiatives that can easily confound the most studious policy wonks. To understand these initiatives, their current status and potential to effect meaningful improvements for behavioral health service recipients one must heed the counsel of W. Mark Felt, special agent for the F.B.I during the Nixon Administration. Acting as "Deep Throat," perhaps the most celebrated informant in our nation's history, he offered investigative reporters Bob Woodward and Carl Bernstein the leads they needed to expose criminality within the White House. "Follow the money," he said. We should do the same.

When Governor Cuomo took office in 2011 he inherited the most expensive Medicaid program in the nation. At $53 billion per year it constituted the largest item in the state budget. Despite expenditures at twice the national per recipient average this program produced mediocre results by many measures. New York ranked 50th in potentially preventable hospital readmissions and only slightly better in other key performance indicators (New York State Department of Health, 2011). Reform of a grand and transformational nature was clearly in order. The Governor appointed a Medicaid Redesign Team (MRT) to conduct a comprehensive review of the program and to offer recommendations that would achieve the vaunted Triple Aim of healthcare reform. That is, they should produce better outcomes for individuals, improved health for the overall population and a reduction in costs essential to ensure the long-term viability of the program. Many of the transformational initiatives presently underway originated in the MRT and were borne of the noble intent to bend the cost curve and promote the welfare of service recipients. The simultaneous integration of these initiatives within the current landscape of healthcare services requires an attention to innumerable complexities and consequences (both intended and unintended) that would leave Rube Goldberg in awe. Nevertheless, these initiatives contain some overlapping themes and objectives through which we can acquire a better understanding of their potential to effect lasting change.

Ashley Brody, MPA, CPRP

Our healthcare financing systems have relied heavily on "fee-for-service" (FFS) approaches that reimburse providers for services delivered irrespective of the quality or outcomes of their interventions. Although commercial insurance providers have imposed a variety of cost containment measures designed to curtail runaway spending, our publicly-funded insurance programs (Medicaid and Medicare, in particular) have been largely exempt from these measures. Medicaid and Medicare recipients have been free to see providers of their choosing and to receive services of whatever frequency, scope or duration their providers deem necessary. It is unsurprising such a system should incentivize "volume" over "value" and produce an unsustainable increase in expenditures. Healthcare accounts for 17.8% of our Gross National Product, more than twice that of other industrialized nations, but we have enjoyed only modest returns on this sizable investment (Centers for Medicare and Medicaid Services, 2015). Herein lies the paradox of American healthcare of which New York is simply a microcosm. More money does not produce better results. The transformational initiatives described below have been adopted to address different dimensions of this fundamental paradox, and although they are in the incipient stages of implementation we can render a preliminary appraisal of their progress.

Managed Care For All

A central recommendation of the MRT was the replacement of a FFS system with a coordinated approach that would effectively manage both service delivery and reimbursement for all Medicaid-funded services. This recommendation formed the basis of a "Waiver" NYS submitted to the Centers for Medicare and Medicaid services (CMS), the federal agency charged with oversight of the Medicaid program. (Inasmuch as Medicaid is administered jointly by the federal and state governments substantial changes within individual state plans require federal approval.) In its approval of our state's Waiver the CMS authorized the administration of Medicaid-funded healthcare benefits (including behavioral health) by privately-operated Managed Care Organizations (MCOs) that would promote newfound efficiencies. MCOs would achieve their objectives via improved coordination of care (especially for recipients with chronic and complex service needs) and "capitated" (i.e., fixed) payments to service providers that would neutralize the moral hazard inherent in FFS models. More services would not produce more payments. This new paradigm should induce providers to deliver better outcomes with the same (or fewer) services and generate newfound efficiencies within the healthcare system. A "Value-Based" system would surely follow. Auspicious as this turn of events might seem, we cannot ignore certain challenges in implementation and the various unintended consequences of such an ambitious undertaking.

In October, 2015 Medicaid-funded behavioral health benefits previously reimbursed on a FFS basis were included in Managed Care within the five boroughs of New York City. An expanded package of Home and Community Based Services (HCBS) became available to select service recipients shortly thereafter. A similar sequence unfolded in the "Rest of State" (ROS) in 2016, and as of this writing the majority of Medicaid-funded behavioral health benefits are administered by MCOs through contracts with their service providers. By some accounts this transition has not been as disruptive as many had feared, but it is far too premature to celebrate its success. Despite a rigorous qualification process through which MCOs were required to demonstrate their readiness to administer Medicaid-funded behavioral health benefits many of these organizations have experienced difficulty in properly processing provider claims during the transition. Similarly, provider organizations (many of which have operated in FFS environments exclusively and are unfamiliar with the intricacies of Managed Care) have often been slow to adopt the management infrastructures necessary to flourish in this new environment. Expertise in contract management, claims processing, utilization management and review, revenue cycle management and related subject matters is essential to successful partnerships with MCOs. Such expertise is well beyond the ken of many organizations, especially smaller community-based agencies that form the backbone of the delivery system for our most vulnerable citizens. It is therefore not surprising this

see Promise on page 26

CCBHC as a Roadmap for Behavioral Health Leadership and Participation within Accountable Delivery Systems

By Heidi Arthur, LMSW, Principal, and Kristan McIntosh, LMSW, Senior Consultant, Health Management Associates (HMA)

Heidi Arthur, LMSW

Kristan McIntosh, LMSW

Uncertainty about the future state of publicly-funded health care is widespread following the presidential election. However, the design of accountable delivery systems committed to comprehensive, cost effective care continues to have bipartisan support. Such systems demand a full array of health, behavioral health, and social services supports, yet behavioral health and human services providers must be strategic in order to ensure effective engagement in the transformation.

