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Advances in Behavioral Health Technology

Mental Health Advocacy With and Without Advanced Technology

By Michael B. Friedman, LMSW
Public Policy Analyst

I just switched from E-mail to Microsoft Word to write this article about mental health and technology. I left 250 E-mails unanswered to make the move. Oy veh! I feel like I'm guilty of E-mail neglect. Who will I offend today by not responding to them?

It wasn't always like this. 45 years ago, when I began working as a mental health advocate, there was no E-mail. In fact, there was no Microsoft Word or any other kind of word processing. I remember when we got a Wang word processor in the early 1980s. We built a little room to house it.

In those days, we did everything on paper, which we filed in folders in file cabinets in file rooms. I went through my mail once or at most twice a day. I was fortunate and had a secretary, who sat with me as I read my mail and to whom I dictated my responses. She (I didn't have a male assistant until after the turn of the 21st century) would then type a draft and give it to me the next day to edit. She would then type the final draft, which I would review the next day. And then she would put it in an envelope, and someone would take it to the post office. It took eight working days to reply—a totally different pace of life.

Of course, it had its problems. Today, I'm drowning in unread E-mail. Then I was drowning in piles of paper. I had three piles. Immediate, get-to-it soon, and can-wait. I never got to anything in the can-wait pile and would throw it away every few months. I probably insulted more than a few people and missed some great opportunities to transform the world or at least my life. Oh well.

How did we do advocacy then? How did we assemble and communicate with coalitions? How did we communicate with the powers-that-be to try to persuade them to see the light? We did it on paper, using snail mail (then just called "mail"), and we did it by telephone, playing a lot of telephone tag.

To set up a meeting we would write a letter, make many copies of it, stuff it in envelopes, type or handwrite addresses, put on stamps, take it to a post office.

To organize a campaign to persuade public officials to do the right thing, we would send sample letters or distribute post cards with our message printed on them to members of our advocacy group and hope that they actually signed and mailed them.

To meet with public officials, we would request a meeting by letter or by phone. Sometimes it took a lot of telephone tag just to set up the meeting.

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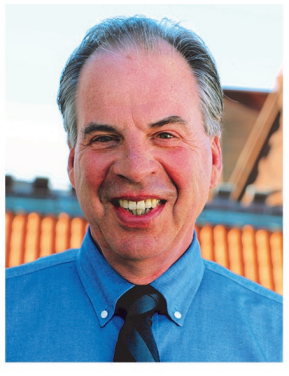
Leaders of the Autism and Behavioral Health Communities To Be Honored at May 12th Virtual Leadership Awards Reception

☆☆☆ **You Are Cordially Invited !** **See Page 20 for Details** ☆☆☆

Marco Damiani
Chief Executive Officer
AHRC New York City
Excellence in Autism Award



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President and CEO
Center for Urban Community Services
Lifetime Achievement Award

Hillary Kunins
Exec. Deputy Commissioner of Mental Hygiene
NYC Department of Health and Mental Hygiene
Healthcare Hero Award

Allison Sesso
Executive Director
RIP Medical Debt
Behavioral Health Advocacy Award

Ian Shaffer, MD, MMM, CPE
VP and Executive Medical Director
Healthfirst - Behavioral Health (Retd.)
Corporate Leadership Award

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From Either to Both"
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MENTAL HEALTH NEWS EDUCATION
PUBLISHER OF AUTISM SPECTRUM NEWS AND BEHAVIORAL HEALTH NEWS

Technology Helps OMH Increase Access and Continuity of Healthcare

By Ann Sullivan, MD
Commissioner
NYS Office of Mental Health (OMH)

As the COVID-19 pandemic spread and intensified last year, the Office of Mental Health and behavioral healthcare workers across the nation faced two great challenges: First, ensuring our patients could access the treatment and services they needed without increasing the risk of exposure; and second, providing support and assistance to the many New Yorkers who were overwhelmed by the anxiety, isolation, stress and depression caused by the pandemic.

