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This Issue: The Challenges and Opportunities of System Reform

The Promise and Peril of Value Based Behavioral Health Care

By Josh Rubin and
 Meggan Schilkie, Principals at
 Health Management Associates

By aligning payment with value, we can achieve the triple aim of better outcomes and better experience of the healthcare system at a lower cost *IF* we define value in terms of wellness, recovery and improved quality of life. In this case as with almost everything in our healthcare system today, the metrics matter. And if the health care system is going to deliver on the triple aim, it will need to leverage the expertise of, and partner with, the behavioral healthcare system. We serve the clients with the most complex needs. We have a long history of knitting together healthcare with social services. We have, in short, spent the last half century developing the skillsets that the medical system needs most today.

But value-based payment (VBP) is not a panacea, and it will not be without its dangers for community behavioral health agencies. VBP is, simply put, a market solution to a problem occurring in a capitalist healthcare system. VBP will increase competition and empower the in-

visible hand of the market. This will, inevitably, lead to creative destruction. How creative that destruction proves to be is as yet unknown, but that the destruction will happen is a given.

The American health care system has a problem. We spend much more on healthcare than anywhere else in the industrialized world, but our health outcomes don't reflect that spending. This stark data has led policymakers at both federal and state levels to propose new ways of purchasing healthcare services based on the theory that our fee-for-service (FFS) driven system has provided the wrong set of incentives to care providers. Rather than being paid to keep people healthy, medical providers have been paid to take care of people when they're sick. This has caused the system to focus on illness, not health and expensive interventions in place of inexpensive ones. And it has led to greater rates of illness and worse outcomes.

The system needs to be held accountable for maintaining people's health as much as possible and returning them to health when needed. In order to hold the system accountable, payment has to be based on the value of any intervention to a person, not based on the volume of services regardless of value. In a FFS sys-

tem, more valuable interventions, those designed to restore people to health and keep them healthy, reduce providers' margins, rather than increasing them. Whereas a move to VBP can create accountability within the care system for maintaining people's health, and improve margins for those providers who do the best job.

This restructuring to VBP could be a very good thing for behavioral healthcare providers. After all, lots of research has shown that people's behaviors have much more to do with their health outcomes than the care that they receive from medical providers. And the same data that show how poorly our health outcomes look when compared with other industrialized countries, also show that when it comes to social services spending, the US is much farther back in the pack. Our poor health outcomes look like they have a lot to do with how well our systems have managed the interaction between health and social services, which is the nexus on which behavioral healthcare lives. Meanwhile, new research has shown that loneliness and social isolation are as unhealthy as grade two obesity. The research base is constantly and continuously shining a light on the importance of behavioral healthcare, not just for people with chronic conditions, but for everyone.

Medical providers tell us that among their biggest challenges are working with their clients to change behavior; providing robust, consistent care management; addressing the social determinants of health like housing, employment and education; providing culturally-competent, patient-centered care; and reaching out and engaging difficult to engage populations. These skills, which provide such huge value, and that are so desperately needed, are precisely those skills that high-quality community behavioral health providers have developed since the passage of the community mental health act. So community behavioral health agencies, if they are prepared (and that's a big if), are well-positioned to play a valuable role in a newly emerging organized health and social services system.

And we should want to. Accountable care is quality care. The dis-coordinated, disorganized, siloed service systems is failing to provide the person-centered services that the people we serve deserve. Too many of our clients are dying too young, entangled in the criminal justice system, struggling to maintain housing and under/unemployed. We need to bring

see Value Based Care on page 11

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Theme & Deadline Calendar

Behavioral Health News 2016 Theme and Deadline Calendar

Fall 2016 Issue:
“Behavioral Health and The LGBTQ Community”
Deadline: July 1, 2016

Winter 2017 Issue:
“Transforming Systems of Care for Children”
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“System Reform Progress Report”
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Maintaining Recovery as a Central Focus of Substance Use Disorder Services

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

For years, the health care system treated addiction as an acute condition: an individual battling addiction would be diagnosed, treated, guided to support and then left to their own devices on whether to succeed, or fail, in recovery. The good news is: for New York State, that is no longer the case. The New York State Office of Alcoholism and Substance Abuse Services (NYS OASAS) acknowledges addiction for what it is: a chronic disease. As a result, our system of care has undergone a complete metamorphosis; it now focuses more on the individual needs of each patient, and the recovery phase of our continuum of care will be successful in part due to the input and dedication of communities across the state.

Our overall recovery efforts align with the vision of the Substance Abuse and Mental Health Services Administration's (SAMHSA) Recovery-Oriented Systems of Care (ROSC). SAMHSA says, "An ROSC is a coordinated network of community-based services and supports that is person-centered and builds on the strengths and resiliencies of individuals, families, and communities to achieve abstinence and improve health, wellness, and quality of life for those with or at risk of alcohol and drug problems." (SAMHSA-ROSC Resource Guidebook-September 2012). By using non-clinical supports to augment clinical recovery services, individuals will get the guidance they need as they move through our continuum of care. Through our ROSC in New York State, we are helping individuals with substance use disorders to overcome their condition and provide them with the tools and support they need to get their lives back on the right track.

Moving in the Right Direction

Recovery services are increasingly becoming a more vital part of the continuum of care model in New York. Our Residential Redesign and Medicaid managed care for substance use disorder services are part of Governor Andrew M. Cuomo's Medicaid Redesign initiative. Providers in New York City have already transitioned to the new reimbursement model under Medicaid managed care in October 2015 and the rest of New York State will implement the new model by July 2016. In addition, OASAS is transitioning to a new treatment paradigm that includes residential treatment options to divert appropriate individuals from higher intensity levels of care to more appropriate community-based options. This will allow for bedded addiction treatment programs that provide both short-term crisis and respite care, as well as longer term rehabilitation options, making the treatment system more responsive to individual needs.

In addition, we have fundamentally changed outpatient care so that it includes a continuing care component after treat-



OASAS Commissioner
Arlene González-Sánchez, MS, LMSW

ment discharge and enables providers to offer services outside the walls of an outpatient program. These changes are part of OASAS's plan to develop New York's ROSC capacity, by allowing providers to see patients where they are in the community, and to have some of those services provided by Certified Recovery Peer Advocates (CRPAs) with the ability of providers to bill Medicaid for those services. These changes create new opportunities for CRPAs to assume a more integral role in substance use disorder care and recovery.

OASAS is leading the way nationally by using these opportunities to drive change in the health care system and aligning our services to better meet the treatment and recovery support needs of those with substance use disorders. We are continually working to bring services to New Yorkers in their communities, to provide residential services that meet the needs of individuals, and to develop peer services to help individuals gain better access to care and aftercare.

Combating an Epidemic: Connecting People in Need to Treatment

You may have seen it in the headlines. The nation is in the middle of an opioid/heroin epidemic, and New York State has not been immune. NYS OASAS is doing everything in its power to help New Yorkers battle all addictions, and recovery remains a key part of our comprehensive strategy. To better connect individuals with treatment and get them on the path toward recovery, we launched the new OASAS Bed Availability dashboard (<https://bi1.oasas.ny.gov/oasasbed>). The new, online resource allows New Yorkers to find available treatment services anywhere in the state, in real time. We are working to expand the tool to include outpatient and other services. In another multi-agency effort to address the prescription opioid and heroin epidemic, NYS OASAS continues to work with the Health Department and other State agencies, to train more New Yorkers on how to administer Naloxone, a medication

which can reverse an opioid overdose. Currently, more than 100,000 people have been trained. This is a crucial step in the continuum of care. We must reverse an overdose first, so that there is an opportunity to connect individuals to care, the beginning step in helping individuals along the path to recovery.

Guiding People to Care

NYS OASAS is also making investments to support New Yorkers' recovery from addiction through our new Family Support Navigator and On-Call Peer Support Advocate initiatives. The family support navigator program assists families as they access care for their loved one and work their way through the OASAS system. Under the On-Call Peer Advocate program, a peer, with experience in accessing addiction services, will work with hospital Emergency Department personnel to help connect individuals in a substance use disorder crisis to appropriate treatment services within the OASAS system before they are discharged from the hospital. We also recently released a new "Access Treatment" video series on our website (<https://www.oasas.ny.gov/treatment/index.cfm>) to help individuals and families navigate their way through the addiction treatment system and obtain the services they need.

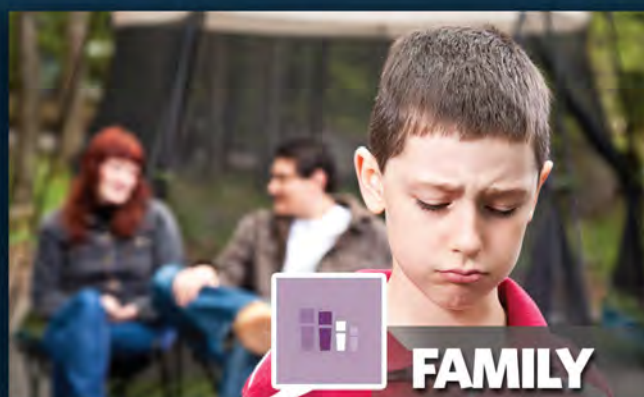
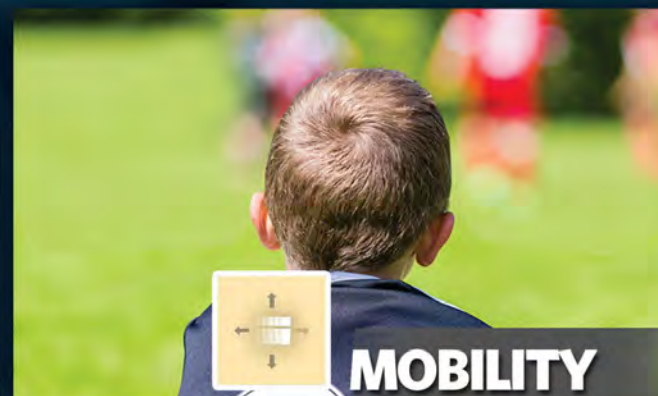
OASAS also works with primary care providers to ensure they are trained to use Screening, Brief Intervention and Referral to Treatment (SBIRT). The SBIRT evidence-based approach to identifying patients who use alcohol and other drugs at risky levels is aimed at reducing and preventing substance use disorder related health consequences, diseases, accidents and injuries. Substance use is a health issue that often goes undetected. In July, OASAS released a video which provides general information about SBIRT (<https://www.oasas.ny.gov/AdMed/sbirt/index.cfm>) so that more primary care and other healthcare disciplines can utilize the approach with their patients.

Supportive Housing

OASAS also recognizes that safe, affordable and permanent housing for families suffering from a substance use disorder is an integral piece of successful recovery. Supportive housing is as critical a component of the recovery process as opportunities for employment, education and access to health care services. The OASAS Housing Bureau is dedicated to providing housing options for individuals through rental subsidies and case managed supportive services. The Housing Bureau currently

see Recovery on page 7

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Congressional Mental Health Policy Reform: Hope or Hype?

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

Since the tragic killings in Newtown, CT in 2013, most politicians have mistakenly maintained that mass murder is largely a consequence of a “broken” mental health system. In Washington, and elsewhere, elected officials have been promising to “fix” the system, and to their credit they have enacted a number of important incremental improvements into law. But so-called “comprehensive mental health reform” has not moved, probably because comprehensive reform bills have included highly controversial proposals to limit rights to refuse treatment and to privacy. This year modified versions of previous bills have been introduced in the House of Representatives¹ and the Senate² that claim to address the controversies while also keeping the promise of comprehensive reform.

Good news? Not very. The ideological controversies, as important as they are, have been a distraction from the fact that these legislative proposals are not really comprehensive. They are just a few more incremental changes, some of which may be worthwhile but which certainly don’t live up to the promise of major reform.

The core problems with the American mental health system are pretty clear. A great many people with mental and/or substance abuse disorders who might benefit from mental health or substance abuse services cannot get services at all, and the services that people do get are often of poor quality. According to the National Comorbidity Study Replication (NCS-R), nearly 60% of people with diagnosable mental and/or substance use disorders do not get treatment. And most people who get treatment, get it initially from primary care physicians, who provide “minimally adequate care” less than 15% of the time. The chances for getting minimally adequate care (which is not necessarily high quality) are better with mental health professionals, who provide it almost 50% of the time, but hardly what one would hope for.³

So the key questions to ask about the so-called “comprehensive mental health reform” bills in Congress are: (1) what do they do to increase mental health and substance abuse service capacity and (2) what do they do to improve quality of care? Let’s see.

A fundamental premise of the current legislative proposals is that the bureaucracy in Washington needs to be reorganized. The bills call for a new position in The Department of Health and Human Services (HHS) — an Assistant Secretary for Mental Health and Substance Abuse. The Office of the Assistant Secretary would oversee (or replace depending on the bill) the Substance Abuse and Mental Health Services Administration (SAMHSA). It would also have authority to coordinate the 112 federal programs that the Government Accounting Office (GAO) recently identified as involved in behavioral health.⁴ These agencies are loosely linked at best, and this is



Michael B. Friedman, LMSW

perceived as a major cause of the fragmentation that plagues the American mental health system.

But is it really clear that poor communication and coordination among public officials in Washington are a major cause of fragmentation on the ground, where services are delivered? And, more importantly, what will improved coordination at the level of federal agencies contribute to the development of more and better services? Lots of meetings in Washington and lots of E-mails (monitored by the Office of the Assistant Secretary?) will do what to increase service capacity and quality? It’s far from clear to me.⁵

Don’t get me wrong. I don’t oppose the creation of a new Assistant Secretary, and I support the idea of a Coordinating Council and a Mental Health Services Laboratory, which are also built into the re-organization proposals. Maybe they will help a little. But reorganization is usually an illusory solution and rarely results in major improvements in caring for people who need care.

Of course, the bills now being considered do propose to increase service, but not nearly on the necessary scale. Let’s think about it. If more than half of people with behavioral health disorders do not get treatment now, it may be necessary to double services in the United States. OK, that’s probably more than needed since not everyone with an untreated mental disorder needs or would benefit from treatment. So let’s guess that the system needs to grow about half that, say 50%. It is currently projected that in 2014 the nation spent over \$210 billion on behavioral health services (about 63% public and 37% private)⁶. Does that mean we would need to spend more than an additional \$100 billion per year overall, about \$63 billion by the government and \$37 billion by the private sector, in order to bring the mental health system to scale? Is there any chance at all that the Congress would authorize or mandate spending of this magnitude?

The bills under consideration do propose what at first appears to be a significant increase in Medicaid spending for inpatient treatment in hospitals. They call

for elimination of the exclusion of Medicaid coverage for mental health services in psychiatric hospitals (“institutions for the mentally diseased”) for adults aged 22–64. According to the Congressional Budget Office (CBO), this could cost as much as \$66 billion over 10 years.⁷

There is, of course, an important question about whether it is sensible to make a major financial investment in acute (these bills limit coverage to an average of less than 30 days) inpatient treatment rather than long-term care or investing instead in community-based services and housing. And there is also a significant question about why it is necessary to lift the exclusion on psychiatric hospitals since there is no exclusion on Medicaid coverage of inpatient psychiatric services in general hospitals. Why invest in state and private, mostly for-profit, psychiatric hospitals rather than creating incentives for general hospitals to expand psychiatric inpatient services, especially in the context of the call for increased integration of behavioral and physical health care services that is an essential element of these bills?