Behavioral Health is Not Yet Fully Integrated within Accountable Care Efforts

An accountable delivery system is comprised of a wide array of providers that agree to share responsibility for care delivery and outcomes for a defined population (Kaiser Family Foundation, Medicaid delivery system and payment reform, 2015). Within the accountable care network, funding for health care is capitated and providers ultimately share in both risk and savings, with the goal of promoting value by improving care and reducing costs. Such systems bear financial risk for health care quality and outcomes, and are thus incentivized to more effectively—and efficiently—use the full array of social services and supports that will maximize the impact of interventions on patients (Mahadevan, R., & Houston, R., Supporting Social Service Delivery through Medicaid Accountable Care Organizations, 2015).

Too often the role of behavioral health is limited within these accountable delivery systems**.** Although most Accountable Care Organizations (ACOs) hold responsibility for some behavioral health care costs, integration of behavioral health and primary care remains low, with most ACOs pursuing traditional fragmented approaches to physical and behavioral health care (Lewis, V.A., Colla, C.H., Tierney, K., Van Citters, A.D., Fisher, E.S., & Meara, E., Few ACOs Pursue Innovative Models That Integrate Care For Mental Illness And Substance Abuse With Primary Care, 2016). Often, behavioral health providers are considered clinical, non-network "specialty providers," resulting in siloed care planning limited to subcontracts with external behavioral health vendors (Kathol, R.G., Patel, K., Sacks, L., Sargent, S., & Melek, S.P., The Role of Behavioral Health Services in Accountable Care Organizations, 2015). Indeed, the majority of metrics to which payment and incentives are tied relate to primary care, and many ACOs are focused on addressing primary care referrals and patient behavior first, concentrating more on influencing rather than integrating behavioral health (Korenda, L., & Thomas, S., Integrating Specialty Care Into Accountable Care Organizations, 2016).

Examples of the Delivery System Evolution

To ensure robust participation in the delivery system of the future, including accountable systems that evolve from entities like health homes and DSRIP PPSs, behavioral health leaders are wisely

see Roadmap on page 29

Eda Franco New Director of the MHA of Nassau County

By Staff Writer
Behavioral Heath News

Several months ago, E. Eda Franco, LMSW, MBA, was appointed Executive Director of the Mental Health Association of Nassau County (MHA). She joins the MHA with a notable reputation in advocacy and behavioral healthcare.

Before joining MHA she distinguished herself as Deputy Chief Program Officer at the Center for Urban Community Services (CUCS). Prior to working with CUCS, Ms. Franco honed her social work skills, passion for helping others, and making a difference in the lives of the disenfranchised through her work at Bronx Addiction Treatment Center, the Bronx Psychiatric Center and Palladia, Inc. She is a New York State licensed social worker with a career dedicated to the fields of chemical dependency and mental health. She not only brings her passion for helping clients, she also strives to inspire her team as a motivational leader who has successfully led organizations in delivering evidenced based practices and client-centered services to those in recovery. Ms. Franco is a skilled leader with years of successful experience managing the financial and operational well being of a number of programs and organizations.

Ms. Franco holds a Master's Degree in Social Work from Hunter College and an Executive MBA from Pace University. Her Undergraduate degree is in Psychology from SUNY Old Westbury.

The youngest of five children, Ms. Franco was born to parents who immigrated in the mid-1960s to the United States from the Dominican Republic. She was born in the Bronx, raised in Queens, and also lived in Miami, Florida. She is a servant leader whose values and strengths come from her devotion to her Christian faith and role as a Baptist deacon and trustee. She also serves as the church treasurer. Ms. Franco is the mother of one child, Dominique and doting "Abuela" of Bryce.

Education and Training Offered at MHA Nassau County

MHA of Nassau County- Education & Training 2017

For updates and information on upcoming training opportunities, join our mailing list here: http://tinyurl.com/MHANC-ET and visit our website www.mhanc.org. For all other questions, please contact Yvonne at 516.489.2322 ext.1257 or ylyon@mhanc.org.