Technology, and in particular telehealth, played a major role in helping us address these challenges. OMH acted quickly in early March 2020, waiving certain regulations to allow rapid approval for the use of telehealth, and providing regulatory and billing flexibility to encourage the expansion of telehealth during the COVID-19 Disaster Emergency.

That effort was a great success, as more than 800 additional sites were approved to provide telemental health services in 2020, bringing the total of approved sites in NYS to 1013.

Streamlining the regulations allowed providers to utilize telehealth services if they certified they were properly licensed to practice in New York, that their communication lines were dedicated and secure, and that they would take the necessary precautions to protect patient confidentiality as required by the Mental Hygiene Law and HIPAA.

Telehealth allowed for the continuity of care while reducing in-person contact and helped address patients' concerns and anxiety about leaving their homes during the pandemic. It also helped providers create an emergency plan in the event of a quarantine that prevented staff and patients from leaving their homes.

Dr. Ann Sullivan

Telehealth was also extremely popular with our patients. In fact, OMH surveyed more than 6,000 service recipients to determine the impact the pandemic has had on their lives and access to care. The survey found that 89 percent of the respondents participated in telehealth services and 85 percent found that telehealth was easy and effective.

Most respondents said they had the same amount of contact with their providers when using telehealth. Overall, the findings show that access to care, including medications and physical health care, was largely uninterrupted. We also found that telehealth was quickly and widely utilized by licensed OMH clinics, as telehealth claims increased from 35 percent of claims in March 2020 to 90 percent of claims in April 2020.

Telehealth has proven to be so powerful a tool that Governor Cuomo has proposed legislation to permanently adopt telehealth innovations in order to expand access to physical health, mental health and substance use disorder services.

These reforms will adjust reimbursement incentives to encourage telehealth, eliminate outdated location requirements and other regulatory prohibitions, and provide training programs to make patients and providers more comfortable using telehealth. These proposals have encouraged more providers to incorporate telehealth into their services, ensuring greater access to care and the potential to improve patient outreach and reduce healthcare costs.

As the telephone became people's most common and safest form of communication, OMH also launched the Emotional Support Helpline, (1-844-863-9314) which to date has handled more than 53,000 calls from New Yorkers who are feeling overwhelmed, anxious and/or depressed by the impact of the pandemic.

The Helpline was first staffed by mental health professionals and volunteers specially trained to help people cope with the typical stress reactions brought on by emergency and crisis situations. The volunteers provided tips on managing anxiety, dealing with loss and strengthening coping skills. They also provided referrals to help people connect with mental health services in their communities.

Today, the NY Project Hope Emotional Support Helpline is staffed by trained crisis counselors who continue to provide free, confidential, and anonymous counseling to all callers, including non-English speaking individuals and people who are deaf or hard of hearing.

We promoted the Helpline through a series of awareness campaigns and used social and digital media to provide New Yorkers with coping tips, as well as anti-stigma messaging to encourage them to reach out for help. While the campaigns were state-wide, we focused in particular on those communities that were hardest hit by the pandemic, including many Black, Hispanic, low-income and immigrant communities that are often medically underserved.

Following up on the success of and demand for the Emotional Support Line, we launched "Coping Circles" -- a free, virtual group support facilitated by volunteer licensed mental health professionals. The six-week program was open to any NYS resident over 18, who also had the option to join specific groups for health care workers, first responders, those who lost a loved one, and those who were unemployed due to the pandemic. Coping Circles ran from June through August of 2020 and provided 187 Circles for more than 900 participants.

The COVID-19 pandemic demonstrated very clearly that there are significant inequities in our healthcare system. It has also shown that technology – and in particular telehealth -- can help address those inequities, expand access to care and lower the costs of providing behavioral healthcare.

Telehealth helped us to maintain continuity of care throughout the pandemic. Expanding telehealth services and integrating it into our existing healthcare system will ensure every New Yorker, regardless of their circumstances, has the support they need to access physical and mental health care.