That aside, one has to wonder about the reality of this call for increased inpatient services when these bills authorize expansion only if the actuary of CMS certifies that more inpatient services will not result in an overall increase in Medicaid expenditures. In its estimate of the costs of this section of the main House bill, the CBO states that it is highly unlikely that CMS would find the new spending to be budget neutral, and that, therefore, it is highly unlikely that these new inpatient services will ever take place.

What about expansion of community services? These bills do call for re-authorizations of some community service demonstrations, for expansions of others, and for some new ones. For example, the primary House bill calls for expansion of the Federal mental health block grant by 2% for states that have “assisted outpatient” programs. If all states qualify, that would amount to an increase of \$10 million nationwide, not very much in the context of over \$210 billion of annual spending on behavioral health. Altogether, proposed community service expansions come nowhere close to a meaningful increase in federal spending.

The point is simple. There is not nearly enough money in these “comprehensive reform” proposals to pay for a major growth in service capacity. Without such growth, what will be different for the vast number of Americans who don’t get behavioral health services when they need it?

To be fair, this legislation does try to address the shortage of personnel trained to provide behavioral health services. If successful—i.e. if the number of well-trained behavioral health professionals increases at greater than the rate of population growth—it would then be possible to serve a greater portion of the population than is now served. Much to be hoped for, but I’m not at all sure we should count on it.

What about quality, the other major problem with the American behavioral health system? Proposed legislation does recognize and try to address the uneven quality of behavioral health services in the

United States. It calls for, and provides some funding for, more research. It calls for, and provides some funding for, better translation of research into practice. It calls for, and would fund some training for, greater use of evidence-based practices. It calls for more attention to the mental health needs of children. Etc.

Will this help? Probably some, and it should certainly be supported. But I remain concerned that these proposals will not address a number of core issues of quality including:

- Lack of interest in the fact that America is aging and needs a “generationally competent” behavioral health system
- Lack of attention to the divide in America between a public and a private mental health system and the reliance on trainees and freshly minted professionals in the public system
- Lack of attention to the failure to reach and appropriately serve people for whom the tradition of office-based treatment is a problem
- Lack of attention to the social determinants of behavioral health and to the kinds of societal level interventions necessary to address them
- And more.

Comprehensive mental health reform? That would be great. Maybe someday a proposal will emerge in Congress that gets beyond rhetoric and really makes more and better behavioral health services available to people who need them. But we are not there yet. The comprehensive reform bills in Congress are, I’m afraid, far more hype than hope.

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

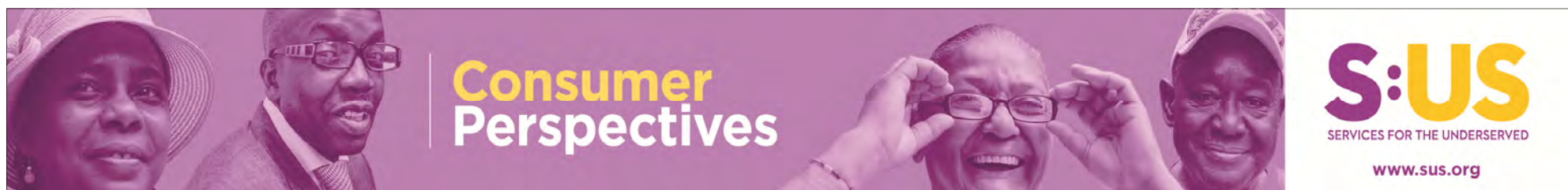
Notes and References

* The observation that there are a great many federal mental health programs is not new. For example, in 1977 the GAO issued a report that identified 135 such federal programs and called for consolidation and improved coordination.⁵ Obviously, in the following years little progress has been made. Will the call for coordination succeed this time?

1. Helping Families In Mental Health Crisis Act of 2015. HR 2646. <https://www.congress.gov/bill/114th-congress/house-bill/2646>

2. Sullivan, P. “Bipartisan Mental Health

see Hope or Hype on page 29



Adapting to System Reform

By Dina, James, Jerald, Jesse, Peter, Taheem, and Thomas

This article is the first 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.

As we sat together to discuss our perspectives on the topic of Adapting to System Reform, we soon realized that street homelessness, hospitalizations, alienation from family and community, substance use, sobriety and living with mental illness were all experiences we shared. We also came to appreciate that we were united by hope, resilience, personal recovery, and a strong desire to help others. And, while we were all “users” of the health care system, the reform of it was not something we had really had the chance to wrap our heads around.

Health care and the way it is provided affects everyone, and while New York may be a tough place to live in many ways, it also has one of the most comprehensive systems available to people anywhere in the country. The problem is that along with being comprehensive, it's complicated and even the most fundamental step of applying for SSI and Medicaid can be challenging. Understanding how the system works, what's available to whom, how to access it, and of course, figuring out what paperwork is needed can be huge hurdles to using the system. But the challenges go deeper than that.

In October 2015, Managed Care got brought into the world of behavioral health in a big way, but none of us feel confident that we understand what that

really means and how this change affects our lives. The way this change was communicated was random and confusing. So rather than feeling empowered to make informed decisions about our health care, the lack of a clear understanding continues to promote our dependence on case workers and care coordinators for their interpretation of the changes. For government and policymakers to be making decisions about the very things that so profoundly affect our lives, without making us a part of the decision-making is at the root of the issue of how we adapt to system reform. For rather than adapting, we should be helping to figure out what adaptations should be recommended in the first place, if in fact the intent of the reform is to keep us out of ERs, prevent hospitalizations, and promote a better quality of life for us. To relegate our decision-making to simply choosing this plan or that plan is to do us a disservice.

One of our biggest strengths is that we all have lived experiences that put us in a position to help others and ourselves in ways that are unique and powerful. People who are trying to understand and navigate the system are much more likely to listen to someone who has taken that journey themselves. Someone with a lived experience can more easily build trust, speak with empathy and guide with compassion. For example, most of us had to either become homeless or be hospitalized in order to learn about what is available. It shouldn't take hitting rock bottom to finally find out that there is a safety net in this city that could be accessed. Programs and system efforts that focus on catching people before they fall are the things that are going to help us move forward, and people with lived experiences can and should be playing a major part in sharing information about this if we are really serious about wanting to keep people out of hospitals, out of jails and off the streets.

But how do we get the word out? People with lived experiences want to be do-

ing public service announcements, writing articles like this one, working alongside social workers, doing outreach and advancing engagement on a lot of levels. And, let's talk about those letters that get sent out from “government.” Are they purposely written so that no one can understand them? We think we all got a letter talking about DSRIPs. It starts by saying there are no changes to my Medicaid and so some of us breathed a sigh of relief and threw it out. Others of us received letters talking about HARP, saw that we could opt out of sharing our information and so did just that, only to find out later that perhaps that was not the best move. Peers should be helping to write these notices so that the very people who need to understand them have a chance to do so. There is a real breakdown in the system and yes, even though a social worker or care coordinator might be available to walk us through the maze, communicating changes that are happening continuously is bewildering and we often receive conflicting advice. The system needs to do better.

We also know that we can't have recovery without housing, and so to respond to the question of “adapting to system reform” we must speak about the central importance of housing. There just isn't any possibility of stability without housing. There's no address to get mail. There's no pride of place. There's no rest for the weary. There's no anything. Housing is the umbrella under which everything else can happen. We need to get focused on this in a huge way, not just with set-asides in buildings and not just as an afterthought - but as a first thought. Any system without true, integrated, community-based permanent housing for people with behavioral health challenges is just a Band Aid.

And that leads us to our final point: discussion. We're not doing nearly enough talking to each other AND to others in general. Awareness, education, and

information sharing need to be at the forefront of system reform in order for it to really mean something and be effective.

In concluding we will summarize some of the thoughts we have shared so far and highlight some other suggestions:

- Any and all communication about the system needs to happen with our involvement in what's being communicated, before it's communicated. Don't decide for us. Decide with us. Have our voice at the table.

- There need to be organized, facilitated, community conversations with information that is clear and easy to understand.

- Use every communication channel available. For people who are homeless, we can't count on them learning about how to get help because a letter gets sent out. And for people who are living in shelters, a Public Service Announcement won't do the trick. Communication needs to be customized and not a one-size-fits-all approach. Lots of us have smart phones and we could be getting information on social media. Why not try that?

- Information workshops should be set up in specific locations and made open to the public and anyone interested in understanding their health coverage options should know about these through a widely publicized advertising campaign, on subways, in newspapers, through social media and community venues.

- And, last but certainly not least, we need to care more about each other. Education, information and empowerment can only happen from a place of compassion. There is still a lot of stigma about mental illness. We need to make a pact with each other that no one, because of the circumstances of their life, gets left behind in our current system or in any system reform. Having our corner in this newspaper is a great starting point.

Recovery from page 4

administers a portfolio of housing contracts funding more than 1,900 permanent supportive apartment units.

Recovery Community And Outreach Centers

NYS OASAS currently oversees four Recovery Community and Outreach Centers. These centers offer information and education to communities on how to access addiction treatment support; assist with the navigation of insurance and treatment issues; and engage peers and volunteers to assist those in recovery on their path toward wellness. Because this initiative has proven successful OASAS will expand it

with funding awards for 6 new centers across the state to be announced soon.

Youth Clubhouses

In January, Governor Cuomo announced more than \$1.6 million in annual funding to create adolescent substance use disorder clubhouses. These first-of-their-kind clubhouses will be based in seven regions across the state and will promote peer-driven supports and services in a non-clinical setting for young New Yorkers in recovery or at risk for substance use disorders. The organizations receiving funding will help young individuals in recovery develop social skills that promote long-term health, wellness, recovery and a drug-free lifestyle.

Recovery Peer Advocates

OASAS is also working with Certification Boards to increase the number of Certified Recovery Peer Advocates (CRPAs) across the state. So far, the Boards have certified 265 peer advocates. OASAS is also collaborating with the New York Alliance for Careers in Health-care and CUNY to explore additional ways to work together to help fulfill the growing need of CRPAs at OASAS treatment providers. We are continually working to address barriers for CRPA certification and to create additional areas of expertise for certain populations. We will be establishing two new peer specialties: family and youth peer specialists. Families faced with a loved one's addiction

often feel scared and alone. Family peers, through their lived experience and training will be able to provide needed support and assistance. Youth peer specialists will also be a much-needed resource for young people entering treatment or who are working on recovery.

There are many exciting initiatives underway focused on recovery from the grasps of the disease of addiction. The first step in recovery is to recognize the addiction problem and to step forward for help. To access help, New Yorkers struggling with addiction, or whose loved ones are struggling, can call the State's toll-free, 24-hour, 7-day-a-week HOPEline at 1-877-8-HOPENY (1-877-846-7369). You can also find information on our website: www.oasas.ny.gov.

NYSPA Report: Raise the Age of Jurisdiction

By Barry B. Perlman, MD and
Demitrios (Jamie) Papapetros

An important part of the mission of the New York State Psychiatric Association is its work to assure the incorporation of good, up to date science into public policy as well as its work to protect vulnerable populations. NYSPA's advocacy for raising the age of criminal responsibility in New York State from 16 to 18 years of age as part of a complex, broader package of juvenile justice reforms aligns with both goals while enhancing the safety of citizens. Indeed, public safety may be improved if what happens in NYS is found to be consistent with the experience in other states.

For the last two years Governor Andrew Cuomo has submitted legislation the goal of which is to phase in a rise in the age of juvenile jurisdiction to age 18 which would bring our state into line with other states. To date, the legislation has not passed; as a result New York continues to be the only state aside from North Carolina, to retain 16 as the age above which youth are tried in adult court rather than in Family Court where access to an array of supportive, rehabilitative services is integral to the actions which can be set in motion by the court. While the legislation has been met by some concerns, many welcome it as an opportunity for New York to be smart on crime, including a broad coalition of organizations representing youth, families as well as members from the law enforcement and district attorney community and unions.

To address the fear that reform would likely lead to increased crime, it is important to point out that violent crime committed by juveniles would continue to originate in criminal court. Recognizing the developmental differences between youth and adults, the Governor's bill would establish "Youth Parts" in criminal superior courts assuring that adolescents who commit the most violent crimes would be handled in adult courts by judges with special training meant to prepare them to address the special issues arising when dealing with offenders in this age group.

Data from Connecticut and Illinois, 2 states which recently enacted comparable changes to their statutes, reveal that recidivism and crime rates can be lowered when non-violent young offenders are removed from the adult justice system and receive mental health and other needed services without adversely affecting public safety. Furthermore, data demonstrate the salutary impact on the young non-violent offenders themselves of not being incarcerated in adult facilities. Beyond reduced recidivism researchers found lower rates of suicide, a lesser likelihood of their being sexually assaulted and a better chance that they will do better after release.

The call for reform is based in the scientific findings of both contemporary neurodevelopmental psychology and behavioral research. Researchers over recent decades have better delineated the evolution during adolescence of the develop-

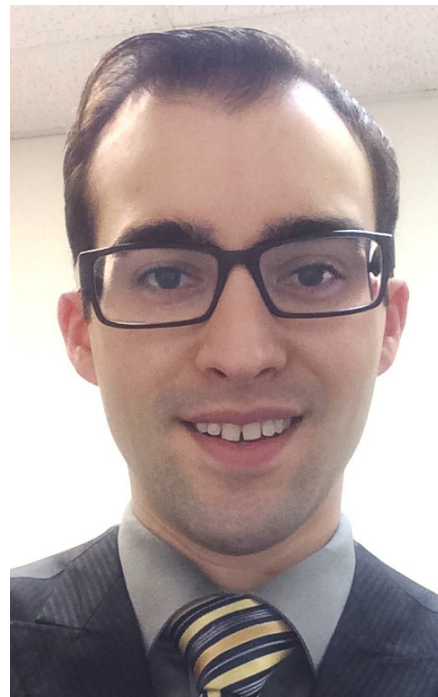


Barry B. Perlman, MD

mental reward, pleasure neural pathways of the brain and the implications of those evolving changes on the behavior of those between 15 and 21 years of age. The brain changes which occur over a period of years may be both sequential and simultaneous. They manifest themselves in changes various anatomic regions and pathways in the brain with consequences on its systems of reward and neurointegration. The result at different developmental points is adolescent hypersensitivity to pleasure seeking experiences, especially when in the company of their contemporaries, and only the gradual ascent of more rational decision making along with better affective modulation more characteristic of adults as the process of maturation unfolds. In this context, it is noteworthy that the U.S. Supreme Court in a series of decisions beginning with *Roper v. Simmons* in 2005, has recognized that youth should be viewed as being less legally culpable than adults as well as being more amenable to rehabilitation.

Absent an agreement to raise the age during the 2015 Legislative Session, the Governor, issued Executive Order No. 150 as an interim measure until the passage of legislation, which directs the Department of Corrections and Community Supervision (DOCCS) in collaboration with the Office of Children and Family Services (OCFS), Office of Mental Health (OMH) and Office of General Services (OGS), to implement the plan to relocate most minors from adult prisons to juvenile facilities in NYS. In anticipation of passing raise the age legislation, the Governor's 2016 budget seeks an appropriation of \$111 million as part of a 5 year financial plan. Of that amount \$110 million would be appropriated to OCFS for the purpose of increasing capacity through the upgrade and renovation of existing facilities and the design of new facilities. \$ 1 million is designated to OMH for program design and staffing for the newly expanded facilities. Relocation of juveniles is to start in August, 2016.