Upcoming Training Events

January 24 9AM- 5PM	**Effective and Audit Ready Documentation*** This all-day training will combine three key workshops into one module: Treatment Planning, Writing a Medicaid billable note and Collaborative Documentation. Presented by Laura Langner, Complete Compliance Solutions, LLC. **More information and registration will be available in the beginning of January*
January 27 9AM-6PM	**Mental Health First Aid** Mental Health First Aid is an 8-hour training certification course which teaches participants a five-step action plan to assess a situation, select and implement interventions and secure appropriate care for the individual. Presented by Jeanne Cacciatore, LMSW, MHANC's Director of Education & Training & Rachel Priest, MS,MHANC's Community Health Educator. **For more information & registration, please go to: http://tinyurl.com/mhanc1701**
January 30 9AM-12PM	**safeTALK** Learn four basic steps to recognize persons with thoughts of suicide and connect them with suicide helping resources. SafeTALK training prepares you to help by using TALK (Tell, Ask, Listen and KeepSafe) to identify and engage people with thoughts of suicide and to connect them with further help and care. Presented by Philip Schoppmann, S.C.P.D. / P.E.E.R. **For more information & registration, please go to: http://tinyurl.com/mhanc1702**
February 1 10AM-12PM	**Understanding Assisted Outpatient Treatment (AOT)** Assisted Outpatient Treatment (AOT) is court-ordered treatment for those individuals in the communities who meet strict legal criteria. Learn about the process and requirements for AOT for Adults in Nassau County, New York, and get answers to your questions about this program. Presented by Maura Gordon, MPA, LCSW-R, Director of Forensic Mental Health Services, NC DHS. **For more information & registration, please go to: http://tinyurl.com/mhanc1705**
February 6 10AM-2PM	**Consumer Forum & Legislative Prep-Day** An expert panel of peer specialists will discuss current hot topics in the community. What services are we missing? What policy changes are needed now? Join us for this all-inclusive community conversation. In addition, we will practice talking techniques to use with legislators, and answer questions. Presented by Jeffrey McQueen, LCDC, MBA, MHANC's Director of Consumer Link and Veterans Services. *Registration will be available shortly.*
February 14 1PM-3PM	**Hearing Distressing Voices** This a two-hour workshop provides a simulated experience of hearing voices that will enhance empathy and understanding of the day to day challenges that people with psychiatric disabilities face. Presented by Lucian Stolzer, LMHC,LPC , Regional Advocacy Specialist, LIFO- Office of Mental Health *Very limited space. Please call Yvonne at 516.489.2322 x. 1257 if you are interested in attending.*
February 21 10AM-5PM	**Motivational Interviewing with Cultural Competency & Trauma-informed Care** This all-day training event will tackle three of the big topics in behavioral health care. The morning session will provide you with an in-depth introduction to motivational interviewing and cultural competency. The afternoon session will focus on the meaning of trauma-informed care. Presented by Laura Langner, Complete Compliance Solutions, LLC. **More information and registration will be available in the beginning of February*
February 24 10AM-12PM	**EATING DISORDERS ON THE FRONTLINE** This workshop will address the multidimensional nature of eating disorders. The development and continuum as well as the functions and the purpose of eating disorders will be addressed. A special focus will be given to Binge Eating Disorders. Presented by Sondra Kronberg, MS, RD, CDN, CEDRD, Executive Director of F.E.E.D. *Registration will be available shortly.*
March 14 10AM-12PM	**Understanding Non-Suicidal Self Injury** This workshop will help you gain a deeper understanding of non-suicidal self-injury behavior; what it is and how it presents. Participants will gain a higher level of competency in order to effectively speak with clients about this behavior and assess level of risk. Interventions and treatment options will be discussed. Presented by Meryl Cassidy ACSW, LMSW , Executive Director, Response Crisis Center. *Registration will be available shortly.*
March 16 9AM-12PM	**safeTALK** Learn four basic steps to recognize persons with thoughts of suicide and connect them with suicide helping resources. SafeTALK training prepares you to help by using TALK (Tell, Ask, Listen and KeepSafe) to identify and engage people with thoughts of suicide and to connect them with further help and care. Presented by Philip Schoppmann, S.C.P.D. / P.E.E.R. **For more information & registration, please go to:** http://tinyurl.com/mhanc1703
March 17 9AM-6PM	**Youth Mental Health First Aid** Youth Mental Health First Aid is designed to teach parents, family members, caregivers, teachers, school staff, peers, neighbors, health and human services workers, and other caring citizens how to help an adolescent (age 12-18) who is experiencing a mental health or addictions challenge or is in crisis. Presented by Debra Caputo, MS.Ed., and Philip Schoppmann, S.C.P.D. / P.E.E.R. **For more information & registration, please go to: http://tinyurl.com/mhanc1704**
March 21 10AM-1PM	**Community Dialogue III- How Do We Help The Homeless?** We invite you to attend the third follow-up meeting of our popular Community Dialogue Meeting. Please join us for an exclusive presentation on the topic of Homelessness in Nassau County in collaboration with the NYS Office of Mental Health Bureau of Cultural Competence. We welcome your continued participation as we build the Regional Multicultural Advisory Committee (RMAC) designed to strengthen the communities' voice with regard to behavioral health services. *Registration will be available shortly.*

Please Mark Your Calendar for the Next Exciting Issue of Behavioral Health News

"Meeting the Needs of Our Vulnerable Populations"

Deadline: April 1, 2017 - Submit Early for Preferred Placement

Grassroots Advocacy: Addiction Recovery Support in New York State

By Robert J. Lindsey, CEO
Friends of Recovery New York

The recently released 413 page, Surgeon General's Report, "Facing Addiction in America – Alcohol, Drugs & Health," (the first report of its kind to focus on the public health crisis of addiction) is being compared to the 1964 Surgeon General's Report on Smoking credited with millions of lives saved. Similarly, in "Facing Addiction," Surgeon General Vivek Murthy has issued a Call to Action to end the public health crisis of addiction, which would also save millions of people.

The Surgeon General announced plans to write the report at the October 4, 2015, "UNITE to Face Addiction" rally on the National Mall in Washington, D.C.. The rally attracted tens of thousands of Americans in addiction recovery, their families, friends and other recovery allies intent on erasing the shame and stigma of addiction, eliminating discrimination and advocating for recovery-oriented attitudes, programs and services. Events like the UNITE rally and those held during National Addiction Recovery Month where recovery from addiction to alcohol and other drugs is publicly celebrated, have brought the reality of long-term recovery out of the shadows and on to the national stage.

In fact, Chapter 5 of the Surgeon General's Report, "Recovery - The Many

Robert J. Lindsey

Paths to Wellness," is dedicated to recovery and the critical need for community-based recovery support services. Almost a decade ago, the New York State Office of Alcoholism and Substance Abuse Services (OASAS) expressed the need to treat addiction as a chronic disease, not an acute health crisis, and recognized that efforts to support individuals and families required a major shift in how to promote and support long-term recovery. As a result, in 2007, OASAS created its Bureau of Recovery Services, established the Recovery Implementation Team (RIT) and began to focus on the development of a Recovery Oriented System of Care (ROSC). Regrettably, the investment of desperately needed funding to make this a reality, was unavailable.

Nearly ten years later, as a direct result of grassroots advocates standing up for recovery, great progress is being made. This year, New York's growing network of dedicated advocates and recovery organizations, inspired policymakers to provide funding for community-based Recovery Support Services (RSS) and here is how it is being implemented:

Recovery Community Organizations (RCOs): Recovery Community Organizations (RCOs) are independent organizations led by local recovery advocates (individuals in long-term recovery, their families and friends, recovery-focused professionals, or concerned citizens). According to the Association of Recovery Community Organizations (ARCO) at Faces & Voices of Recovery, RCOs "help to bridge the gap between professional treatment and building healthy and successful lives in long-term recovery. They increase the visibility and influence of the recovery community and engage in one or more of three core activities: 1) Educating the public about the reality of recovery, 2) Advocating on behalf of the recovery community, 3) Delivering peer-support services."