AsOne LEADS: Lessons Learned in Building a Behavioral Health and Family-Centered Healthcare IT and Data Solution

By Caroline Heindrichs, MA, Jawad Sartaj, MBA, Jessica Frisco, RN, BSN, MPH, and McKenzie Pickett, MPH

AsOne Healthcare IPA launched the LEADS platform in February of this year, a first-of-its-kind IT and data solution to facilitate population health management and improve patient outcomes. LEADS was a collaborative effort: conceived by AsOne, developed by Netsmart Technologies, Inc. (Netsmart), and implemented by Informd. It is designed uniquely to aggregate data from all AsOne community-based network providers and other sources to enable the integration of services between members, quality improvement activity and the ability to track and monitor outcomes by family groups. Along with the electronic health records (EHR) of our network providers, LEADS also ingests from the New York State Health Information Exchange to provide historical data, real-time hospitalization alerts and COVID-testing alerts. LEADS houses actionable data on approximately 250,000 majority Medicaid lives.

The platform drives off of a Master Patient index (MPI) which merges unique clients from disparate patient records from different EHRs, different partners, and even different data sources, facilitating a 360 view of patients. This is key to clinical integration; with all the data driving directly from our partners' databases and aggregated in one place, we can access a more complete and timely snapshot of a patient or a population's status. In the future, we hope to connect to even more sources to improve the richness and completeness of our data.

Through this nearly two-year process, our IPA has worked through various challenges and identified opportunities and lessons learned that might benefit other networks /providers engaged in building and aggregating vast volumes of data from disparate sources for population health purposes.

Caroline Heindrichs, MA

Jawad Sartaj, MBA

Jessica Frisco, RN, BSN, MPH

McKenzie Pickett, MPH

Building the Platform Functionality

Quality work is a critical component of an effective network, and being able to calculate quality measures and report on performance data is a key feature of this platform. One of the main decisions in selecting metrics to include in the LEADS platform was differentiating between HEDIS, CMS, and other versions of measures. The HEDIS measures technical specifications drive off of claims data, requiring CPT Codes, ICD-10 codes, etc., while CMS metrics pull more from fields, fill data, and notes within EHRs. We considered whether to include the more widely-used HEDIS measures, which may not have as much data readily available to complete the measure, or CMS, which is slightly less standardized compared with MCOs and other payers but drives off of data that is more readily available from our partners. Weighing the needs of our network, we ultimately chose a combination of several HEDIS metrics and several CMS.

Viewing high-quality and timely data was also key for our network, so building functional and attractive dashboards to help interpret the data visually was a crucial piece of the platform. However, given the breadth and diversity of our services and network partners, it was a challenge to anticipate the various use cases for the dashboards. We brought together representatives from across the network to provide input on the dashboard configurations, functionalities, and features they would need to see to accomplish their own agency goals and support the goals of the AsOne network. We developed use cases before the dashboards were developed in order to ensure they met our intended purposes before being built.

Family Grouping: Innovation in Intergenerational Care

A key component of AsOne's mission is to establish the family as the nexus for health, not only addressing the health and lives of one client or patient at a time but entire families at once, to break the cycle of co-occurring illness that often afflicts high-risk families and communities. We believe the healthcare system fails to adequately enable family-based approaches to treat patients with complex illnesses and co-morbid conditions. For example, Medicaid does not enroll family members on the same insurance plans and Managed Care Organizations (MCOs) do not group families together for treatment or cost analysis. Healthcare providers tend focus on one individual patient's diagnosis and even if family are involved, it's often only for decision-support.

AsOne believes the delivery system of the future takes a longer-term view to integrate behavioral health and primary care and involves the whole family. One of the challenges we aimed to solve with the launch of the LEADS platform was creating the infrastructure to support family-based models of care. Working with our Netsmart partners, we designed a novel functionality by which disparate members of our platform could be joined together into one "family."