The expansion of the Youthful Offender Status, the provisions to allow



Demitrios (Jamie) Papapetros

court proceedings and conviction to be sealed after a certain period of time in certain cases are two additional important aspects of the "Raise the Age" legislation that are noteworthy; they highlight the

increasing recognition at all levels of policymaking that youth can be rehabilitated and deserve a second chance to learn from a mistake made during their formative years rather than being saddled with a record which limits their future opportunities for higher education, including financial aid assistance, as well as employment.

In conclusion, NYSPA, along with many other interested groups such as Families Together, is advocating for a change in NYS law that would recognize the advances in the scientific understanding of developmental neuropsychology of the brain by "raising the age" of criminal responsibility for non-violent youth offenders in NYS and at the same time offer appropriate protections to youth who, not having reached mature adulthood, deserve to have their treatment by our legal system mitigated as a result of that new knowledge. NYSPA hopes that during the 2016 Legislative Session a bill can be crafted which will pass both chambers, be signed into law by the Governor and will serve the youth of NYS well while also protecting public safety.

Dr. Perlman is the Chair, Committee on Legislation, New York State Psychiatric Association and Mr. Papapetros is the Coordinator of Research and Communications at Richard Gallo Associates.



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Join Us in Honoring Four Champions of the Behavioral Health Community

Limited Tickets Still Available - See Page 16 for Details

By Staff Writer
Behavioral Health News

Behavioral Health News will hold its Annual Leadership Awards Reception on June 21st at NYU Kimmel Center's Rosenthal Pavilion. Jorge R. Petit, MD, Board Chairman of Mental Health News Education, Inc. (MHNE), publisher of *Behavioral Health News*, made the announcement saying, "We are extremely excited to be holding our second annual Leadership Awards Reception and equally excited to be honoring four outstanding leaders of the behavioral health community: Ann Marie T. Sullivan, MD, Peter C. Campanelli, PsyD, Linda Rosenberg, MSW, and John Coppola, MSW. We hope all of our friends, colleagues and supporters will come out to pay tribute to our honorees and to help support MHNE's vital behavioral health education mission."

Ann Marie T. Sullivan, MD, is Commissioner of the New York State Office of Mental Health (OMH). Dr. Sullivan was confirmed by the New York State Senate as Commissioner on June 20, 2014. New York State has a large, multi-faceted mental health system that serves more than 700,000 individuals each year. The Office of Mental Health operates psychiatric centers across the State, and also oversees

more than 4,500 community programs, including inpatient and outpatient programs, emergency, community support, residential and family care programs. As Commissioner, she has guided the transformation of the state hospital system in its emphasis on recovery and expansion of community based treatment, reinvesting over 60 million dollars in community services. Previously, she was the Senior Vice President for the Queens Health Network of the New York City Health and Hospitals Corporation.

Peter C. Campanelli, PsyD, is Senior Scholar, Organizational and Community Services and a Senior Research Scientist for the McSilver Institute for Poverty Policy and Research at New York University Silver School of Social Work. Among other initiatives, Dr. Campanelli co-developed and co-directs NYU Silver's six-module Advanced Certificate in Integrated Primary and Behavioral Health (IPBH). He is the former President and Chief Executive Officer of the Institute for Community Living.

Linda Rosenberg, MSW, is President and CEO of the National Council for Behavioral Health. A healthcare architect who has advanced quality care for people with mental and substance use disorders, Linda is a national expert in the financing and delivery of mental health and substance services. Under her leadership, the

National Council for Behavioral Health has become our nation's most effective advocate for behavioral health prevention, early intervention, science-based treatment, and recovery.

John J. Coppola, MSW, is the first Executive Director of the New York Association of Alcoholism and Substance Abuse Providers, Inc. (ASAP). He has held that position since June of 1996. Mr. Coppola is responsible for representing the interests of substance use disorder and problem gambling treatment, prevention, recovery, research, and training providers throughout New York State. John serves on a variety of national, state, and local working groups and committees that address major issues affecting the field.

Ira Minot, LMSW, Founder and Executive Director of MHNE stated, "Our Leadership Awards Reception this June will celebrate our 16th year of providing vital behavioral health education to the community. I am very honored that we will have this opportunity to pay tribute to four outstanding leaders of our community, and hope everyone will come out in support of their lifetimes of achievement." More on our honorees...

Ann Marie T. Sullivan, MD

As Commissioner of the NYS OMH, Dr. Sullivan has worked closely with all

mental health providers and health plans, and is responsible for the movement of the health benefit for the seriously mentally ill into managed care beginning in October 2015. This new Health and Recovery Plan (HARP) benefit will embed in the Medicaid benefit critical recovery services such as crisis respite, peer, educational and employment supports. She has also been instrumental in expanding services for the mentally ill in prisons and in expanding the much needed community based continuum of care for the seriously mentally ill leaving prison and returning to their community.

As the former Senior Vice President of the Queens Health Network of the New York City Health and Hospitals Corporation, Ann was responsible for Elmhurst and Queens Hospital Centers, two public hospitals which serve a community of over 2 million New York City residents. Along with ensuring the seamless integration and coordination of services across the Network, Dr. Sullivan aligned and helped to implement key corporate programs such as the Care Management Initiative on the inpatient units and in the emergency services; the launching of best practices to improve patient safety; and the integration of behavioral health and medical sciences.

see Awards Reception on page 28



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Becoming a Millennial Nonprofit

By Kristin M. Woodlock, RN, MPA
Chief Executive Officer
Woodlock & Associates, LLC

Health and human services nonprofits across the country are in the midst of a developmental crisis. Taking a page from Erikson's stages of psychosocial development our sector is in the "industry vs. inferiority" stage battling with the question "Can my organization make it in the world of value based payment?" Developmental mastery is always preceded by chaos, crisis, learning and struggle. This article confronts this developmental challenge through presenting the context for the struggle with an architecture for organizational mastery.

Nonprofits began as charities, created for doing "God's Work." Settlement houses, orphanages or food pantries were often initiated by a religious organization or a wealthy benefactor to care for the less fortunate. While the work was extremely challenging, the mission and corporate structure were clear and simple. With the advent of the Great Society in the 1960's Government needed extenders across America to meet an ambitious agenda for social, health and education improvements. With a proliferation of 501(c)(3) organizations between 1970 and 1990, the focus of nonprofits shifted to doing "Government's Work." A robust stream of government contracts expanded the reach and complexity of nonprofits. Over five decades, significant advances in the healthcare, social supports, housing and education have been made.

The results, however, are not all positive. This prior developmental phase left us with a lasting moniker as a "charity" where it is acceptable for government to underfund services while simultaneously messaging that nonprofit's should think and act like a business. The mismatch of expectation places unrealistic demands on an outdated architecture for nonprofits as agents of government. While their mission is strong, the current nonprofit scaffolding of budgeting, finance and business intelligence is too frail and inelastic to support the changes necessary to move to a value-based environment. Delivering value is akin to the retail market. The developmental challenge we face, to



Kristin M. Woodlock, RN, MPA

"deliver value" is an existential-level change from simply "doing good." Not unlike the difference between a rotary phone and a smart phone, that do the same function in remarkably different ways.

To complete the analogy, nonprofits need to develop an operational vision and framework for taking care of people which comports with a competition-based, product-driven market. Without this structure and attention, the magnitude of the change required in government policy, regulation and funding in the nonprofit sector could quickly create paralysis in organizations fighting fires on a number of fronts. An architecture for moving to the value-based world connects and inspires people inside the organization and beyond. Nonprofit boards and leaders need to articulate a clear vision of what "value-based" means to them from the beginning, breaking it down into clear action steps, communicating what it will look like at mile-markers along the journey, and translating it into a story that can be told and retold.

A well-constructed transformation story paired with an implementation structure will guide the organization through the turbulent waters of change as individuals understand what must change and why. Millennial Nonprofit is an architecture that leaders can use to build core

competencies for success in a value-based environment and perhaps most importantly to build hope and conviction across the organization. Organizational mastery is articulated by performance in eight (8) core Millennial Nonprofit™ characteristics of Mission, Distinctiveness, Expertise, Highly Efficient (ROI), Messaging, System Affiliate, Results and Location. Nonprofits can both drive internal transformation and communicate their capability as a value-based provider externally using the Millennial Nonprofit standard.

A shared vision of what a "mastery model" for a nonprofit is in the era of value-based payment must be achieved among agencies, payers, government and philanthropy to ground critical transition work in public policy, finance and payment, regulation and outcomes.

To effectively move towards a Millennial Nonprofit standard one must realistically know where one stands today. The pathway to mastery demands organizations pursue rigorous assessment across many domains. While each is important, the fragility of the financial position and infrastructure of nonprofits makes attending to the organization's capacity to keep the doors open during a transition priority one. Our approach to financial and infrastructure assessment must recognize that self-assessment is limited. Nonprofits have thick reputational veneers and neither governmental, Foundation accreditation bodies nor outside auditors have really cracked the code to identification of risk. How might we look differently at assessing the health of our agency? Chief Executives of major corporations are always looking at their company's performance and risk. Risk is a constant presence, but its form is continuously changing. In reviewing their approach, nonprofits could consider a "health scan" for the Agency.



By example, a scan administered by an objective source across nine (9) domains using a select group of indicators scored in a basic color code of green (meets or exceeds)/yellow (partially meets)/red (does not meet). Whatever the tool, the assessment should build transparency, accountability and conversation across the organization leading to action. Organizational health assessment before, during and after the transition to value-based payment creates the rigor needed to achieve mastery.

We in the nonprofit community can master this developmental challenge before us if we are good students of history and deploy a strong vision and architecture for the change within our field and in our organizations. It also seems wise for us to heed Erikson's caution that challenges in the developmental stages not successfully completed should be expected to reappear as problems in the future.

Kristin M. Woodlock is the CEO of Woodlock & Associates, LLC a consulting firm specializing in nonprofit health and human services. She can be reached by phone at (917) 244-4221 or by email at woodlockassociates@gmail.com

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Value Based Care from page 1

our understanding of how to weave medical and social services together to our potential partners in the medical system while positioning ourselves to negotiate a portion of the shared savings that the outcomes we generate achieve.

The current cost-based contract system and FFS reimbursement is not working. Behavioral health providers are failing under the weight of rates that don't cover costs. Behavioral healthcare spending is a small and shrinking piece of the healthcare pie, and while the people we serve are accessing some of the most expensive services, the vast lion's share of the money spent on them is spent outside of our programs. And important pieces of the

services that community behavioral health providers frequently provide are not compensated at all under current reimbursement structures. Providers routinely provide services for which they know they will not be paid, but do it anyway because it is what the people they serve need. As a result a large portion of the behavioral health sector's long-term financial sustainability is currently at risk.

How well things work out for our agencies and the people we serve will, in no small part, depend on how well we meet the critical challenge of defining value as not just a reduction in clinical symptoms and diminished costs. Value must be defined as recovery. The metrics must include improvements in the social determinants of health and quality of life

such as housing stability, employment, education, community inclusion and connectivity. This is the value that behavioral health providers have been providing for decades and for which they should be compensated appropriately. The performance metrics to which managed care organizations and accountable care entities will be held will be determined in a contested, complex, political and bureaucratic process. It is absolutely essential that those metrics capture the value that community behavioral health agencies add; otherwise, there will be no way for our community to get our share.

Providers also have a lot of work to do internally. VBP requires that the Board, the agency's leadership and the staff are all aligned in understanding and rising to

the strategic challenges created by the transition. New program models and care pathways will be required, as will new relationships with a wide range of other providers both within and outside the behavioral health sector. In addition, providers will need to implement data capture, analysis, sharing and reporting systems that combine clinical, programmatic and administrative data. Providers will need to update and strengthen financial reporting and analytic systems to better understand and manage the total costs of care and costs per unit of value.

And it's clear that VBP advantages a certain type of provider. Larger, more sophisticated providers with deep benches

see Value Based Care on page 29

From Neighboring Institutions to Collaborators: A Joint Effort to Improve Integrated Care

By Julie Chipman, LCSW, MPA
Jean-Marie Bradford, MD, and
M. Goretti Almeida, MBA

The integration of primary and behavioral health has become a major focus of healthcare restructuring across the country in the past several decades. New partnerships, emerging from a historically siloed system, share the triple aim of improving health status, containing costs and enhancing service delivery to individuals with behavioral health conditions. The growing number of federal, state and local health initiatives, rolling out alongside those of the health insurance and technology industries, highlights the myriad stakeholders committed to achieving integrative care models. Still, the challenges facing providers and systems of care are many and often require new approaches to successful collaboration.

While there is robust evidence supporting the addition of behavioral healthcare services to primary care settings, less exists to support embedding primary care within mental health clinics (L.E. Raney, ed., *Integrated Care: Working at the Interface of Primary Care and Behavioral Health*, 2015). Data from a community-based sample of adults with serious mental illness (SMI) – whose high rates of medical comorbidities and excess mortality disproportionately drive health care expenditures – show that over 60% of subjects had difficulty taking medication, keeping medical appointments, and identifying symptoms (Skinner et al, Met and unmet needs for assistance and quality of life for people with severe and persistent mental disorders, 1999). In addition, the stark association of SMI and poverty with modifiable risk factors and poorer health outcomes underscores the need for targeted integration efforts in public settings (Vick, Jones, & Mitra, *Poverty and severe psychiatric disorder in the U.S.: Evidence from the Medical Expenditure Panel Survey*, 2012). Individuals with SMI often identify their behavioral health providers as their primary resource in the community and their mental health clinic as their unofficial health home. It therefore stands to reason that placing physical health services in the behavioral health setting would produce better outcomes.

In 2014, New York State finalized the terms of a waiver from the federal government to allow the State to reinvest \$8 billion in federal savings for Medicaid redesign. Over \$6 billion was allocated to the Delivery System Reform Incentive Payment (DSRIP) Program to streamline healthcare delivery and reduce avoidable hospitalizations and emergency department visits by 25% over five years. DSRIP promotes community-level collaboration between providers of care into formal, sustainable care networks called



Performing Provider Systems (PPS) (Algonquin Studios, NYS DSRIP: An \$8 Billion Experiment in Working Together for Better Healthcare, 2014; Schuyler Center for Analysis and Advocacy, *Overview of the Delivery System Reform Incentive Payment Program*, 2014). PPS are required to streamline the delivery system and make quality health care accessible to Medicaid members as the foundation to achieve the program milestones. The level of funding and coordinated effort involved in DSRIP speaks to the priority given to enhancing services to residents with behavioral healthcare needs.

Under this initiative, NewYork-Presbyterian (NYP) is leading a PPS and collaborating with the Washington Heights Community Service (WHCS) to embed primary care in two state mental health clinics in Upper Manhattan. The collaboration arose from a mutual, long-standing concern and interest in the poor health of the Washington Heights and Inwood communities. NYP and WHCS are separate organizational entities located in Upper Manhattan. NYP is a large private not-for-profit academic medical center, while the WHCS is a state-administered and -operated community mental health service of the New York State Psychiatric Institute. Each organization has its own mission, leadership, governance, and operational structures. The NYP-WHCS team, while excited about this unique opportunity to provide comprehensive care to adults with SMI, has come to understand that systemic integration and physical colocation – a first for both – presents both challenges and opportunities for growth and innovation.