The first RCOs in New York, the Long Island Recovery Association (LIRA), established in 2000 and Friends of Recovery Delaware and Otsego (FOR-DO), established in 2004, and other local advocates have led the way. Today, there are fourteen active RCOs throughout the state and three (3) more are in development. Progress!

Recovery Coaching: Recovery coaching is a form of strengths-based support for persons in or seeking recovery. In most cases, the individual in or seeking recovery, focuses on their own program of recovery and the Recovery Coach helps the recoveree set and achieve important goals that support positive change. Current estimates indicate there are over 300 Certified Recovery Peer Advocates (CRPAs) and more than 350 Certified Addiction Recovery Coach (CARCs) in New York State. Without question, the value of peer recovery professionals is critically important to system reform and full implementation of the Recovery Oriented System of Care. Progress!

Recovery Community & Outreach Centers (RCOCs): Recovery Community & Outreach Centers (RCOCs) provide a community-based, non-clinical setting that is safe, welcoming and alcohol/drug-free for any member of the community.

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transitional period has been marked by frequent denials of payment, most notably for "specialty" behavioral health services such as Assertive Community Treatment and Personalized Recovery Oriented Services (New York State Office of Mental Health, Division of Managed Care, 2016).

This poses an economic threat to providers that will loom ever larger as certain "protections" expire at the conclusion of a 24-month transitional period. MCOs are currently required to offer contracts to virtually all Medicaid-licensed service providers and to reimburse them at prevailing Medicaid reimbursement rates. These requirements will eventually cease and "free market" forces will then govern contract negotiations. The long-term fiscal and programmatic implications of these trends warrant great concern and casualties are unavoidable. Financially fragile organizations and others that cannot adapt to changing demands will surely falter, as might the vulnerable individuals they serve.

Movement to value-based delivery and reimbursement systems poses additional challenges for service providers, particularly within the realm of behavioral health which encompasses an exceedingly diverse array of symptom classifications, diagnostic criteria, treatment approaches and expected outcomes. The behavioral health community has failed to achieve a consensus on valid and acceptable outcome measures, and there is widespread concern such measures could inadvertently penalize providers who elect to treat recipients with chronic or complex conditions. These recipients face innumerable challenges that cannot be ameliorated by conventional medicine alone. The social isolation and intractable poverty that often accompany serious mental illness and substance use disorders require innovative interventions that attend to the social and physical determinants of health, and outcome measurements for this population must be calibrated accordingly. An emerging body of evidence suggests "healthcare" (as it is traditionally defined) accounts for approximately 10% of our health status and the balance may be attributed to other factors including social context, environmental influences and personal behavior, among others (Asch & Volpp, 2012). Herein lies a clue to the aforementioned paradox of American healthcare that must be acknowledged if transformational activities are to achieve their intended goals. Our nation's exorbitant investment in healthcare has produced mediocre results because it fails to address the primacy of social determinants of health in the healthcare equation. According to 2009 data from the Organization for Economic Cooperation and Development (OECD) the U.S. spent $7,960 per person per year, whereas most other industrialized nations spent less than $4,000. Nevertheless, our nation lags far behind most others in key performance indicators of population health such as maternal mortality, life expectancy, low birth weight and infant mortality (Bradley & Taylor, 2013). This enigma is easily resolved when considered alongside our meager investment in social services relative to ten other "high income" countries (Squires & Anderson, 2015). Therefore, if transformational activities currently underway in New York are to achieve true value and approach the Triple Aim of healthcare reform they must consider both the constituent elements of "value" (i.e., health and social factors) and their influence on desired outcomes.

A Clinical Advisory Group (CAG) has been convened to establish appropriate outcome measures for the behavioral health service population, and its preliminary activities suggest it acknowledges the importance of social determinants in healthcare outcomes. The CAG has proposed to incorporate measures of recipients' educational and employment status, residential stability and social integration in holistic determinations of "value" (NYS Department of Health, 2016). This promising development signals a commitment to address root causes of enduring health disparities, but it must be embraced by a broad cast of actors within our health and social service systems in order to achieve its intended aim. It must also align with other reform initiatives currently underway.

Delivery System Reform Incentive Payment (DSRIP) Program

This program frequently dominates policy discussions as there is little within our healthcare system that remains untouched by it. DSRIP, an ungainly acronym now deeply embedded in our lexicon, denotes a grand initiative that aims to accomplish nothing less than a 25% reduction in potentially preventable hospital readmissions and a replacement of institutional (i.e., hospital) services with community-based systems of care. These goals are surely laudable and consistent with principles of community reinvestment and person-centered, recovery-oriented care. They are also aligned with the recommendations of the "Olmstead Cabinet" convened by Governor Cuomo in 2012 to develop a comprehensive plan to support persons with disabilities in the least restrictive settings practicable. This Cabinet bore the name of the defendant in a landmark ruling of the U.S. Supreme Court (Olmstead v. L.C.) that effectively enshrined the right of individuals with disabilities to receive services in integrated settings (Report and Recommendations of the Olmstead Cabinet, 2013). In fact, a host of reforms unfolding within long-term, institutional and residential care settings bear the imprimatur of the Olmstead Cabinet and its proponents.

DSRIP is another product of the MRT Waiver described above and a central mechanism through which the state hopes to achieve the Triple Aim. Simply put, it was designed to promote changes in the existing delivery system by inducing providers to establish partnerships through which certain "projects" (and corresponding outcome measures) would be achieved. These projects are being implemented under the auspices of Performing Provider Systems (PPSs), networks of healthcare and community service providers that collaborate in pursuit of project goals developed in accordance with local and regional needs. Projects vary greatly in their nature and scope but they share certain essential elements. All DSRIP projects must achieve at least one of three overarching goals related to systems

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PCLS have reached out to all New York City, Westchester, Rockland, Orange, Suffolk, and Nassau County HCBS providers and have developed training on all aspects of service delivery to ensure provider readiness. This includes connecting providers with internal and external resources to assist with the implementation of HCBS, maintaining ongoing communication with HCBS providers, and offering technical support and training, when needed. Additionally, responsibilities include:

• Delivering trainings to Health Homes on the completion of members plans of care (POC) as well as a myriad of related topics tailored to the needs of the providers.