Developing this functionality led us to ask simple but difficult questions like what is the definition of "family"? For the purpose of platform function, we landed on a "family" revolving around one selected index patient and the social support network identified by that index patient, biological or not. Ultimately, we believe that this functionality is a crucial first step towards providing comprehensive intergenerational care, viewing outcomes by family units, and moving forward family-centric models of care.

Challenges in Data Exchange, Quality and Security

Pivoting to the build of the platform, which was a nearly two-year endeavor in collaboration with Netsmart and Informd, there were three key concepts that required significant discussion and thought. Data exchange, data quality, and data privacy and security.

Data Exchange

Data exchange generally involves writing technical code to extract data from a database, conforming or transforming that data to specifications understood by an application, and sharing (loading) that information to a location where the receiving database can ingest. There are two main schools of thought on how to best operationalize the data exchange flow – Extract Transform and Load (ELT), prioritizing quality vs. Extract Load and Transform (ETL), which prioritizes velocity.

Given the variety, velocity, and volume - the very definition of big data - of EHRs across the AsOne network, deciding which path to take was not something we contemplated lightly. Further complicating the choice was AsOne's decision to pursue the entirety of each agencies' EHR dataset rather than a narrow band selection of demographic and encounter information for measures. Our ambitions were to ingest all available data points that could be housed in our data warehouse including demographics, healthcare encounters, medications, screenings, and some social needs such as housing status. Case notes and other loose text was not included. The chief reason behind this pursuit of volume was to create a true longitudinal patient record encompassing all known information for our attribution and to avoid spinning subsequent data extraction initiatives, which would create fatigue for our network members and be resource intensive for AsOne.

In the end, we opted to provide choice to each organization on how best to operationalize a dataflow process so long as their core datasets conformed to a set of standards. This provided organizations with flexibility on the 'how' while providing AsOne with consistency on the 'what.' The Netsmart team recommended, and our IT committee approved, the CDC Public Health Information Network Vocabulary Access and Distribution System (PHIN VADS) code set as a network-wide data dictionary. Having a common standard across client, diagnosis, insurance, visit, laboratory, and medication data allowed us to harmonize and quantify our data in a manner that created consistency in ingestion and, more importantly, predictability in reporting.

Data Quality

Data quality is a journey, not a destination, something that was especially true as we required a continuous improvement mindset when dealing with the complexity and variation in our datasets. By creating lineage - the tracing of the information displayed on dashboards, to the algorithms that shape data into information and the initial extracts which brought that data into LEADS, we are able to quickly identify and address gaps in data. Even though we tried to ingest "everything"

see AsOne LEADS on page 32

Outsourcing: Frequently Asked Questions (FAQs)

By Unidine Corporation
Healthcare Culinary Group
Behavioral Health Division

Outsourcing is the strategic use of outside experts to perform activities traditionally handled internally. It is a strategy which employs the contracting of specialized service providers having expertise in targeted areas. This expertise can deliver measurable value to your business.

Why outsource? To improve quality of service to your customers; improve employee productivity and engagement; control costs; gain access to additional resources, increased capital and specialized capabilities; free internal resources for other purposes; increase efficiency; and share or shift risk.

How can you ensure a successful outsourcing relationship? Successful outsourcing relationships are the result of collaboration. Too often, outsourcing initiatives fail because they are the result of "bids" and "RFPs," neither of which fully convey the culture, needs, expectations, nuances, and key drivers that warrant interest in outsourcing. Food service, in particular, is a very personal business and requires a thorough understanding of the role it plays.

How can you determine the right fit for your organization? Explain your business goals and objectives, and the expectation for food service against them; Share your strategic vision for food and dining services, and nutrition, health and wellness; Select a vendor that demonstrates an understanding of your culture and the capabilities that are required to bring your vision to life; Maintain open communication between your vendor partner and all stakeholders; Create a channel of communication between senior leadership; Justify financial expectations by asking how they will be achieved with mitigated risk; Manage the relationship; Communicate relationship throughout all organizational departments; Be informative with your vendor partner; Be specific; Keep your vendor partner current on business needs, especially as they change or evolve; and Structure the vendor agreement so there is a mutually clear understanding of obligations and commitments; memorialize service levels.