The WHCS has provided psychiatric care to adults with SMI since its inception in the 1970s. It currently serves approximately 1,000 individuals, most of whom are of low socioeconomic status (95%), from racial-ethnic minority groups (82%), primarily Hispanic (62%) and non-Hispanic black (19%), and have a psychotic spectrum disorder (56%) or mood disorder (39%). Its multidisciplinary teams of psychiatrists, social workers, nurses,

peer providers, occupational therapists, and trainees of all disciplines work together to provide the range of clinical and recovery services needed to help ameliorate psychiatric symptoms, address psychosocial stressors and rebuild the functional shortfalls commonly seen in this population. Factors such as low health literacy and side-effects of psychotropic medication compound the challenges for these providers in managing and coordinating clients' physical and behavioral health services.

Prior to DSRIP, the WHCS recognized the need to address the medical problems of their clients and made efforts to integrate behavioral and physical healthcare. The WHCS hired an internist for weekly medical consultation to clients and case consultation to staff managing complicated medical comorbidities. The WHCS participated in the Office of Mental Health PSYCKES pilot project to identify and track cardiovascular risk factors and interventions to reach targeted outcomes. Until now, more comprehensive integration has been stalled by factors that include financial and regulatory constraints, and difficulty providing discipline-specific support and supervision to primary care providers housed in mental health settings.

The NYP-WHCS collaboration provides vital resources to achieve the goal of full integration. DSRIP funding is available to cover start-up costs, including building and equipping primary care space in each of the two clinics and hiring primary care staff. Primary care providers at the clinics will receive support and supervision from the professional community of NYP. Clients will have access to routine primary care and walk-in services. Staff can leverage clients' engagement with the clinic to increase their utilization of on-site primary care services as an alternative to the emergency room, and to improve modifiable risk factors and physical health outcomes. However, the sustainability of the model has been of primary consideration as the project unfolds. Examining the staffing ratios of other integration models and gathering

data on client primary care utilization and need have been key aspects of the project design. As the state moves toward a value-based payment model, a combination of improved health outcomes and lower utilization of high-cost services will be key to programmatic fiscal sustainability.

The merging of the two systems to form a new culture has been greatly facilitated by the framework created by Substance Abuse and Mental Health Service Administration (SAMHSA). The Integrated Practice Assessment Tool (IPAT) is a tool that places practices on the level of collaboration/integration defined by the Standard Framework for Levels of Integrated Healthcare (Waxmonsky, Auxier, Romero, & Heath, *Integrated Practice Assessment Tool*, 2014; Heath, Romero, & Reynolds, *A Review and Proposed Standard Framework for Levels of Integrated Healthcare*, 2013). The latter has enabled the team to understand the continuum of collaboration and their future objectives by operationalizing three ways of joining efforts: coordination, colocation and integration. The project aim of primary care integration into the clinics' existing structures and cultures has entailed discussions around documentation, access to a shared medical record, and primary care participation in team meetings and rounds. In addition, while DSRIP's focus on innovation and evidence-based, population-based care builds upon the clinic's existing quality projects, the aim to bridge communication with collaborating agencies accelerates the need for enhanced technological capabilities and will require staff to adjust to new systems and forms of communication and documentation. The SAMHSA tools have helped to mitigate culture clashes and resistance to change through the development of a common language about integration.

Still, the initiative is in its inception, and cross-fertilization of ideas will need to continue within and between the two organizations to meet programmatic and fiscal goals. DSRIP has provided sorely-needed start-up resources and structures to facilitate collaboration and systemic change in the hopes of achieving improved health outcomes for clients with SMI. This NYP-WHCS team is fortunate to have this opportunity to develop a program that will not only improve its clients' health but contribute to the development of best practice models for integration. The learning curve has been, and will continue to be, steep but the anticipated payoffs are great.

Julie Chipman, LCSW, MPA, is Primary Care-Behavioral Health Integration Program Manager of New-York Presbyterian DSRIP Programs; Jean-Marie Bradford, MD, is Director of Washington Heights Community Service; and M. Goretti Almeida, MBA, is Administrator of Washington Heights Community Service.

Behavioral Health News is Now Accepting Articles for our Fall Issue

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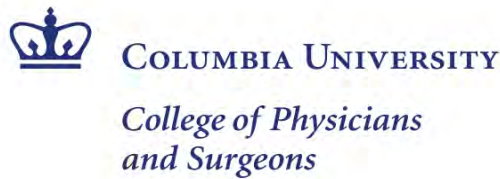
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Addressing the Social Determinants of Health: Steps to Achieving Service Integration

By Mary Pender Greene, LCSW-R
MPG Consulting

Mental health is a vital part of every person's overall health and well-being. Every adult, child, youth and family should receive essential services and support regardless of how they enter the healthcare system. According to the Social Equity Report (Yale Global Health Leadership, 2015), there is strong evidence that increased investment in social services – as well as various models of partnership between health care and social services – can result in substantial health benefits and reduce health care costs for targeted populations.

We know that achieving optimum health requires much more than just controlling disease. It requires ensuring conditions in which people can be healthy. Good health results from having choices – that is sound reasonable options. Conditions in the social and physical environments determine the range of options that are available and their ease or difficulty of use. Healthful social and physical conditions can ensure that all members of society benefit from the same basic rights, security, and opportunities.

By addressing inequalities in social and physical environmental factors, we can increase health equity and decrease health disparities. Doing so involves recognizing the substantial, often cumulative effects of socioeconomic status and related factors on health, functioning, and well-being from even before birth throughout the entire life course. Reducing inequalities in the social environment and physical environment, as well as addressing behavioral health disparities can help people meet their health objectives (Healthy People 2020). Strategies aimed at eliminating behavioral health disparities include (SAMHSA-HRSA, 2012):

- Increasing knowledge and implementation of integrated primary and behavioral healthcare models that serve communities of Color and those with limited English proficiency.
- Promoting best, promising and evidence-based practices that are racially/culturally/linguistically appropriate.
- Supporting efforts to build a multidisciplinary, racially and culturally diverse, knowledgeable, bilingual and racially and culturally attuned workforce and leadership for integrated care.
- Improving health and behavioral healthcare by first understanding then addressing the role of social determinants of health.
- Improving information dissemination strategies through learning collaboratives.



Service Integration

Service integration as an example of a quality health care delivery design that facilitates communication and coordination based on consumer and family preferences and sound economics (Position Statement 13, Mental Health America-MIA), 2016.

- **Communication:** Each clinician caring for the patient (consumer) shares needed clinical information about the patient (consumer) to other clinicians also treating the patient (consumer)
- **Collaboration:** A multidimensional, shared understanding of goals and roles, effective communication, and shared decision-making.
- **Care Coordination:** The outcome of effective collaboration and corresponds to clinical integration.
- **Service integration:** The extent to which patient (consumer) care services are coordinated across people, functions, activities, and sites over time so as to maximize the value of services delivered to patients.

The main responsibility for providing mental health care continues to fall on primary care, with 42% of patients with clinical depression and 47% with generalized anxiety disorder first diagnosed in primary care (The American Academy of Family Physicians, 2015). Although primary professionals provide the majority of mental health care, they may lack the knowledge or the time to adequately diagnose and treat mental health conditions. Many individuals prefer to receive their mental health care within primary care since it is perceived as less stigmatizing. As such, the role of primary care identification and treatment of mental health conditions is especially important for special

populations who often go undiagnosed due to lack of access.

Communities of Color and persons with limited English proficiency often seek behavioral health assistance through their primary care providers. The Office of Minority Health (OMH) first examined the role of integrated care in 2004 to find solutions for improving access, engagement and utilization of mental health services. Since then, the field has gained significant momentum. OMH highlighted and promoted models that provided efficient and seamless coordination of access, quality and delivery of care. The goals were centered on promoting health equity, building on innovation and leadership, working collaboratively with other federal and non-federal partners, leveraging dollars, and bridging gaps. Below are some models of integrated care aimed at improving the overall quality of care for underserved communities (SAMHSA-HRSA, 2012):

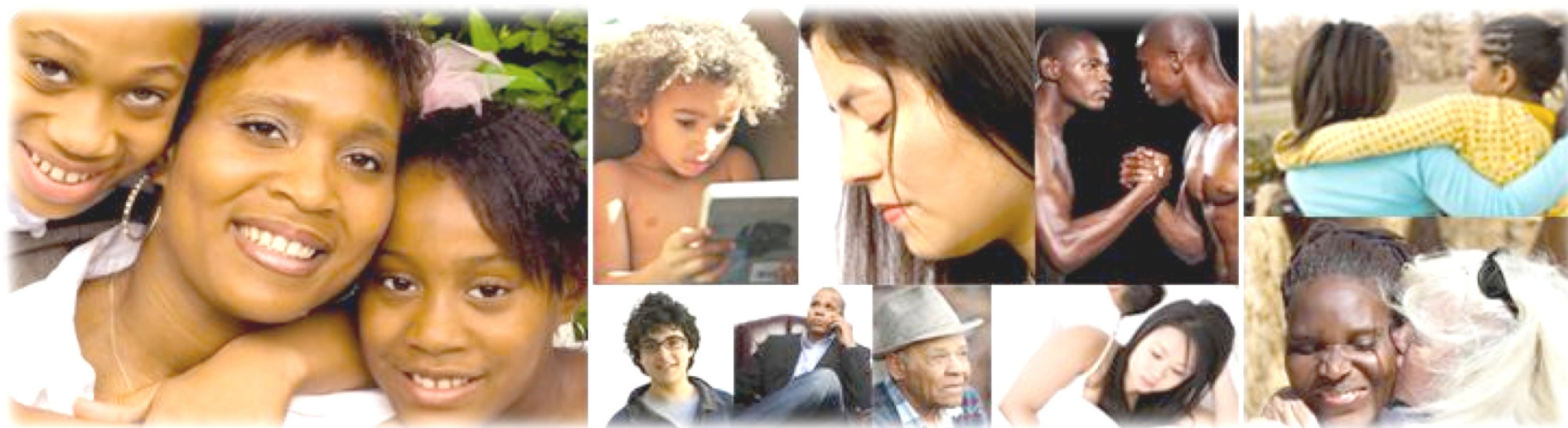
- Integrated Care for Asian American, Native Hawaiian & Pacific Islander Communities: A Blueprint for Action Summit (August 2011) and A Blueprint for Action. Consensus Statements and Recommendations (2012).
- Eliminating Behavioral Health Disparities through the Integration of Behavioral Health and Primary Care Services for Racial and Ethnic Minority populations: Establishing Models for Improving Clinical Outcomes. Hogg Foundation for Mental Health. Consensus meeting: Nov. 2011. Consensus paper: Jan. 2012. Final rollout: February 7, 2012. Review of the literature due May 2012.
- Mobilizing Social Work as a Resource for Eliminating Behavioral Health Disparities: a Disparities Curriculum Infusion Project, National Association of Deans and Directors of Schools of Social Work. Literature Review. Due April 2012.

- Dialogue and Strategies for Effective Holistic Health for African Americans-Blacks: Addressing the Integration of Mental Health, Substance Abuse and Primary Care (2010) and Pathways to Integrated Health Care, Strategies for African American Communities and Organizations: consensus statements and recommendations (2011).

For clinicians working in integrated care settings, racial and cultural understanding and sensitivity are vital to engaging and caring for communities of Color in the care they need to achieve recovery and improved health. The goal is to empower the community and their families to enjoy healthier and more fulfilling lives by providing culturally affirming and affordable behavioral health and prevention services. Below are 10 tips that can help build stronger, more culturally competent relationships with clients (SAMHSA-HRSA, 2012).

1. Recognize that culture is a defining characteristic for some clients, and that their cultural identity may be at the root of their presenting health problem.
2. Do not assume that culture is a defining characteristic of all clients.
3. Do not assure any client that you understand. Rather than try to prove how much you know about a client's culture, demonstrate your willingness to learn from the client.
4. Treat each client as an individual, not as a member of a group.
5. Do not assume you have an advantage with clients of the same culture as you.
6. Remember that human beings are more alike than different – do not overlook obvious interpretations of behavioral health and health symptoms by only interpreting a client's actions in context of their culture.
7. Accept that we all relate to others within the context of our own set of values, knowledge and experiences.
8. Assume that you have biases and beliefs that may hinder optimal provider-client relationships.
9. Draw upon your own expertise at the same time you honor and acknowledge each client's expertise.
10. Realize that as an integrated healthcare provider, you are the expert on strategies of health behavior change and treatment and services (and each of your clients is the expert on his or her own culture and the place it holds in his or her life and healthcare).

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Maintaining a Focus on Recovery For People Within the Supported Housing System

**By Jose Cotto, LMSW, Vice President,
Residential, Rehabilitation, and
Support Services, ICL**

The changes that have taken place over the last few years in the behavioral health field are affecting the way staff view “clients” as well as the way these same “clients” are being helped to view themselves. There is a swirl of information and expectations, and government funding is changing (and seemingly decreasing). Managed care means the government is paying for outcomes, not for individual services. The question then remains, with all that is changing, how do you maintain a focus on recovery for both your clients and yourself?

Agencies at the forefront of change are utilizing evidence-based practices, harm-reduction, and strength-based approaches. These changes encourage staff to rely more on relationship building and clinical skills, which continue to improve overall quality of services and supports and vastly increases quality-of-life measures.

The changes occurring from the transition to managed care are further complicated by New York City’s housing market. Supported housing apartments are funded on an annual per-person bed rate.



Jose Cotto, LMSW

The money given needs to cover both rent subsidies and the services people need to maintain their independence. According to a survey conducted by the Office of New York City Comptroller Scott M. Stringer, from 2000 to 2012, median apartment rents in New York City rose by 75 percent (compared to 44 percent in the rest of the country). Yet the per-person bed rate did not meaningfully increase within that same time period.

Agencies offering Supported Housing have had to acquire more two-bedroom apartments and then move people who have been living on their own into the shared space. How does staff support people through this transition? How do we get folks to focus on recovery while keeping up with system changes? We emphasize recovery and goals and make them a priority.

Why has the move from one-bedroom to two-bedroom apartments become more common? Well, in New York City, gentrification has been spreading across the boroughs like wildfire, while the demand for affordable housing is also growing by leaps and bounds. Although gentrification may make a neighborhood more appealing, it also makes it more expensive. People moving into a gentrified neighborhood may not want Supported Housing in their community. It is then up to staff and residents to show that they have been steady and reliable neighbors for years. Staff also needs to work with people facing a gentrifying neighborhood by empowering them and stressing that the neighborhood belongs to everyone. Continued advocacy efforts can be achieved by supporting legislation that will protect the right for our folks to continue residing in these up-and-coming neighborhoods and allow them to feel worthy and included.

A case manager asked me how someone who’s been living in a one-bedroom apartment for 15 years is supposed to feel good about moving into a two-bedroom apartment with a roommate. My short answer centers on how a roommate can counter the effects of chronic isolation. My long answer entails different ways of getting people onboard. Under the frame of recovery-oriented practice, you give people options, take your time to match folks, and have people meet each other and get to know each other before making a final move. You also give people the opportunity to look at different apartments, apartments that you yourself would reside in. You remind folks of their resilience and ability to adapt and stress the importance of social connectedness. Just like with any road to recovery, you inform people that setbacks with a roommate are normal and expected and that dealing with issues offers them an opportunity to try a different approach next time a problem arises and to learn more about themselves.