• Updating and maintaining a list of active HCBS providers to assist Health Homes in the process of referring members to HCBS (per the HCBS workflow).

• Developing quality measures to ensure effective service delivery of HCBS for members.

• Regularly attending MCTAC, the Coalition of Behavioral Health Agencies, and Health Home Coalition meetings and trainings.

• Providing in-person case consultations for members enrolled in Assertive Community Treatment (ACT) sites, per the request of partnered ACT providers. This streamlines the utilization review process for the ACT teams.

• Collecting Follow-up after Hospitalization (FUH) Supplemental measures for ACT and Personalized Recovery Oriented Services (PROS) sites to ensure 7- and 30 -day follow-ups have been met to comply with state HEDIS measures.

• Attending Health Home calls to assist our plan partners in answering questions or responding to concerns related to HCBS.

To date, the PCLS have conducted multiple Provider Roundtables, having invited over 40 community-based providers to come to Beacon to discuss HCBS services and receive HCBS Education as well as conducting on-site visits and training to over 70 provider groups across the 5 boroughs, Long Island and Orange County. In 2016, PCLS convened 4 Provider Information Forums throughout New York State, delivering in person HCBS training to community-based providers who were invited to a breakfast meeting.

Manager, Provider Partnerships (MPP)

The mission of the Manager of Provider Partnerships (MPP) role is to build highly collaborative relationships with providers, drive provider performance improvement year-over-year through education and data, and identify top-performing providers for innovative programs/pilots. The Manager, Provider Partnerships (MPP) functions as a single point of contact for these providers, resolving provider issues through relationships with internal Beacon colleagues. The purpose of this unique service serves to decrease the provider and Beacon's time on routine interactions, such as payment and authorization, and focus on clinical and quality initiatives. The MPP meets with their assigned providers at least quarterly to review key performance indicators that are benchmarked against regional averages. Opportunities for improvement are identified, and the MPP works with our regional leadership team and the providers to propose strategic initiatives to remedy any concerns around underperformance. The MPP role is intended to promote adoption of evidence-based practices, reflecting our philosophy that emphasizing treatment quality will yield desired outcome metrics. MPPs deliver aggregate data to providers to engage the provider in shared performance improvement goals. This data is gathered specifically for providers and highlights opportunities for Beacon to engage providers in shared goals to improve healthcare outcomes. Some of the measures include HEDIS rates, clinical outcomes (such as readmission and effective transitions of care), and cost, setting the stage for Value Based Payment.

In 2016, the MPPs completed 125 MPP-convened and lead meetings with key, strategic providers. The array of providers encompasses hospital systems, freestanding Psychiatric Hospitals, high volume Substance Use Disorder (SUD) providers, and Article 31 clinics. The MPPs have also been made efforts to reinforce trainings about workflows for HARP/QMP implementation.

Beacon remains committed to the State's ongoing efforts at transforming the Behavioral Health system of care and is closely aligned with our health partners to ensure that our members live their lives to the fullest potential.

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Behavioral Health News Theme and Deadline Calendar

Summer 2017 Issue:

"Meeting the Needs of Our Vulnerable Populations"

Deadline: April 1, 2017

Fall 2017 Issue:

"The Vital Role of Housing in the Recovery Process"

Deadline: July 1, 2017

Winter 2018 Issue:

"Addressing the Opioid and Suicide Epidemics"

Deadline: October 1, 2017

Spring 2018 Issue:

"Understanding & Treating Co-occurring Disorders"

Deadline: January 1, 2018

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people in their recovery journey. These services can range from helping people develop and work on recovery plan goals, to setting follow-up appointments with mental health providers, to connecting people to support groups and other helpful resources.

Implementing peer support programs as a service enhancement helps achieve improved recovery outcomes and reduce costs by fostering community tenure and reducing the need for inpatient care. An Optum-covered Medicaid member who has recently begun to receive peer support services has noted that "I finally feel like I can actually do this. I am not ashamed of who I am, and I know there are other people in the world just like me who are thriving, and I can too." (Source: Idaho Behavioral Health Plan survey response.)

As states consider implementing managed care solutions to transform their behavioral health systems of care, their strategy may also include the method they reimburse clinical services. Optum has observed a growing interest among state and county stakeholders in shifting payment models to focus on value-based reimbursement and population health management. Optum believes that incentive-based contracting, one that rewards provider systems for meeting clearly defined clinical metrics for positive care outcomes, is the best way to promote quality -driven, person-centered care. In fact, Optum has implemented such pay-for-performance provider contracts in several markets throughout the U.S.

Optum has demonstrated that effective implementation of managed care models can improve outcomes while reducing overall costs. For example in Pierce County, Washington, system transformation has resulted in an annual increase of individuals served by over 50% without increasing the total costs of care (based on a 2015 Optum analysis of the results of a redesigned regional support network over a five-year period). This was achieved by improving access to services, and the introduction of peer-based and person-centered services that focused on maintaining recovery and keeping members in the community. This approach has reduced the need for involuntary treatments and hospitalizations, while also reducing the rate of readmissions within 30 days. This system transformation in Pierce County was achieving by following the recommended framework of ensuring clinical excellence, establishing partnerships, promoting collaboration with all providers, and enhancing programs and services.