Richard B. Schenkel

How does Unidine recruit and retain talent? Recruitment: There are multiple layers to this process. Unidine always looks internally first to determine which managerial candidates are best suited for consideration. The candidate pool is then expanded to include individuals outside of Unidine who have responded to postings and portray demonstrated success and achievement. Every candidate, both internal and external, is then vetted through the competency validation process to determine how well they match up to the expectations and requirements of the respective client. The client also participates in the selection process to define the management role and the type of manager who they believe would be a good fit for their culture and organization. After a series of internal interviews Unidine narrows the field and presents several qualified candidates to the client for final vetting after which client and Unidine collaborate on the final selection.

Retention: Competitive salaries and benefits play a part in retaining great team members. However, what enables Unidine to develop and retain top managers and teams is its emphasis on the Unidine culture. At Unidine it is all about treating others with respect; helping team members grow and achieve their personal and professional goals; unparalleled customer service and hospitality; responding to customer needs with a sense of urgency and empowering all team members. Unidine is a learning and teaching organization where everyone can learn from each other to deliver the most effective solutions for our clients, guests and team members.

Does Unidine support clinical needs and patient education? Clinical needs: Unidine provides and budgets for the effective level of onsite dietitian support based on specific client's needs. Service levels range from menu signoff to inpatient consults and assessments, with ongoing diet and nutrition support for inpatient and outpatient care.

Patient education: Unidine provides educational materials and experiences to patients that promote healthy choices and lifestyles. Healthy cooking classes, how-to-shop seminars and other food-related life skills events are led by executive chefs and registered dietitians. A defined Wellness, program that positively impacts everyone – patients, staff and employees – can be developed.

Healthy menu options: Unidine offers healthy menu options at every meal. There are currently over 600 specific recipes that are the result of an ongoing collaboration of Unidine senior culinarians and dietitians. Each menu item is nutrient-rich, properly portioned and prepared with healthy cooking processes.

Is Unidine's Fresh Food/Scratch Cooking program more costly than ready-to-serve food products that only require rethermalization and plating? No. Cost is driven by client menu preferences, patient consumption and overall scope of food service rather than by the cost of goods and labor. Most client facilities are already staffed to transform a 'can-to-pan' program to one that requires fresh whole ingredients and scratch cooking. Unidine trains staff to cook with fresh ingredients while following standardized recipes. Additionally, there is a labor cost already baked into the cost of prepared, pre-cooked and convenience foods. Why pay for that when your existing production team utilizes the different parts for the daily menu while bones and trimmings are used to flavor sauces, stocks and gravies. In addition to a better-quality end product, there is nearly 100% product utilization which reduces the cost and minimizes waste. A 'can-to-pan' program requires purchasing prepared, frozen products or canned goods that only have a singular purpose: the remaining product sits on the freezer shelf or in the storeroom which comprises quality and contributed to costly inventory.

How will Unidine manager our costs? Identification: Unidine requests a list of all food service budget categories prior to the formal assessment process. The list will be revisited several times prior to the development and delivery of a proposal. All relevant cost categories will be budgeted against historical data from Unidine facilities and industry standards.

Tracking: Unidine will ensure that budgeted expenses align with client expectations and an established scope of service. Financial performance is routinely monitored so that variances and adjustments are data driven.

Avoidance: This is an ongoing process throughout the term of our engagement to consistently seek future cost reductions. Unidine conducts formalized Quarterly Business Reviews that include forward-thinking initiatives and recommendations to positively impact operational and financial performance.

Technology: Unidine deploys its proprietary management information system, My-U-Suite, to manage all department costs including menu-management, production, inventory, suppliers and staffing.