What about staff? They too are often affected by system changes and have to realize that their own needs should have priority and need advocacy as well. When helping staff, I find it useful to have a holistic approach and to encourage them

see Focus on page 30

Addressing the Social Determinants of Health in Program, Payment, and Policy: Extrapolating the Triple Aim for Population Health

**By Briana Gilmore, MSc, Director
Planning and Recovery Practice
Community Access**

There is much more to being healthy than traditional health care. In fact, “health care” is a surprisingly minor factor in health and the prevention of premature death, just 10 percent. Social circumstances, environmental exposures, genetic predisposition, and personal behavior combined contribute to 90 percent of preventable deaths.¹ Unfortunately, trying to design, deliver, and be paid for these non-treatment factors is extremely difficult, but critical if we truly want to improve the health outcomes for the largely poor and socially marginalized people in our programs.

In his instructive 1997 book *Purchasing Population Health: Paying for Results*, David Kindig notes that population health goes beyond aggregate health outcomes for a group of people, and must take place “in an economic framework that balances the relative marginal returns from the multiple determinants of health.” This definition speaks to the reasons why Medicaid and other health care financing systems ignore social determinants to a large degree: there are so many factors that go into the way people achieve well-being that paying for each of them would yield relatively marginal returns compared to the more discretely measurable elements of acute care.

So how can actors in the traditional system of care take into account the vast array of experiences that promote well-being? Encouraged by the Affordable Care Act’s focus on the “Triple Aim” of health care (better population-based health outcomes, better quality care, and lower cost), state health agencies, insurers, providers, and health networks are all looking at how to improve an overall experience of well-being for participants while incentivizing an economic framework that reduces costs.

In pursuit of the ACA’s Triple Aim, policymakers, payers, and providers can adopt a three-tiered approach to population health. First, all actors should focus on a range of options that promote well-being and meet the needs of the people they work with. Second, social determinant options should be complemented by a range of supports with discrete and measurable quality indicators. Third, these practices should be supported by financial mechanisms that invest in the entire range of health promotion activities, and managed by people with a vision that supports whole-health activation.

Community Access has supported social determinants toward population health since its inception. The conviction that a safe and stable home environment – that afforded individuals independence and space to account for the dignity of personal risk and accountability – evolved into a 42-year mission of offering housing

as a first step toward achieving community well-being.

Today, Community Access participants are encouraged to utilize a multitude of options that improve their health. In 2002 we initiated a pet adoption program called Pet Access when employees realized how beneficial the support of dogs and cats is to people who live in our apartments. Pet ownership is well known to promote quality of life and even a longer lifespan, but it also encourages sociability and self-reliance. Similar motivations led to the creation of the Art Collective, where participants learn and practice artistic skills and are supported in entrepreneurial efforts to sell artwork for profit. In 2015 an expert in urban gardening joined the Community Access team to build gardens in the backyards of Manhattan and Bronx housing sites, and to help participants and families grow, cook, and use food harvested by hand. In the spring of 2016 we are introducing a fleet of bicycles at one of our Bronx housing locations that participants can use for exercise, group activities, or traveling to the grocery store or health care appointments.

Promoting social determinants at Community Access is balanced by community approaches that yield discrete and measurable outcomes. We offer supports that are now being encouraged within a Medicaid framework: a growing health division that teams care managers with population health experts who can train staff and

support participants in whole-health management; education support services for people having trouble in post-secondary school and training or wanting to achieve a high school degree; workforce development for peers who want to work in human services and position for radical change in the health care system; and crisis respite that promotes community resilience and recovery while reducing the enormous financial and personal toll of a hospital stay.

Alongside these community supports are robust financial, administrative, and quality assurance mechanisms. Our strategy depends upon: a quality assurance team working closely with all programs to design an environment that is favorable to the whole-health experiences and outcomes of participants; a human resources department that affirmatively hires people with lived mental health experience and removes the barriers to employment that service users often experience; and a development team that focuses on strategic planning and communications to attract a broad range of donors. Additionally, central to our mission is self- and systems-advocacy work. Our advocacy commitments include informing city and state policy and even supporting Community Access participants to address shortcomings within our programs.

Policymakers can adopt these approaches

see Health on page 24

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A New Face on Familiar Trends

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

Last year I attended a conference at which Dr. Michael Hogan, the former Commissioner of the New York State Office of Mental Health, delivered a keynote address on emerging issues and trends within health care reform. He distilled a seemingly inchoate mass of movements, mandates and initiatives into a select group of “Megatrends” he believed would direct the course of reform (Hogan, 2015). Although our landscape has continued to evolve and some of the Megatrends he identified have risen or receded in importance, his conceptualization provided both a welcome framework through which today’s challenges and opportunities could be understood and a tool to distinguish true signals from continuous background noise. I believe another confluence of Megatrends promises to challenge and transform our health and social service systems in the coming decade, and service recipients, providers and other key stakeholders would do well to heed them.

Continuing deinstitutionalization of highly vulnerable populations is an overarching trend whose repercussions extend well beyond our health and social service systems. This is hardly a new trend but its current iteration is markedly different from its predecessors. Fifty years ago President Kennedy signaled a major shift in national policy concerning the treatment and support of individuals with mental illness in his sponsorship of the Community Mental Health Act (National Council for Behavioral Health, 2016). Borne of the noblest of intentions, this Act spawned a movement to reintegrate individuals into their communities of origin and to provide support services essential to their lasting stability and community tenure. Evidence to date suggests this movement accomplished much of its primary objective. The census of state-operated psychiatric facilities has dwindled to approximately 5% of its peak capacity in 1955 (Fisher, Geller, & Pandiani, 2009). This movement has faltered in pursuit of its secondary objective, however. Investment in community-based services has often failed to meet the needs of those with serious behavioral health conditions, and this failure effectively transformed a movement of deinstitutionalization into one of “transinstitutionalization.” Many individuals formerly treated in state-operated psychiatric centers found themselves in homeless shelters and correctional facilities in the absence of essential community support systems. There is a well-established inverse correlation between the census of state-operated psychiatric centers and the population of individuals with serious behavioral health conditions within correctional facilities. During the past 50 years the former has decreased as the latter has increased (Primeau, Bowers, Harrison, & XuXu, 2013). Few would suggest this is merely coincidental. Simply put, we have transferred our most vulnerable citizens from facilities that provided a modicum of care and support to others that offered



Ashley Brody, MPA, CPRP

neither. Many who have avoided transinstitutionalization have nevertheless struggled to access the basic resources and amenities that make community life worthwhile.

The current trend in deinstitutionalization is arguably even more ambitious than previous ones in the pursuit of its primary objective. It has gained currency through the Recovery Movement which has rightfully placed individuals and their expressed needs and preferences at the center of care. Most individuals naturally prefer to reside in fully integrated, community-based settings irrespective of the scope or severity of their health concerns or impediments to stability. The current trend has garnered additional support through legislative and judicial developments, including the passage of the Americans with Disabilities Act (ADA) and the ruling of the U.S. Supreme Court in *Olmstead v. L.C.*, a decision which enshrined the right of individuals with disabilities to reside in the least restrictive settings available to them. In view of these developments there is great impetus to reduce the census of state-operated psychiatric centers, adult homes and nursing facilities and to offer their former denizens opportunities for treatment and rehabilitation in fully integrated settings. These goals are laudable insofar as they respect the expressed needs and preferences of vulnerable individuals and mitigate the deleterious effects of institutionalization, but a successful deinstitutionalization movement must deliver on its promise to provide robust community-based support services for this population. Sadly, another emergent trend suggests these services will likely remain as elusive for the newly-deinstitutionalized as they did for their forebears.

The widespread implementation of managed care models of payment and service delivery within publicly-funded healthcare systems is another trend that is inextricably linked to the latest chapter of the deinstitutionalization movement. This trend was logically borne of the state’s broken Medicaid program and its failing Fee-For-Service system that has produced exorbitant costs and mediocre results. In

2011 New York’s Governor Cuomo charged a Medicaid Redesign Team (MRT) to reduce its bloated budget and enact the principles of the Triple Aim of healthcare reform. This ambitious, tripartite pursuit of increased efficiency, improved population health and enhanced quality has informed the MRT’s activities since its inception. Much of the MRT’s activity proceeds from its premise that Fee-For-Service systems incentivize healthcare providers to deliver more, but not necessarily better, services. Its replacement with managed care models that cap providers’ compensation and reward quality over quantity should promote the Triple Aim. The logic behind this premise is axiomatic and beyond reproach, or so many observers contend. But a bird’s eye view of systems transformation may obscure failures of implementation that occur at a granular level.

New York is not the first state in the Union to delegate the management of its Medicaid program to private Managed Care Organizations (MCOs). Many other states have recruited MCOs to limit their Medicaid expenditures. These arrangements have typically entailed some form of budget capitation wherein MCOs receive fixed “per member per month” payments for the provision of all covered services to enrollees, and they are reputed to reduce costs by eliminating the perverse incentives characteristic of Fee-For-Service systems. Simply put, providers

whose fees are capped have no incentive to deliver more care. These reductions do not merely represent improvements in quality and efficiency, however. A portion of savings is retained by MCOs to offset their operating and administrative expenditures and, in the case of for-profit enterprises, a return on investment to shareholders. These “savings” are significant resources that would otherwise be committed to treatment. It is therefore not surprising that some of the states that zealously adopted managed care models subsequently encountered serious problems when they failed to deliver on their initial promise (Geyman, 2015).

Moreover, MCOs have operated within the realm of primary and surgical care for many years, and their utilization management and review procedures are largely informed by medical models. These models are appropriate when applied to the management of specialty care and surgical procedures, but they cannot properly capture the needs of individuals with serious behavioral health concerns for whom a broad array of medical, rehabilitative, psychosocial, environmental and economic factors must be considered. A rapidly growing body of evidence suggests social determinants of health, including safe and affordable housing, basic income assistance and psychosocial supports are more determinative of health outcomes

see Trends on page 26



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Creating and Sustaining a Culture of Recovery In the Redesigned Health Care System

By Edye Schwartz, DSW, LCSW-R
Director of Systems Transformation
New York Association of Psychiatric
Rehabilitation Services (NYAPRS)

Why should we embrace change? Should we always strive for a better answer, a more gratifying way to walk through life or a more humane and just way to interact with those around us? Or do we change only when the forces pushing us towards change are stronger than those that are resisting? For us now in New York's Behavioral Health System, there's not much choice. Our system is changing rapidly and if we don't embrace it I am not sure we will survive. And, that may be the push we all need to take a hard look at what our service system is doing, discard what has not worked and embrace what does.

Although there are many theories of change, they all start with a similar premise; if you know where you are and you have a vision of where you want to be, you *can* change and strive to move towards that vision. The first step is to adopt a vision and then begin to operationalize the desired outcomes for a system of services that helps you reach that vision. For a recovery oriented system of care, these outcomes are based on the values of choice, hope, person orientation and part-



Edye Schwartz, DSW, LCSW-R

nership. (Farkas, M. The vision of recovery today: what it is and what it means for services. *World Psychiatry*, 2007, 6.)

Incorporating the value of *choice* means increasing access to and integration of services and creating an expanded continuum of services for people to explore and achieve rehabilitation and recovery. If our behavioral health system led with the value of choice, our services would help people with real life goals like employ-

ment, education, and economic self-sufficiency, as well as strengthened social relationships, dating, marriage and raising children. People would have a *choice* of who they might work with, and there would be ample opportunity to experience the power of peer support.

If the value of *hope* was common throughout our services, we would see more recipients and staff who actually believe that a change in the way we do business would be a good thing and that it would be supported by regulators, funders, professionals, peers and family.

True *partnership* would be seen through increased numbers of people with a lived experience involved in the planning and delivery of services at all levels. If our services were *person oriented*, we would see fewer rules that excluded and discharged people from our services and more flexibility in accessing and utilizing them. We would also see people become less dependent on our behavioral health system and more actively involved in community activities and roles.

With all the changes to our healthcare system and especially the shift from volume to value, the time has come to put these theories into practice. Recovery has finally become good business because people who are attaining their goals and realizing their dreams are the "satisfied customers" that we need to not only survive but to succeed in a value based

world. The success of our organizations will require a transformation of organizational culture and staff competencies to truly deliver recovery-oriented services based on the principles of recovery and wellness, as well as on the belief that all individuals can set and reach their desired life goals and dreams. Services will be delivered in a positive atmosphere of respect, hope, growth, and support and will be culturally competent, trauma-informed, and person-centered. Services should be readily accessible, with easy entry, exit and reentry if desired. Services are not seen as an endpoint, but rather as a means by which a person can remain a full participating member of his or her community.

In order to successfully transform, our staff and services must grow past old ways of doing business and embrace a new recovery orientation. As change agents and leaders we can assist them by assessing our readiness to change, exploring what we are best at and what we are truly passionate about and then starting the hard job of making choices about what we will provide and how we will provide it. To aid this process, we can help develop our agency's readiness to change (Cohen, M. & Forbess, R. *Training technology: Developing readiness for rehabilitation*. Boston: Center for Psychiatric Rehabilitation, 1992) by opening lines of

see *Culture* on page 30

With Hope, All Things Are Possible.

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

- Person-directed support for the whole person, regardless of their age or stage in life
- Building on the strengths and abilities of each individual
- Cultural competence
- Techniques, tools, and technology to empower people to live purposeful lives
- Peer support from others who have been there
- Flexibility and innovation at every step
- Inspiring hope to drive recovery

At Optum™, we put these principles into action every day, serving individuals and communities in over 25 states. We're proud to partner with state, county, community, and provider stakeholders in their efforts to further individual recovery.



BEHAVIORAL HEALTH NEWS DESK

Grant to Train Residents in Mental Health First Aid

By Staff Writer
Behavioral Health News

The New York State Office of Mental Health's Hutchings Psychiatric Center and SUNY Upstate Medical University announced that they have been awarded a \$375,000 three-year grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) to support the training of a diverse group of adults in Mental Health First Aid. This training will help adults detect mental illness occurring in youth in Onondaga County and connect them with needed services.

"One in four Americans will experience a mental illness in their lifetime. As with many other health issues, early identification and intervention of mental illness is key to helping people find support and begin their journey to recovery. Mental Health First Aid is a nationally renowned program that is making a huge difference in the way that mental illness is recognized, treated, and accepted by communities. This is a very exciting program and I cannot wait to see the impact it has within Onondaga County and beyond!" said New



York State Office of Mental Health Commissioner Ann Marie T. Sullivan, MD.

Mental Health First Aid (MHFA) is an internationally-recognized public education program that introduces adults to the risk factors and warning signs of mental health problems in young people and builds an

understanding of the importance of early intervention. Participants are introduced to local mental health resources, national organizations, support groups, and online tools for mental health and addictions treatment and support. By implementing MHFA, Hutchings Psychiatric Center and SUNY

Upstate Medical University expect to see increased mental health awareness and literacy among adults and community organizations, and thereby earlier interventions and better access to care for young people.

"SUNY Upstate Medical University is pleased to work with New York state and Hutchings Psychiatric Center on such an important initiative," said Dr. Danielle Laraque-Arena, president of SUNY Upstate Medical University. "This collaborative approach to enhancing early identification of and linkage to evidence-based treatment for mental health problems, as well as, community-based efforts at health promotion in support of resiliency, has the potential to move us forward by leaps and bounds in how our community cares for and nurtures its youth."