As states and counties continue to evaluate the quality, clinical effectiveness, and costs of their behavioral health systems, it is important to recognize that improvements are possible. Managed care programs help control costs and benefit all stakeholders across the community. Transforming these systems through effective partnerships helps assure that individuals receive evidence-based, person-centered care focused on positive outcomes and maintaining recovery.

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

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transformation (e.g., replacement of institutional modes of care with community-based alternatives), clinical outcomes (e.g., integration of primary and behavioral healthcare) or population health (e.g., reduction or cessation of tobacco use). Moreover, many payments made to participating providers are indexed to certain performance or outcome measures. In this respect DSRIP constitutes another departure from the norm of FFS-based reimbursement schemes that compensate providers for their activities irrespective of the effects of these activities. Providers who collaborate in pursuit of DSRIP project goals do so at their own risk and incur financial penalties if they (or their partners) fail to achieve desired outcomes. These objectives hold great promise to replace antiquated FFS standards with value-based alternatives, but their fate rests largely on our collective will to dismantle an expansive infrastructure of institutional services on which our system has relied. This task would seem Herculean under even the best circumstances, but a fundamental flaw in the architecture of this program poses an additional obstacle that might prove insurmountable.

The surpassing complexity of DSRIP is apparent to the most casual observers of healthcare reform, so it is unsurprising that PPSs are generally led by entities that possess the capital and organizational resources necessary to coordinate projects and to meet myriad administrative demands associated with them. These entities include hospitals and healthcare networks – the same entities targeted for substantial reform by DSRIP initiatives – and they hold a disproportionate share of authority in the stewardship of program resources. They are charged to distribute funds to their community-based providers and, in doing so, to substantially alter the landscape of healthcare services and their roles therein. It might be naïve to expect such vested interests to dispose of said interests in exchange for incentive payments or the greater public good, and recent findings of the Independent Assessor (IA), an administrative body charged with oversight of the DSRIP program, confirms this. In its Mid-Point Assessment Report the IA determined a majority of PPS lead entities have neglected to effectively engage their community-based partners and to compensate them accordingly (Public Consulting Group, 2016). The systems transformation envisioned by the progenitors of DSRIP requires nothing less than full cooperation among a panoply of health and social service providers and a nimble redistribution of resources toward community-based interventions. The IA's findings portend problems for the final years of this project lest

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Each RCOC responds to local needs by promoting sustained recovery through social and emotional support, skill building, recreation, wellness education, employment readiness, civic restoration opportunities, and other activities. In 2009, OASAS funded the state's first three RCOCs; and in 2016, as a direct result of recovery advocacy, Governor Andrew M. Cuomo announced $12 million in funding to establish eleven (11) more RCOCs. Once they open, New York will have an RCOC in each of its ten Economic Development Zones (EDZ) and each of the five boroughs of New York City. Progress!

Youth Clubhouses (YCHs): New York's Youth Clubhouses are first-of-their-kind, community-based havens that promote peer-driven support and services in a non-clinical setting for young New Yorkers (ages 13-17 and 18-21). Each YCH helps young people build and sustain recovery, as well as supports those at risk for addiction to develop social skills that promote prevention, long-term health, wellness, recovery and a drug-free lifestyle. A variety of services including homework, tutoring, college and job preparation, community service opportunities, sports and fitness activities, group entertainment activities and peer mentoring may also be available. In 2016, Governor Cuomo announced nearly $2.6 million to create eleven (11) clubhouses across the state. All are expected to be operating in early 2017. Progress!

Family Support Navigators and Peer-Support Specialists: Family Support Navigators (FSNs) and Peer-Support Specialists are valuable new positions being established. Governor Cuomo recently announced $2.85 million in annual funding to support two of each position in the ten Economic Development Zones and Long Island. Progress!

Clearly, the voice of recovery is being heard, and we're seeing tremendous system reform in the area of addiction recovery in New York State. Recovery advocacy has resulted in the investment of needed funding to expand community-based Recovery Support Services (RSS) across the state, and policymakers and the healthcare system are recognizing the critical need for RSS in responding to the greatest public health crisis modern American society has faced.

Individuals and families can and do recover from addiction as long as evidence-based treatments and responsive, long-term, community-based recovery supports are available and accessible to all. The Surgeon General's report calls for more research on recovery supports and services. We look forward to the advances that future research will provide and to continuing to build recovery supports and services that ultimately save lives.

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credits are too low, it will be impossible for many, many retirees to buy health insurance at all. Even with Medicare, many older adults find it exceedingly difficult to get behavioral health services. Without Medicare, forget it.

Crossing State Lines

One of Trump's most frequently repeated promises is to permit the purchase of health insurance across state lines so that employers and individuals can get the best price possible. Holding down prices is, of course, important. But this would vitiate state insurance mandates, some of which have been important in the fight to improve behavioral health coverage—especially for parity. Yes, health insurance prices would likely come down as states allowed insurers to cut benefits to the bone, but this would come at the cost of transparent and adequate coverage—especially behavioral health coverage.

Fighting Back

The loss of behavioral health benefits through repeal of the ACA, the elimination of Medicaid and Medicare as entitlements, and permitting interstate competition among health insurance plans is very far from a *fait accompli*.

Yes, both Trump and the leadership of the new Congress have promised to repeal "Obamacare." But they are also promising to retain provisions of the ACA that are of vital importance to the American people. We must do all we can to make clear that coverage of behavioral health conditions through both government-based and private health insurance must be among the provisions that survive repeal.

And, Republican efforts to end Medicaid as an entitlement via block grants are not new. President Reagan made this one of his major goals. Advocates and the health care industry fought back together, using all the clout at their disposal to successfully protect health care funding for medically indigent people. We can do it again.

The possible attack on Medicare is far from a unified goal of Republican federal elected officials. Splitting them on this issue should not be at all difficult though it will take advocacy to do it.

Eroding the power of the states to regulate the health insurance industry may also become far less appealing to Republicans if we make the case that permitting sale of insurance across state lines effectively violates states' rights.