Can we use local suppliers? Many

see Outsourcing on page 36

Technology Revives the Forgotten "Secret Weapon" Addiction Treatment Needs Now

By David R. Gastfriend MD, DFASAM
Co-Founder and Chief Medical Officer
DynamiCare Health

What if I told you that one of the most powerful and evidence-based clinical interventions for substance use disorder was nearly abandoned and forgotten? It's true.

With the opioid epidemic raging, the stimulant epidemic on the rise, and the COVID-19 pandemic exacerbating behavioral health issues more than ever, we need to use every effective tool in the addiction treatment toolkit. There are no shortages of ideas for helping people with addiction, but unfortunately, many ideas that seem promising at first don't stand up to rigorous scrutiny in clinical research. All the more reason why when we find something that really does work, it's imperative that we, as a field, adopt it and bring it to the people who need it.

Yet, we nearly missed that opportunity with one powerful, yet overlooked intervention: Contingency Management. Also known as CM, Contingency Management is the practice of motivational incentives — treating the disease of addiction as a brain reward disease. CM uses rewards that are contingent on good behavior, such as negative substance tests and attendance

David R. Gastfriend MD, DFASAM

at appointments. Every time patients show up to their outpatient appointments and test negative, they earn a reward for their progress.

For over 50 years, research has piled up showing that CM is one of, and perhaps the most, effective psychosocial interventions for substance use disorders (Dutra 2008). It consistently *doubles* to *triples* abstinence rates, and it works for tobacco, alcohol, opioids, and even stimulants — where little else works and there are no FDA-approved medications. There have been over 100 research reports on CM, and its use is recommended by the NIH, U.S. Surgeon General, and American Society of Addiction Medicine.

The reason CM works is simple: it uses frequent & immediate positive reinforcement to reshape pathways in the reward system of the brain. The reward system of the brain, called the limbic drive system, is deep-seated within our skulls and evolutionarily ancient — we share the structure with lizards. It drives our basic motivations for life and survival. What sets humans apart from other animals is the complexity of our cortex, the outer layer of our brain, where we do our high level thinking. But the reward system is the master. It sets the goals and recruits the cortex (where we generate conscious thought and speech) to do its bidding. When chemical reward signals from alcohol or drugs hijack the reward system, the reward system hijacks the rest of the brain, leading to the disease we know as addiction. CM's power lies in its ability to directly impact the reward system, something other psychosocial interventions like talk therapy cannot do.

Yet, few providers have even *heard* of CM (Petry 2011), let alone utilize it routinely in clinical practice (with the notable exception of the U.S. Veterans Administration). Researchers and experts were well aware of its efficacy, but outside of that small circle, CM languished in obscurity. After 100 studies, researchers and the NIH began to lose hope that the 101st study would make any difference. Bringing CM into routine practice would require changing clinical training, payer policy, and government regulations, a daunting task with no clear solution in sight. Without a drastic innovation or disruption, nothing was likely to change.

Enter the Smartphone. By the 2010s, they had become ubiquitous, and technologists were making great strides in applying technology to address healthcare problems, with the advent of the digital health industry. And CM was ripe for automation, because of its simplicity. Apps are perfect for reward systems (think of hotel/airline points apps or video games)!

There are now multiple companies with apps that use rewards to help people with substance use disorders. These apps verify positive behaviors, such as completing an in-app Cognitive Behavioral Therapy module, or showing up to a therapy appointment (using GPS), and then automatically deliver rewards, such as points or gift cards. My company,

see Secret Weapon on page 33

Intelligent Automation in Mental Health Care: Improving Patient Outcomes and Reducing Clinician Burnout

By Joshua Klein, CPA
Director of Strategic Planning
New York Psychotherapy and Counseling Center (NYPCC)

New York Psychotherapy and Counseling Center (NYPCC) has been providing quality mental health services to the most underserved communities of New York City for almost five decades. NYPCC currently has a network of locations in the Bronx, Brooklyn and Queens where we serve more than 25,000 clients a year. NYPCC believes that everyone deserves access to the best mental healthcare, and we translate that belief into action every day. During these difficult pandemic times, NYPCC has worked hard to ensure that we are available to the community whenever help is needed. Throughout the pandemic we have kept our doors open, offering both in-person and telehealth sessions 7 days a week with no waiting list. NYPCC has kept up with the increased demand for mental health services thanks to our dedicated staff who have worked tirelessly to ensure that all New Yorkers are able to access services to help address their mental health needs.