It is estimated that by the end of the three year grant period, Project AWARE will be able to conduct 70 MHFA workshops, train approximately 1500 - 1750 people in MHFA and in the process reach 20,000 - 25,000 youth in Onondaga County. These workshops will be free of charge to those youth-serving agencies and organizations. This program will significantly expand and

see First Aid on page 25

Grant to Strengthen Mental Health and SUD Programs in NYS

By Staff Writer
Behavioral Health News

The New York State Office of Mental Health and Office of Alcoholism and Substance Abuse Services announced today that New York has been awarded a federal planning grant of \$982,373 to strengthen its community-based mental health care and substance use disorder programs through the development of new Certified Community Behavioral Health Clinics (CCBHC) in pilot sites across the state. This program, consistent with the objectives of Governor Cuomo's Medicaid Redesign Initiative, will help New Yorkers access better primary care, mental health, and substance use disorder services, strengthen Medicaid service providers, and improve the overall health of New York residents, while reinforcing the system that serves them.

"The modern mental healthcare and substance use disorder service systems must be comprehensive and available when and where people need them. Under Governor Cuomo's leadership, New York State has been transforming the way we deliver care, focusing on individual specific treatments and wrap-around services that are available in communities throughout the state," said

New York State Office of Mental Health Commissioner Dr. Ann Marie Sullivan. "I am proud that New York has been selected to be a part of this valuable program and am eagerly anticipating the expected positive outcomes at our pilot sites."

Through this grant, New York will establish multiple CCBHC pilot sites across the state, and site selection will reflect the regional diversity of the state's population and service delivery systems. The pilot sites will develop outpatient networks of primary care, mental health, and substance use disorder programs that will adopt a common set of tools, approaches, and organizational commitments to treat individuals in a seamless and integrated fashion. Stakeholders will be able to provide input into the networks' design and provide advice on ways to improve services, as this process moves forward.

"We are excited about the opportunity to participate in this planning grant and hope New York State will be selected for the demonstration program," said New York State Office of Alcoholism and Substance Abuse Commissioner Arlene González-Sánchez, M.S., L.M.S.W. "This grant will enable us to continue to further positively reinforce our State's Medicaid Redesign Initiative and improve access to key health care services that many New Yorkers need."

The goal of New York's Certified Community Behavioral Health Clinics will be to:

- Improve New Yorker's health outcomes by increasing access to quality care for all Medicaid eligible individuals;
- Reduce avoidable hospital use and complications through the development of intermediate levels of service;
- Foster better partnerships between primary care and mental health and substance use disorder providers through collocation; and
- Improve the fiscal outlook for mental health and substance use disorder care providers by improving Medicaid reimbursement.

New York State's Medicaid reform efforts during the last five years have helped create an environment for establishing relationships, management structures and integrated evidence-based care models that will enable the swift growth of a network of CCBHCs. This grant will take this effort to the next level by supporting the state infrastructure necessary to pilot the implementation of these needed services.

"We applaud the Governor's ongoing efforts to expand and strengthen commu-

nity-based treatment of mental health and substance abuse issues," said Lauri Cole, Executive Director for the New York State Council for Community Behavioral Healthcare. "This grant will enable the state to take another step forward in providing New Yorkers with a full range of healthcare services, while improving access and service availability for people who need those services the most."

This planning grant is part of \$22.9 million awarded nationwide by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA), the Centers for Medicare & Medicaid Services and the Assistant Secretary of Planning and Evaluation, and is administered in New York by the Office of Mental Health, Office of Alcoholism and Substance Abuse Services, and the Department of Health.

The planning grants are the first phase of a two-phase process. When the planning grant phase ends in October 2016, New York will have an opportunity to apply for a two-year demonstration program that will begin January 2017. Under the demonstration program, up to eight states with certified community behavioral health clinics will provide mental health and substance use disorder services to individuals eligible for the program in their respective state.

BEHAVIORAL HEALTH NEWS DESK

New CEO Appointed at The Coalition of Behavioral Health Agencies

By Staff Writer
Behavioral Health News

Christy Parque has been named Chief Executive Officer of The Coalition of Behavioral Health Agencies (The Coalition), an umbrella advocacy organization representing more than 130 of New York's community-based behavioral health nonprofits. The appointment was announced by The Coalition's President Tino Hernandez, on behalf of its Board of Directors. Ms. Parque will begin her new position on April 4, 2016.

Ms. Parque joins The Coalition from Homeless Services United (HSU) where she has served as Executive Director since 2007. Her work at HSU, a 50-member association of non-profit organizations serving homeless people, has focused on creating sound homeless and housing policy, providing advocacy, information and



Christy Parque

training to providers around the provision of housing and support services for homeless populations in New York City. Trained as a social worker and with a healthcare, labor and social justice background, she is a consummate advocate and has worked tirelessly to develop collaborative relationships with elected officials, government professionals, community partners and service providers.

During her nine-year tenure at HSU, Ms. Parque has grown the organization, significantly increasing its funding and offering greater training opportunities for her member agencies. She has developed and implemented successful advocacy campaigns at the city, state and federal levels and has championed programs and funding to study and support best practices in the field. She has been an active participant on several high-level City and State task forces with sector and government stakeholders. She co-authored "A Roadmap to End Homelessness in New York

City," (2013), a guide written for the incoming Mayor and City Council detailing proven, cost-effective policies to prevent and end homelessness in New York City.

"After a nationwide search, we are very fortunate to have found Christy Parque who will bring her considerable organizational and advocacy skills to The Coalition," said Tino Hernandez. "We are looking forward to her stepping into our sector at a time of great complexity and rapid change. She will bring new energy and ideas to the community-based behavioral health sector. Her knowledge about homelessness will be an important asset as The Coalition also represents many service providers that provide specialized services to homeless New Yorkers with mental illness and addictions."

Ms. Parque is succeeding Phillip A. Saperia, who has served as CEO of The Coalition for more than 21 years.

see New CEO on page 25

\$350 Million Bronx Behavioral Health Campus Opens

By Staff Writer
Behavioral Health News

The New York State Office of Mental Health (OMH) and the Dormitory Authority of the State of New York (DASNY) announced the opening of the new \$350 million Bronx Behavioral Health Campus in the Morris Park section of the Bronx, New York City. The new 436,310-square-foot facility features modern amenities for the 156-bed Bronx Psychiatric Center, the 86-bed New York City Children's Center-Bronx Campus, and an expanded 188-bed residential village providing transitional and supported housing to adults with behavioral health issues.

"Throughout the history of our agency, the Office of Mental Health has understood the role that healing environments play in an individual's recovery. The beautifully designed Bronx Psychiatric Center and the Bronx Campus of the New York City Children's Center represent the State's continued commitment to the City of New York and its most vulnerable residents. This new campus offers safe and secure facilities for individuals with mental illness to find hope, realize recovery, and build resiliency in a setting that exemplifies the best of what New York State has to offer," said Office of Mental Health Commissioner Dr. Ann Marie T. Sullivan. The project was managed by DASNY, from the design that began in 2008 to its completion in December 2015. More

than 5,000 workers, with approximately 18 percent from the Bronx, were employed in its development. Over 30% of all contracts were delivered to Minority and Women Owned Business Enterprises, exceeding New York State's goals.

"DASNY is proud to have partnered with the Office of Mental Health in delivering the state-of-the-art Bronx Psychiatric Center and the Bronx Campus of the New York City Children's Center as we continue to strengthen New York's safety net. This new facility will provide comfort, security and the tools its inhabitants need to help them recover and restart their lives. Constructing, and often financing, the infrastructure that comprises the essential fabric of our communities is at the core of what DASNY does," said DASNY President and CEO Gerrard P. Bushell.

The new campus replaces the current Bronx Psychiatric Center, which opened in 1963, and Bronx Campus of the New York City Children's Center, which opened in 1969 as Bronx Children's Hospital. It offers a modern mental health treatment environment designed to provide services in a respectful manner within a safe, secure, and inspirational setting. The inpatient buildings feature secure indoor and outdoor recreation areas, cutting-edge electronic monitoring technologies, motivating educational settings, and comfortable living quarters. All treatment areas within the inpatient buildings were specifically designed to put patients at ease and provide a safe working environment for OMH employees.

In addition to the inpatient buildings on the new Bronx Behavioral Health Campus, the development also includes a new residential village, which expands the availability of much-needed supported, transitional, and crisis housing for New York City residents with mental illness. In total, three OMH residential programs will be operational on the site; a 48-bed Apartment Treatment program, a 96-bed Transitional Living Residence, and a new facility for OMH's 44-bed Horizon House-Haven House crisis residence.

"The Bronx Campus of New York City Children's Center has a proud history of service to children with serious emotional disturbances and their families, and we will continue such service through the years in this modern and accessible facility. To serve as inspiration for the resiliency they will build there, the children have named each new unit in the building. Hope. Unity. Dream. Life. These words will guide us as we help these children find the success they deserve as they look towards happier and healthier futures," said Acting Interim Executive Director of the New York City Children's Center-Bronx Campus Marcia Alkins, MA.

"Bronx Psychiatric Center provides first-rate mental health care to thousands of New Yorkers each year. The new architecturally welcoming space, brightened by natural light from hundreds of windows and surrounded by thoughtful landscaping, will help our patients feel connected to the outside world and feel hopeful for the future. The open design of the

treatment units will enable our employees to provide better supervision of patients and have the space they need to provide safe one-on-one care," said Bronx Psychiatric Center's Acting Executive Director Anita Daniels, MS, RN-BC.

The campus features a new Central Services Building to provide support services to both the inpatient buildings and the residential village. This building contains administrative offices, a centralized kitchen, maintenance shops, and other services that were previously scattered throughout the campus. The consolidated location of these services allows for more efficient operation of the new buildings and reduces duplicative systems throughout the campus.

In its new location, the Bronx Behavioral Health Campus is more closely integrated with the immediate neighborhood and transforms what was a secluded campus into a connected part of the community. Adjacent to the facility is a recently constructed Residence Inn and Applebees Restaurant, which provides visiting family members with nearby food and lodging options. The close relationship with the surrounding area will help patients feel less isolated and more hopeful for their future return to the community.

The campus is constructed to operate as an energy efficient building, with a pending goal of LEED-Silver certification from the United States Green Building Conference. This energy-conscious construction should reduce the facility's energy consumption by 21% or nearly \$300,000 annually.



Spotlight on the Behavioral Health Community



Phillip A. Saperia Receives National Council Award of Excellence

By Staff Writer
Behavioral Health News

Phillip A. Saperia, former Chief Executive Officer of the Coalition of Behavioral Health Agencies was awarded the *Visionary Leadership Award of Excellence* from the National Council for Community Behavioral Health. Phillip was chosen as an awardee from over 1,000 applicants to receive this prestigious award.

The Visionary Leadership award also comes with a sizable donation to an organization of the honoree's choice and we are so pleased that Phillip has selected The Coalition to be the recipient of this \$10,000 donation. The award is a fitting way to honor Phillip's 21-year tenure and his considerable achievements at The Coalition as he retired at the end of March.

Phillip has played an integral role in shaping public policy and behavioral



Phillip A. Saperia

health in New York City for more than two decades. Ushering The Coalition of Behavioral Health Agencies members through the wake of de-institutionalization through the launch of Medicaid managed care; Phillip has created multimillion-dollar funding initiatives that support behavioral health safety-net providers so that they have the resources to deliver services to those who need it most. Deeply involved in mental health and addictions public policy, he has been frequently called upon to by New York State and city government officials to offer expert advice and testimony.

"I am much honored to receive this prominent award," said Mr. Saperia. "These 21 years at the helm of The Coalition have afforded me many blessings. I have gotten to know, a sterling group of people who do indispensable work that makes our world better; and helps individuals and groups of people who are quite vulnerable. I am fortunate to have

worked with a dedicated Board. I also have been privileged to work side by side with a talented, committed and productive staff—both current and alumni—who have given their all for this organization and its cause. How lucky I am to be identified with the good deeds of Coalition members and to have helped make possible the continuation and wellbeing of the community safety net."

Phillip received his award at the National Council's conference in Las Vegas which was held on March 8.

The Coalition is the member based umbrella association and public policy advocacy organization of New York's nonprofit behavioral health providers (delivering mental health and substance use services). It represents over 130 community based nonprofit member agencies. These agencies serve more than 350,000 adults and children and deliver the entire continuum of behavioral health care in every neighborhood of New York City and the metropolitan area.

Steve Coe Wins National Award for Mental Health Advocacy

By Staff Writer
Behavioral Health News

Steve Coe, CEO of Community Access, a New York City nonprofit organization, received the National Council for Behavioral Health's prestigious *Individual Achievement in Advocacy Award*. Mr. Coe is being recognized both the breadth of his achievements over the course of a 36-year career, and his prominent role in more recent advocacy initiatives.

Coe's award particularly honors his commitment to improving police responses to individuals experiencing emotional distress, via the implementation of Crisis Intervention Team (CIT) training for NYPD officers, in partnership with local mental health providers.

Because of Coe's advocacy, hundreds of agencies and caring citizens joined an alliance calling New York City to bring CIT training to the NYPD. These efforts resulted in policymakers investing vitally needed resources to pilot training for 5,500 officers and to develop diversion centers where the NYPD can bring people experiencing psychiatric distress, keeping them out of jails and hospitals.



Steve Coe

The Awards of Excellence honor exceptional people and organizations that improve the lives of people living with mental illnesses and addictions, increase understanding of behavioral health in their communities, advocate for public policy

reforms, advance professional development and devote their lives to helping others. The award comes with a \$10,000 donation which Coe has given to Community Access.

"I'm delighted and humbled by this honor from the National Council," said Coe. "I would also like to acknowledge and express my gratitude to all my colleagues who have enthusiastically participated in our many advocacy campaigns. I share this recognition with all of them."

Throughout his career, Coe has strived to improve mental health care, and advance the rights of people with mental illness and those who have experienced trauma and abuse.

Over 20 years ago, under Coe's leadership, Community Access became one of the first New York City agencies to embrace mental health consumers – known as "peers" – as members of its workforce. Today, the agency's goal is that 51% of staff should be mental health consumers. In 1995, the organization developed Howie the Harp Advocacy Center, an innovative peer-run program that prepares people in mental health recovery for employment in human services. The program has graduated more than 1,000 peers, and is considered the gold standard in peer training.

In 2012, Coe's efforts also led to the creation and rollout, citywide, of an alternatives to hospitalization initiative, through which Community Access opened New York City's first crisis respite center and first peer-operated support line. These models are poised to improve health outcomes for thousands and save millions of tax dollars within the Medicaid Managed Care system.

Community Access' mission is to expand opportunities for people living with mental health concerns to recover from trauma and discrimination through affordable housing, training, advocacy and healing-focused services. We are built upon the simple truth that people are experts in their own lives. Each year, Community Access programs help over 10,000 New Yorkers who connect with the organization for a home, a place to learn, and opportunities to reach their potentials. A finalist in the 2014 New York Community Trust Nonprofit Excellence Awards, Community Access runs NYC's first peer-operated support line (646-741-HOPE), a contact point for New Yorkers experiencing emotional distress, as well as the city's first crisis respite center, a cost-effective alternative to hospitals, jails and shelters. To learn more, visit www.communityaccess.org.

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too, for the benefit of Medicaid members. Non-provider stakeholders can ensure that ample opportunities are afforded for social determinant expansion alongside more traditional integrated health care approaches, all supported by administrative

and financial mechanisms that recognize the value of paying for population health.