Whatever arguments we make to head off the potential disaster for people with behavioral health conditions, it is entirely clear that advocates, hospitals, community behavioral health providers, professionals, and the unions and trade associations that represent them will need to put aside self-interest and ideological differences to fight off policies that would have grave impact on our nation's capacity to provide behavioral health services.

Michael B. Friedman is an Adjunct Associate Professor at Columbia University School of Social work, where he teaches courses on health policy and mental health policy. He can be reached at mf395@columbia.edu. Other writings are available at www.michaelbfriedman.com.

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the kinds of correspondence they are sending to peers? If they did, we might all be getting letters we could actually understand. This may sound like just a small point. After all - it's only a letter - but actually it's a big, major point because the information contained in these letters can sometimes mean the difference between moving in a good direction or moving in a disastrous direction.

Communication around change also has a lot to do with where people are in their lives when a communication needs to happen. For one of us living in a shelter, it was impossible to receive letters and it just became a big nightmare trying to understand how to get the medications that were needed. For another who was in and out of emergency rooms all the time, having someone making an approach about insurance just when you're at your very worst isn't a very helpful way to communicate. The one thing we know for sure is that communication really matters and we've got to understand what's happening before it happens so we can plan and be prepared.

One specific change in the system is that the amount of the vouchers for over-the-counter drug store needs has been reduced, and sometimes, reduced drastically. In one case, it went from $100 a month to $40 a month, then up to $55 a month - all without explanation. And certain drugstores honor these vouchers and others don't, leaving us to have to look around and make sure we can get our needs met when a lot of times, we can't.

Another change that has been difficult for many people is that there seems to be less coverage for us to get help from mental health professionals who are not our psychiatrists. Seeing a psychiatrist once a month is important, because this is the person who is managing our medications and making adjustments based on how we tell them we're doing. The problem is that there are a lot of limitations that prevent us from seeing a mental health professional when we need to, like once a week, and we are usually told that we only have coverage on a very limited basis. This backfires on everyone because when we hit a rough patch and don't have anyone to talk to, we wind up in the emergency room and that's exactly the opposite of what everyone wants.

Case managers play a really positive role in many of our lives because they are there for us, making home visits, checking on how we're really doing on a day-to-day basis, and helping us navigate the system. We all felt that if we had more case managers on staff who were not so pressed for time with such big case-loads, we would be working with a much more efficient system and people would be in recovery in a more solid way.

For one of us, the predominant life problem was addiction, and after having lived on and off the streets for many years, this individual is now in stable housing, with supports, with yoga, with a writing group, with medication management - and with a dog. After almost a whole life-time spinning in circles, life is now starting to make sense and have some hope attached to it. When we all sat and listened and focused in on this one person's life story, the thing that emerged is that in some ways, Managed Care has done a good job. The reason comes down to care coordination.

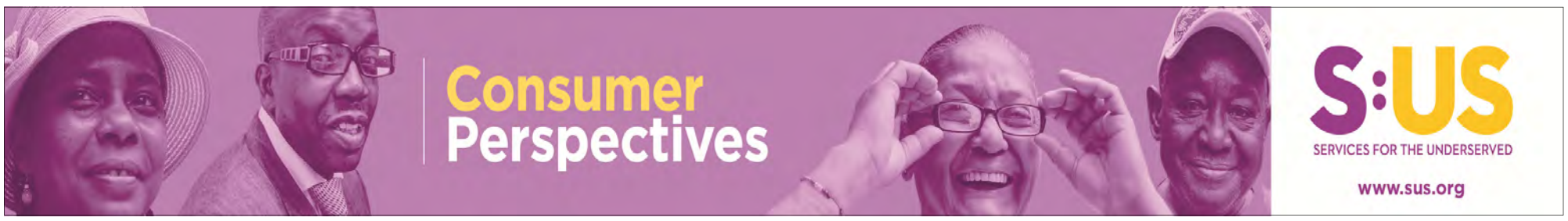
The way Medicaid used to work was like a credit card. You used it when you needed to use it, and sometimes, people abused it. Now, Managed Care came in to really manage our care - and save money. The problem is that saving money sometimes seems to be the first order of business - with managing care coming in second or even third or fourth place. That's never good, and we see it day by day. Doctors and psychiatrists are squeezing in too many patients, and sometimes they only have 15 minutes for an office visit. Waiting rooms are packed with people and everyone is on overload.

At the end of our focus group, we were asked to talk about what we would change if we could wave a magic wand. All of us pretty much had the same answer: we need to put the real care back in Managed Care, and we need to make sure that care comes with care coordinators, understanding, compassion and support for everyone.

We also all agreed that right alongside Managed Care needs to be a better system of communicating about care, and not just from doctors and insurers to people receiving services - but between doctors themselves. Time and time again, this lack of coordinated care between providers just seems to bog down the system and make things frustrating and slow when they don't have to be.

We all acknowledged that there really are lots of services out there, and that sometimes, we just don't know how to access them. If there were one word that best summarizes the biggest need in this changing word - it would be communication. Once we get that right, a lot of other things will fall right into place.

This article is the fourth in a quarterly series giving voice to the perspectives of individuals with lived experiences as they share their opinions on a particular topic. The authors of this column facilitated a focus group of their peers to inform this writing. The authors are served by SUS (Services for the UnderServed), a NYC nonprofit that is committed to giving every New Yorker the tools they can use to lead a life of purpose.



Roadmap from page 23

seeking to expand their volume, enhance their service continuum, and increase their value by actively partnering. The following examples offer a preview for how systems are converging.

In New York City, NYC Health + Hospitals is the largest health care system. OneCity Health Services is its subsidiary Performing Provider System, comprised of 220 different health care and social services organizations with responsibility for almost 660,000 attributed Medicaid lives. As its next step toward building its integrated delivery system (IDS), OneCity Health Services will facilitate care management and conduct the administrative contracting and coordination necessary with community providers. Its recent Request for Expressions of Interest from venders to support its planned infrastructure described a vision for managing risk-based service arrangements on behalf of over one million members—80% of whom are expected to be Medicaid Managed Care recipients throughout all five boroughs.