For example, Managed Care Organizations (MCOs) can be optimal partners for community-based providers, because insurance companies appreciate that strategic innovation can save money by improving health-related concerns. Partner-

ships between MCOs and providers across the country have demonstrated some of the innovative approaches – including peer community health workers and peer-run crisis respite – that are now being built systematically across New York. MCOs can continue with innovative investments by promoting new service ap-

proaches that integrate a range of social determinant solutions as well as integrated whole-health management. They can also improve by accelerating their understanding of acute responses that provide alternatives to costly Medicaid expenditures,

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What Will We Learn? The Care Transitions Network

By Linda Rosenberg, MSW
President and CEO
National Council for Behavioral Health

After a hospital stay which patient is most likely to be re-hospitalized? Did they “fall through the cracks”? Can changes in practice reduce re-hospitalizations? These are questions the Centers for Medicare and Medicaid expect the Care Transitions Network for People with Serious Mental Illness (www.CareTransitionsNetwork.org) to answer.

The Care Transitions Network for People with Serious Mental Illness is a four-year initiative in New York State that is funded by the Centers for Medicare and Medicaid Services. The purpose is to help people get the community care needed to avoid re-hospitalizations. The Care Transitions Network will follow patients with severe and chronic mental health conditions and support the practitioners and organizations that are providing post-discharge services.

Understanding what’s needed to avoid re-hospitalization will also have the benefit of preparing the involved practitioners and organizations for payment structures that put them at financial risk – commonly called value-based purchasing.

The Care Transitions Network is taking a threefold approach to supporting enrolled providers in becoming high performing practices that reduce all-cause readmission rates for people with serious mental illness, while confidently transitioning to value-based payment models:

- Clinical and technical consultation that gives enrolled organizations access to medical faculty with specialty in comor-

bid medical-behavioral issues, both to address the clinical as well as administrative aspects of high quality, evidence-based care.

- Short-term care transitions support to facilitate and ensure engagement with outpatient practices and health homes for patients after discharge from psychiatric hospitalizations.

- Clinical, utilization, and financial data to inform quality improvement and give community-based providers a clear picture of total system spend on their clientele with certain health profiles.

The National Council for Behavioral Health – in partnership with Montefiore Medical Center, Northwell Health, the New York State Office of Mental Health, and Netsmart Technologies – is committed to focusing resources in a way that prioritizes people with serious mental illness. Health homes, DSRIP, Medicare ACOs, advanced primary care, and the move to alternative payment models are all in play. But people with serious mental illness may still get the short end of the stick if the people and organizations designed to serve them don’t get the help they need to survive.

We’re just at the beginning of forming the Care Transitions Network; and we are still accepting new organizations from across the state to join us. I am looking forward to sharing our lessons learned in this forum. What questions do you have as this initiative begins? Tell me at LindaR@theNationalCouncil.org.

To learn more about the Care Transitions Network for People with Serious Mental Illness, visit us online at www.CareTransitionsNetwork.org or call (202) 684-3753.

First Aid from page 22

enhance the ongoing mental health literacy programs in the community, and improve health and mental health outcomes for children in Onondaga County.

“Being part of a program that normalizes mental health issues, taking mental health even further from the shadows is very exciting. To be able to do so through partnership makes the endeavor all the more impactful. This is exactly the kind of thing we want to be doing in our community, for our community,” said Hutchings Psychiatric Center Executive Director Dr. Mark Cattalani.

Program participants will be identified through extensive outreach to various academic, faith-based, and community organizations, as well as to first-responders and youth centers. Collaborative partnerships for this program have already been established with Onondaga Community College, LeMoyne College, OCM-BOCES,

Teen Challenge, Southwest Community Center, Onondaga County, and Upstate Emergency Medicine, Inc.

Mental Health First Aid is an 8-hour training certification course that teaches participants a five-step action plan to assess a situation, select and implement interventions and secure appropriate care for the individual. The certification program introduces participants to risk factors and warning signs of mental health problems, builds understanding of their impact and overviews common treatments. Thorough evaluations in randomized controlled trials and a quantitative study have proved the CPR-like program effective in improving trainees’ knowledge of mental health issues, reducing stigma and increasing the amount of help provided to others.

For more information about Project AWARE’s programs and services in Onondaga County, contact Laurie Best, Project Director, at 315-426-6812 or Laurie.Best@omh.ny.gov.

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Mr. Saperia guided The Coalition from a coalition of mental health providers in just New York City to a larger and more

robust organization representing more than 120 downstate members who provide behavioral health services to people with mental illness and substance use disorders.



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than access to medical treatment for highly vulnerable populations (Doran, Misa, & Shah, 2013). MCOs that have never been tasked to coordinate recipients' access to social determinants of health might be ill-equipped to do so, especially in environments of relative scarcity. For instance, the stock of affordable housing within metropolitan and suburban areas is simply insufficient to absorb the population of individuals released from state-operated psychiatric centers, nursing facilities, adult homes and correctional facilities (Guelpa, 2015). Although the state has released a steady stream of funding for the provision of rental subsidies for this population, these subsidies are unavailable to many and insufficient to cover rental costs in competitive housing markets (Association for Community Living, 2016). Recent initiatives of the New York City and State governments to develop thousands of additional units of subsidized housing notwithstanding, this development is bound to lag behind rapidly rising need. Many among the newly-deinstitutionalized will inevitably be relegated to homeless shelters, rooming houses and similarly substandard residential options that will compromise their tenuous grasp on stability.

The architects of the state's movement to incorporate all Medicaid-covered services into managed care plans surely recognized the potential importance of social determinants of health to the enduring stability of the most vulnerable individuals. This prompted the acquisition of a federal waiver that permits the delivery of an array of psychosocial rehabilitative services within community based settings – a seemingly auspicious development for recipients. Once again, however, as sound as the principle underpinning this approach may be, a closer inspection of it at the point of implementation reveals potential flaws that would deny many individuals access to these essential services. These “Home and Community Based Services” (HCBS) may offer many of the most vulnerable individuals the assistance and support needed to flourish in non-institutional settings, but the byzantine mechanisms through which they must be accessed will likely deny their benefits to many. Individuals presumed eligible for these services must undergo assessments administered by Care Managers under contract with regional Health Homes. The Health Home model has delivered care management services to many recipients who were unable to access them under previous models, but in many regions it does not support the staffing ratios necessary for the provision of intensive support services to the most vulnerable individuals. It is not uncommon for Care Managers to maintain caseloads of 40, 50, 60 or more clients, and it is unrealistic to expect them to also coordinate the provision of HCBS to eligible individuals. This coordination requires administration of the aforementioned assessment and development of recipient-specific support plans in ongoing consultation with MCOs and the providers charged to deliver services identified in these support plans. Rube Goldberg would be mystified by the complexity inherent in this framework of service delivery. Thus, we can expect many newly-deinstitutionalized and

would-be recipients of HCBS to languish in substandard residential accommodations while they await essential services that founder in a bureaucratic malaise.

Consider all of this in the context of labyrinthine contract and quality assurance activities characteristic of MCO governance. Many nonprofit social service organizations that attend to recipients' social determinants of health have never executed contracts with MCOs. Most do not possess the infrastructures necessary to effectively manage innumerable contract requirements with multiple payers. Utilization management and review, data analysis and outcome measurement activities serve useful purposes insofar as they promote efficiency and continuous quality improvement, but these activities entail countervailing inefficiencies that could prove especially burdensome for many providers. A recent analysis by researchers at Weill Cornell Medical College and the Medical Group Management Association indicates providers spend approximately \$15.4 billion a year on data management and outcome reporting activities (Rice, 2016). A disparate array of quality measures and reporting requirements is bound to increase the administrative workload for organizations unable to shoulder it.

Furthermore, as the lion's share of public funds devolves to MCOs resources previously allocated via State Aid are bound to vanish. Many providers who deliver psychosocial support services or coordinate access to social determinants of health depend on contracts with state agencies that seldom cover the costs of service delivery. This tragic fact became evident in the dissolution of one of the most senior and well-respected social service agencies in New York. The recent collapse of Federation Employment and Guidance Service (FEGS) under the weight of underfunded contracts with various government agencies is a bellwether for the industry according to forensic analyses of this event (Human Services Council, 2016). The Jewish Board of Family and Children's Services (JBFCS) inherited many of the contracts FEGS released upon its insolvency. It might have also inherited a flawed financial structure that yields ever-increasing deficits. This trend augurs a tipping point from which the nonprofit service sector may not return.

The confluence of trends poised to transform our service system surely warrants concern. It also entails opportunities for stakeholders to cultivate new payer and provider relationships that reward increasingly holistic approaches to service delivery that account for the full array of supports necessary to ensure the enduring health and wellbeing of individuals entrusted to their care. Rigorous analysis and reevaluation of systems and structures that could thwart our pursuit of the Triple Aim must be part of this equation. MCOs, their governmental patrons and contracted providers possess the collective financial capital and professional expertise to deliver on the promises of healthcare reform, and we have the benefit of history to guide us. Let us not condemn ourselves to repeat it because we have chosen to ignore its lessons.

The author may be reached by phone at (914) 428-5600 (x9228) or by email at abrody@searchforchange.org.

Helping Moms and Kids

By Jorge R. Petit, MD
Regional Senior Vice President,
New York Region, Beacon Health Options

Health care delivery is generally complicated, but it doesn't always have to be. Change can occur through a simple step. Take the case of maternal depression.

It is undisputed that depression is a highly treatable medical condition, especially if identified and treated early. It is also well-known that a mother's depression negatively affects her ability to properly bond with and care for her child(ren). Like other forms of depression, maternal depression does not discriminate. It is widespread across socioeconomic groups and race, but research shows that poverty is a strong predictor, regardless of ethnicity. Depression interferes with work, sleep, appetite, and most importantly, a parent's ability to parent his/her child. Maternal depression has been associated with fewer positive parenting behaviors and more negative interactions with their young children. Consequently, outcomes of children raised in a home with a depressed parent show a higher likelihood of developing behavioral problems and depression. It is also well-known that a mother's depression negatively affects her ability to properly bond with and care for her child(ren).

Yet despite all that is known about maternal depression, women – especially low-income women – often do not get the treatment they need due to fear of discuss-



ing mental health concerns with their providers or a lack of education about depression. Several weeks ago, Beacon Health Options (Beacon) issued a white paper (<http://beaconlens.com/integration/>) on what the evidence shows as the best approach to behavioral and physical health care integration. In that paper, screening emerged as a critical tool. That same week, the U.S. Preventive Services Task Force (<http://jama.jamanetwork.com/article.aspx?articleid=2484345>) found convincing evidence that screening improves

the accurate identification of adult patients with depression in primary care settings, including pregnant and postpartum women. The American Congress of Obstetricians and Gynecologists has also called for more depression screening of pregnant and postpartum women and referral for evidence-based therapy.

Timing: Strike While the Iron is Hot

In spite of the consensus, screening for maternal depression is not standard or routine. We know that there are many models of effective collaborative/integrated care that are embedded into routine care at women's health clinics, OB-GYN, and/or pediatric clinics, as well as targeted interventions in early childhood programs, such as home-visiting or Early Head Start programs. Various studies show that contacts in different treatment settings are potential opportunities for the screening, even if only using a two-question paper-based screen (<http://www.ncbi.nlm.nih.gov/pubmed/15956865>), to achieve a diagnosis of, and referral for, treatment of maternal depression. We need to conduct routine maternal depression screening during all points of possible contact, from prenatal visits through well-child visits.

It's time for screening to become routine. We need to conduct routine maternal depression screening during all points of possible contact, from prenatal visits through well-child visits. Doing so, improves detection of mothers who are will-

ing to discuss depression and stress issues with their physician. Further, screening should be facilitated by a collaborative care infrastructure, such as discussed in Beacon's white paper, where everyone has a role. For example, as a managed behavioral health organization, Beacon works with many of its health plan partners to address perinatal depression by collaborating on perinatal teams and screening pregnant and postpartum members with the Edinburgh Postnatal Depression Scale. In Massachusetts, Beacon's Massachusetts Child Psychiatry Program (MCPAP) launched its MCPAP for Moms (<https://www.mcpapformoms.org/>) program to help physicians treating pregnant and postpartum women and their children to identify and manage depression up to one year after delivery. Another example is New York City (<https://thrivenyc.cityofnewyork.us/>), where a new initiative is underway between NYC Health + Hospitals and Maimonides to develop a citywide effort at universal screening and care for women experiencing material depression.

In brief, screening is the logical thing to do and the necessary thing to do. We must follow New York City's example and embrace the goal of universal screening, starting in our own communities, so that we can treat maternal depression, once and all.

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Awards Reception from page 10

Dr. Sullivan grew up in Queens, New York City. She graduated from NYU and its School of Medicine and completed her Psychiatric Residency at New York University/Bellevue Hospital in 1978. She has served as Associate Director of Psychiatry and Medical Director of Ambulatory Care at the Gouverneur Diagnostic and Treatment Center and joined the Queens Health Network as Regional Director of Psychiatry in 1990, overseeing the administrative, budgetary, and clinical aspects of the psychiatric services of both Network hospitals. She has enjoyed an extensive career in public psychiatry and has lectured and published on best practices in community care.

Dr. Sullivan is an active advocate for her patients and her profession, is a Distinguished Fellow of the American Psychiatric Association and has served as the Speaker of the American Psychiatric Association's Assembly and on its Board of Trustees. She is a fellow of the New York Academy of Medicine, a member of the American College of Psychiatrists and the Group for the Advancement of Psychiatry.

Peter C. Campanelli, PsyD

Dr. Campanelli founded the Institute for Community Living in 1986 as part of his doctoral dissertation project, and served as President and CEO until 2012. Under his leadership ICL and partner Agencies developed a diabetes manage-

ment protocol for seriously mentally ill people along with the first community based health home under the chronic illness demonstration project (CIDP). ICL's healthcare integration efforts also led it to develop its own health care clinic which latter evolved into a specialty federally qualified health center (FQHC). He has served as Board Chair of The Association of Community Living and Managed Care Innovations, as well as President of the Coalition of Voluntary Mental Health Agencies' Board of Directors. He also served on the Board of the National Council for Community Behavioral Health, and is a past Chairman of the Mental Health News Education, Inc. Board of Directors.

Dr. Campanelli holds a Doctorate in Clinical Psychology from Rutgers University, Graduate School of Applied and Professional Psychology, and is a past recipient of the university's Peterson Prize for Community Service. He is also a past recipient of the Visionary Leadership Award from the National Council of Community Behavioral Health, and the Congressional Community Corporate Partnership Award from Hon. Edolphus Towns. His work has twice been recognized with the Gold Medal Award from the Hospital and Community Psychiatry Division of the American Psychiatric Association.

Linda Rosenberg, MSW

Harnessing the voices of the 10 million adults, children, and families served by the National Council's 2,500 member

organizations, Linda Rosenberg helped secure passage of the federal parity law, expanded integrated behavioral and primary care services, introduced Mental Health First Aid in the U.S., and built an array of organizational, clinical and workforce improvement initiatives. The National Council's strong support of the Mental Health Excellence Act will result in the first comprehensive effort to establish community accountability for the health of people with serious mental illnesses and addictions, the consistent utilization of evidence-based practices, and the standardized measurement of outcomes.

Linda was Senior Deputy Commissioner of the New York State Office of Mental Health prior to joining the National Council. She has over 30 years of experience in designing and operating hospitals, community and housing programs, and implemented New York's first Mental Health Court. She serves on an array of boards of directors and is a member of the Executive Committee of the National Action Alliance for Suicide Prevention.

John J. Coppola, MSW

Mr. Coppola is a Past-President of the State Associations of Addiction Services, the national association of state associations that represented substance use disorders services providers and which recently merged into the National Council for Behavioral Health. John has served on nu-

merous national advisory committees, including the SAMHSA/CSAT Partnership for Recovery, the CSAT Recovery Month Advisory Committee, and the National Council of State Legislators Addictions Committee. He has also served and is on a number of regional and statewide advisory committees, including NYS Governor Andrew Cuomo's Medicaid Redesign Team Behavioral Health Work Group, former NYS Governor David Paterson's Commission on Juvenile Justice Reform, the Northeast Addiction Technology Transfer Center Advisory Committee, Council on Accreditation, and numerous NYS Office of Alcoholism and Substance Abuse Services (OASAS) workgroups. John also served in an advisory role with the Office of National Drug Control Policy.

Prior to becoming Executive Director of ASAP, Mr. Coppola worked for Catholic Charities of the Diocese of Albany from 1981 through 1996, serving most recently as the Executive Director of Montgomery County Catholic Charities. During his tenure at Catholic Charities, Mr. Coppola served as Chairperson of the Catholic Charities USA Alcoholism and Substance Abuse Committee and as Chairperson of the NYS Catholic Conference Alcoholism and Substance Abuse Committee.

Mr. Coppola received his Master's Degree in Social Work from the State University of New York at Albany and his Bachelor of Arts in Psychology from Dominican College.



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How ABA Improved Executive Functioning Deficits

By Tiffany Salmon, RBT
Rhea Rodrigues, RBT, and
Amanda Duva, BCaBA
Services for the Underserved (SUS)

Rosie is a young woman in her early 20s, who attends one of the senior CUNY colleges in New York City, Baruch University. Rosie is diagnosed with mild intellectual disability and schizoaffective disorder. She entered into her third year of her bachelor program in January 2015 realizing that she had significantly fallen behind with several assignments and exams due to poor organization skills and time management. She was at risk for failing out of the program. In late Spring 2015, Rosie found herself completely overwhelmed emotionally and did not know how to get herself back on track. Due to overwhelming stress, she was admitted to the hospital for a psychiatric break. That summer, Rosie's parents were concerned that she would not finish her degree and began looking for additional supports to help her finish college and gain the necessary skills needed for fulltime employment.

During this time, Services for the Underserved was awarded a Balancing Innovation Program (BIP) Grant that would support 25 individuals with disabilities. Five of these individuals were targeted because they were living at home, but were at risk for more restrictive residential settings or frequent psychiatric hospitalizations due to challenging behaviors. The grant allowed for a team of behaviorally trained specialists, Board Certified Behavior Analysts (BCBAs) and Registered Behavior Technicians (RBTs), to develop and implement strategies based on the principles of Applied Behavior



Rosie

Analysis to promote independence and minimize high risk incidents that often lead to emergency services.

In August 2015, the team began working with Rosie twice a week for two hour sessions. Initially, the behavior team met with Rosie to identify goals that would assist her with obtaining her bachelor degree and gaining fulltime employment. In addition, Rosie identified specific skill deficits related to education, employment, and social skills that she wanted the team's assistance to improve. Once these goals were identified, the team developed strategies utilizing visual cues, such as daily and weekly schedules, and incentive programs to increase the motivation for her to complete assigned tasks.

To start, Rosie wanted to file an appeal to return to her BA program in Business.

In order to accomplish this task, she had to meet several deadlines and provide her support providers at Baruch the information she received from her professors. Without the support of the behavior team, this would have been a daunting task that Rosie would have difficulty completing on her own. The BCaBA developed a task analysis for Rosie and identified organizational skills that she would need to maintain these behaviors in the future. The RBTs created checklists and color coded tasks by date and importance. In addition, the RBTs supported Rosie with organizing a meeting with her school counselor and developed a list of her specific needs so that she could independently advocate for herself during the meeting. As part of the instruction, the RBTs taught her how to use visual cues and electronic devices as prompts to remind her daily obligations.

As the team worked with Rosie, they realized that she had a very low motivation to complete the steps necessary to graduate. The BCaBA developed an incentive program to increase her motivation to meet her deadlines. Rosie successfully filed her appeal!

Following the appeal, the team observed that Rosie was productive in completing tasks, but was not using the organization tools that the RBTs were using with her between sessions, thus not generalizing the skills. In order to implement a successful fading program and foster generalization, the BCaBA expanded on the incentive program to motivate her to complete tasks outside of her session time. For instance, if Rosie completed the tasks outlined during the first session, her second session would allow her access to a preferred activity where she would be accompanied by the RBT, who was also a preferred staff. If the assignments were

not completed by the second session, Rosie would complete the tasks on the checklist and would not have access to the preferred activity.

Rosie has a part time job on the weekends, but had difficulty in following a budget and wanted the RBTs to assist her with this skill. The RBTs introduced Rosie to banking apps and a spending log app that she could download onto her phone. The team then tied these skills into her incentive program and planning goals by having her identify social activities that she wanted to access, determine the cost of the activities, and develop a plan to budget for these activities. For instance, Rosie wanted to get sushi with the RBT. In order to do that, Rosie had to identify a sushi restaurant that she could access via public transportation, determine the cost of menu options, how much her meal would cost, and then determining if she could afford to eat at that establishment. This strategy was generalized to social activities with peers so that she could maintain her budget outside of her sessions with the RBTs.

Over the past six months, Rosie has acquired and mastered the skills necessary to move forward with reaching her goals. In addition to organization and time management skills, she has learned self-advocacy skills and as a result is receiving assistance from her University's Office of Disabilities to maintain the necessary support she needs to graduate. She is another semester closer to receiving her BA in Business and has the same goals as her peers like: gaining fulltime employment, entering into a loving relationship with a significant other and living on her own. Through the support systems the RBTs and BCaBA developed, Rosie is on her way to reaching this level of independence.

Value Based Care from page 11

and strong, strategic leadership will do better in an environment in which every contract is contested and every relationship is complicated. In addition, VBP requires a robust infrastructure, especially with respect to health information, so a program portfolio large enough to support a significant infrastructure will be essen-

tial. VBP also incents risk, so providers who are willing and prepared to enter into contracts with risk elements will have the opportunity to partake in a greater proportion of potential shared savings.

VBP is coming. In some pockets of the system where providers and payers are on the leading edge, it is already here. It will have a profound impact on the community behavioral health sector. As a community,

we need to come together to advocate to ensure that metrics are embedded in VBP structures that matter to the people we serve and that measure the impact of the work our sector does. Individual providers also need to start by assessing their own organizational readiness, perhaps by using HMA's VBP readiness tool, engaging their Boards in conversations about the environmental changes and the organiza-

tion's risk tolerance, and developing strategic plans that prepare for these new payment models.

HMA is a national Medicaid consulting firm with a significant behavioral health practice in the New York tri-state region. HMA's Accountable Care Institute is dedicated to helping providers transition to new payment and practice models.

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Hope or Hype from page 6

Bill Advances in the Senate". The Hill. March 16, 2016. <http://thehill.com/policy/healthcare/273231-bipartisan-mental-health-bill-advances-in-senate>

3. Wang, PS, et al. "Twelve-Month Use of Mental Health Services in the United States: Results From the National Comorbidity Survey Replication". Archives of General Psychiatry. June 2005. <http://archpsyc.jamanetwork.com/article.aspx?articleid=208673&resultclick=1>

4. United States Government Accountability Office. Mental Health: HHS Leadership Needed to Coordinate Federal Efforts Related to Serious Mental Illness. December, 2014. <http://www.gao.gov/products/GAO-15-113>

5. Comptroller General of The United States. Returning the Mentally Disabled to the Community: Government Needs to Do More. United States General Accounting Office. HRD-76-152: Jan 7, 1977. <http://www.gao.gov/products/HRD-76-152>

6. Mark, TL, et al. "Spending On Mental and Substance Use Disorders Projected to Grow More Slowly Than All Health Spending Through 2020." Health Affairs. August 2014. <http://content.healthaffairs.org/content/33/8/1407.short>

7. Hall, K. "The Direct Spending Effects of Title V of H.R. 2646, the Helping Families in Mental Health Crisis Act of 2015." Congressional Budget Office. November 3, 2015. <https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/costestimate/hr2646directspendingeffectsofitlev.pdf>

Health from page 24

such as more “risky” models of mobile crisis and respite.

Policymakers have made sincere efforts to take into account the abilities of community-based organizations to make an impact in the whole-health needs of New Yorkers receiving Medicaid. However, significant investments should still be made in order to achieve integration of whole-health priorities at the community level. For example, commitments by Department of Health and Office of Mental Health policymakers to reinvest savings from Medicaid Redesign initiatives back into the behavioral health field can take into account new approaches to population health. Social determinant advances can be driven by community-based providers agile enough to use reinvestment money to meet the particular needs of the communities they serve.

New York’s Value Based Payment roadmap to financial reform may be the most significant step to build incentives for community agencies to integrate population health into a single payment bundle with built-in rewards and risk.

Community-based providers can prepare for this in concrete ways, by diversifying the investments they are already making in achieving health and well-being for participants and designing quality assurance processes to collect and analyze data that indicates not just relief from acute symptoms of diagnoses but that also correlate to changes in population health metrics. This shift requires intensive planning and time for administrators who have limited financial resources for investing in technology systems and a proficient workforce. New York can invest in the administrative and financial resources of its providers to prepare for this shift, as providers use shared information across systems to prepare for innovation in service delivery.

Along with investments in providers’ ability to manage value-based contracts, policymakers should support the creation of analytical software for risk assessment and modeling that takes into account social determinants of health. This is not a simple task: currently, there is no existing model that can (for example) analyze the Medicaid costs associated with an individual experiencing complex behavioral and

physical health needs as well as housing instability, and project how those Medicaid costs would change if that person achieves housing stability. Instead of waiting for a software product that can achieve this, state policymakers can incentivize MCOs to pilot projects that test models that can account for the previous example and others that target food insecurity, social integration, early childhood trauma, and other social determinants. New York is already leading the way in Medicaid system reform, but it could also develop projects that manifest insights for the creation of the first risk projection tools that take into account population health.

The preceding examples indicate strategic ways that policymakers, payers, and providers can all make room for a focus on population health by building sustaining platforms of investment in social determinant approaches, integrated health management, and financial and administrative planning.

Population health management can take many forms for community-based providers, as well as for hospitals, MCOs, and policymakers. At Community Access, our own “triple aim” relies on a frame-

work that positions the social determinant well-being of participants with equal importance to community-based recovery supports with discrete and measurable outcomes, and progressive administrative practices. Preparing for the policy shifts that can support this framework today and in the future has required a robust investment of staff expertise and collaboration as well as pursuit of “non-traditional” funding supports including grants and a large base of donors. But as we strategically plan and await effective policy and financial mechanisms for inclusion of social determinants, we are actively providing a range of investments into the well-being of participants today.

To learn more about how your agency can use peer-informed practice to enhance social determinant opportunities for participants while preparing for value-based system reform, contact Briana at bgilmore@communityaccess.org.

1. J. Michael McGinnis, Pamela Williams-Russo, and James R. Knickman, “The Case For More Active Policy Attention to Health Promotion,” *Health Affairs* 21 (2) (2002): 78–93.

Culture from page 21

communication and sharing information with staff and recipients increasing their understanding of what is happening around them. We can develop activities to increase exposure to alternative ways of doing things so that knowledge and understanding and thus readiness is increased and decisions can be easier to make knowing that there are choices. We can expose staff to new recovery focused techniques and evidence based practices to which they may have not previously been exposed. We can let people know that the change is possible, positive and will be supported. And most important, we can be strong and present leaders, creating a shared vision and outlining the steps needed to accomplish that vision.

This is not an easy process so why engage in change? First, because when we offer services in a recovery-oriented system, people have the possibility to improve more quickly. People become active in stating what they want and need, and they work harder to achieve their goals mainly because they are *their goals* and not our goals. Offering recovery-oriented services requires sharing power between practitioner and participant, and this power sharing ultimately reduces staff burden as staff come to realize that the life and the outcomes of their work belong

to the participant and not to them. The recovery journey is the participant’s journey. Practitioners cannot force individuals to walk a path that they don’t choose or take the journey for them. This eventually helps to empower both practitioners and participants, leading to better staff retention as participants rediscover and follow their dreams and practitioners and service recipients learn to celebrate success.

This kind of culture change is not without challenges for providers. Person-centered, recovery-oriented work takes time and a new way of looking at things. Believing in recovery for all and putting participants in the driver’s seat are not approaches many of us learned in our professional education. If we are to expect practitioners to practice in this way, we must provide training in the philosophy of recovery and in evidence based tools for practice.

How do we get started? To begin the transformation, first adopt a clear recovery-based mission statement and fund and support only those services that are consistent with that mission. Then, to assure that the recovery vision is embedded within the structure of the agency, it’s critical to clarify staff expectations by revising personnel policies, job descriptions, and performance reviews so that they match the goals and needs of recovery-oriented services. Lastly, it’s important to assure that agency policies and

procedures are personally accepted, and that the language encourages and supports the recovery services being offered. Training and sustaining belief in recovery is the key to beginning the process. Once staff believe that people actually can and do recover, they will want access to state-of-the-art practice guidelines.

Critical elements that sustain customer satisfaction include easy access, involving service participants in policy making and in planning and designing services, and creating person-centered services that contain goals and objectives congruent with a person’s real life hopes and dreams. Documentation is also critical, and user friendly Electronic Health Records are now essential for information sharing as well as careful documentation. Clinical records must be useful to the participant and staff, as well as to funding and regulating bodies. Real life functioning, not just symptom improvements, should serve as goals that are analyzed and reported as outcomes.

System transformation is not easy and leading during a period of intense change such as what we are currently experiencing, is a very hard job. Managing is difficult in any environment, but in our current environment of shrinking and changing funds, increased risks of litigation, the need for major changes to our infrastructure and the move from volume to value, leaders

can easily lose their vision and also lose their way. And yet this transformation offers our leadership a rare opportunity. “Leaders, through their words and actions, fill in the details of the vision. The metaphors, the anecdotes, the traditions, past successes and failures ... serve to elaborate on the vision” (Anthony, W., Cohen, M., Farkas, M., & Gagne, C. *Psychiatric rehabilitation, second edition*. Boston: Center for Psychiatric Rehabilitation, 2002.)

Let’s work together to assure that the programs we offer have the direction as well as the resources they need to provide recovery-oriented services so that every member of society gets a chance to lead a productive and satisfying life. Our vision can propel our staff and service recipients to go through the hard work of change in order to move from where they are to where they want to be. Finding innovative ways to lead our agencies through the turbulence of change can help assure that developing and sustaining a culture of recovery for all people remains foremost on the agenda of our behavioral health care system now and in the future.

Edye Schwartz oversees the education and training division at NYAPRS and trains and speaks often on organizational and culture change, recovery oriented systems of care and achieving excellence in management. She can be reached at edyeschwartz@nyaprs.org.

Focus from page 18

to take care of their overall well-being. As a supervisor, I emphasize the importance of managing our physical and mental health in and out of work. I promote self-care and model it during supervisions, staff meetings, and other regular encounters. This should be accomplished in the context of recovery principles: Build on staff strengths, offer them different options to make their workload more manageable,

incorporate peer support to take on some of the responsibilities, and constantly remind them the purpose of the work by sharing stories of how people have gotten better as a result of their efforts.

In the midst of system reform, you maintain a focus on recovery by including it in your everyday language. You allow it to become the frame of practice and integrate recovery principles to everything work related, from staff interactions to the people residing in Supported Housing.

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