In the Hudson Valley, the Coordinated Behavioral Health Services (CBHS) IPA is a behavioral health provider-led independent practice association (IPA) that has formed a comprehensive behavioral health network designed to enter into accountable care arrangements. Services across the network include a broad range of clinical, housing, supportive, and recovery-oriented behavioral health services (Anderson -Winchell, A., Kocsis, A., Kohn, A., Madison, S., & Trager, A., One Group's Pathway toward Preparing for Managed Care, 2014). Among other initiatives, the CBHS IPA has established a partnership with the area's largest Federally Qualified Heath Center (FQHC), creating a delivery system able to offer integrated care to attributed individuals within value based payment (VBP) arrangements. Currently, this integrated IPA, CBHCare, is leading a number of integration initiatives across the Hudson Valley as an active partner within Delivery System Reform Incentive Payment (DSRIP) program Performing Provider Systems (PPS') and health home networks, and they have successfully established a phased VBP contract with an managed care organization, which, beginning January 1, 2017, will incorporate total cost of care payments, as well as upside and downside risk (Hardesty, M. Advancing Value-Based Care in New York's Hudson Valley, 2016).

Certified Community Behavioral Health Centers: A Model upon which Behavioral Health Providers can Build

The CCBHC structure can offer a valuable roadmap for behavioral health providers seeking to take action. New York was recently selected as one of eight demonstration states and is implementing CCBHC pilots designed to "strengthen payment for behavioral health services for Medicaid and CHIP beneficiaries, and…help individuals with mental and substance use disorders obtain the health care they need to maintain their health and well-being" (HHS, HHS selects eight states for new demonstration program, 2016). Though designed for funding under a Prospective Payment System (PPS), the CCBHC model fully aligns with the principles and goals of accountable care and CMS' Triple Aim, and offers a template for a comprehensive behavioral health system that can successfully be integrated into an accountable care network.

Each CCBHC offers both mental health and substance use treatment services for individuals of all ages and holds responsibility for the behavioral health of the population within their designated geographic area. They have open access, offer mobile crisis, and maintain established relationships with local emergency departments to facilitate care coordination and follow-up post-discharge. Accessibility is promoted via peer, recovery, and clinical supports in the community and increased access through the use of telehealth/telemedicine, online treatment services and mobile in-home supports (SAMHSA, Section 223 Demonstration Program for Certified Community Behavioral Health Clinics, 2016).

Even providers who are not certified under the official demonstration can seek to build out their continuum via partnership and affiliations that mirror the CCBHC model, while also leveraging available housing resources and other social service linkages necessary to promote health, wellness, and sustained recovery. Such networks will be well positioned to partner with accountable provider-led entities, like hospital systems and FQHCs, in preparation for value based arrangements. Should the demonstration be successful, the PPS financing mechanism may be federally adopted, which also makes this model worthy of early attention.

Conclusion

The success of accountable care demands thorough attention to behavioral health, but proactive leadership and well considered partnerships are critical. Models are available and means for adoption are currently at hand. Providers planning to survive within the new healthcare economy must be actively building their continuums, expanding their reach, and evolving toward value based payment.

Health Management Associates is a consulting firm with deep expertise across all domains of publicly funded health care, including behavioral health practice transformation. Founded in 1985, Health Management Associates has 19 offices across the country, including Albany and New York City. For more information, call (212)575-5929 or visit www.healthmanagement.com.

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significant midpoint corrections are made.

Promise Amidst Pitfalls

Notwithstanding the host of challenges inherent in any transformative enterprises, Managed Care, DSRIP and associated initiatives enjoy common elements and synergies with federal programs. As such, they are poised to achieve at least some of their aims and to effect incremental movement toward integrated, community-based, recovery-oriented and fiscally conscious systems of care. The recent enactment of the 21st Century Cures Act signifies a federal commitment to bolster our primary and behavioral healthcare infrastructures via investments in both traditional services and community-based alternatives. Similarly, renewed attention to provisions of the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 has prompted payers and other key stakeholders to promote greater access to behavioral health services. Parity of access is not merely a matter of principle. It is integral to our management of a national epidemic of opiate abuse. In addition, criminal justice reform has found patronage on both sides of the political aisle, and any measures that institute community-based alternatives for nonviolent offenders will surely benefit individuals with behavioral health concerns who constitute a disproportionate share of inmate populations within our local jails and state prisons. Even the specter of a Trump Administration and its promise to repeal the Patient Protection and Affordable Care Act (i.e., "Obamacare") should not be cause for despair. Transformative activities that pursue the Triple Aim are bound to find champions in all quarters, and New York boasts broad regulatory and advocacy resources that can erect a bulwark against regressive measures. Nevertheless, these resources must remain mobilized in a concerted and coordinated fashion if our system is to achieve a truly integrated, person-centered, recovery-oriented and value-driven result.

The author may be reached at (914) 428-5600 and at abrody@searchforchange.org.

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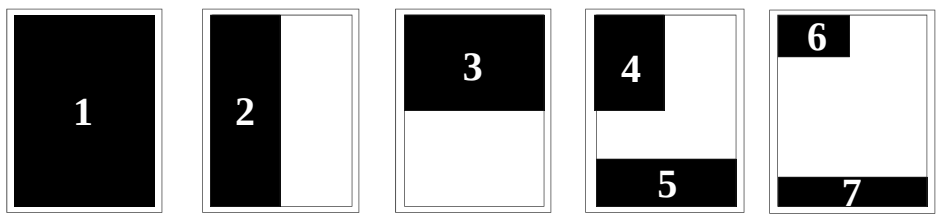

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