NYPCC has also enlisted the assistance of our digital workforce, comprised of software and robots, to support our staff meeting the needs of our clients. Over the past year, NYPCC embarked on a digital journey working with technology partners to identify areas where innovations can be utilized to both improve patient outcomes and reduce staff burnout. We have investigated how we can utilize intelligent automation to improve the quality of our staffs' lives, allowing them to focus on what they do best – providing exceptional mental health services to their clients.

NYPCC launched a digital Center of Excellence (COE) which works full time to see how we can work smarter through the use of automation technologies such

Joshua Klein, CPA

as Robotic Process Automation (RPA), Analytic Process Automation (APA), Artificial Intelligence (AI), and Machine Learning (ML). The COE is focused on identifying processes throughout our organization which would benefit from automation and provide significant benefits to our clients and staff. Some of the areas where these technologies have been beneficial, include patient record requests, referral and intake processing, and patient communication. As a result of these automations we realized significant time savings, increased accuracy, and have streamlined complex tasks.

In March 2020, NYPCC was quickly able to pivot to telehealth, ensuring no service disruption to our clients and their families. We implemented an integration of Microsoft Teams with our EHR to allow for a seamless process where video sessions are scheduled and managed directly within our EHR with no extra steps required by our clinicians. Our clients receive text message appointment reminders with a link to their session and can join with just the tap of a button. NYPCC partnered with a major telecommunications company to give NYPCC the ability to send text messages to our clients who either do not have access to an email address or prefer to communicate by text. We have also implemented secure messaging within Microsoft Teams which allows our entire multidisciplinary team to provide coordinated care. These tools allowed us to facilitate a hybrid work environment where our clinical staff can work in-person at the office or remotely from their home, based on the needs of our staff and clients.

We also employed tools which allowed NYPCC to better analyze and utilize our EHR data. Utilizing a self-service data analytics platform as well as a data visualization tool, we empowered our staff to gain insights that helped them improve quality care while reducing burnout. For instance, we were able to quickly identify patients with high no-show rates by analyzing EHR data and flag these patients early on to ensure increased engagement efforts by our clinicians. Throughout our data analytics process, we have wanted to make sure that our staff can focus on the most pertinent and important clinical information and allow them to decide how data is presented to them. We have developed data dashboards which allowed our clinical and compliance teams to track, analyze, and monitor key performance indicators (KPI) and address any matters requiring further analysis. This gave our teams a global view of the treatment being provided by our clinicians. We have also used a data analytics platform to extract data from our EHR and provide daily reporting to our clinicians with focus areas to ensure the best possible care. Our staff now have a constant real time view of their caseload overlaid with key indicators and are able to more effectively stay on top of their work. They can now spend less time focusing on administrative tasks and more time speaking with their patients. By using these tools, we have democratized data and enabled our staff to have access to the data which helps them in their role.

RPA has allowed us to include our digital workforce, helping our staff keep up with increased demand for mental health services due to COVID. RPA is a tool which allows you to automate repetitive tedious tasks, while allowing staff to focus on providing care to our patients. This technology has helped NYPCC to more effectively have staff focus on the most critical time-sensitive tasks thereby assuring quick access to our services. A huge benefit of using RPA was reducing the amount of time needed to process new patient referrals and admissions. Especially during this stressful time, NYPCC believes that any patient seeking mental health services must be seen as soon as possible and RPA has helped NYPCC achieve that goal. We have been able to automate a number of processes which has increased staff satisfaction and employee engagement.

While we have already accomplished great things through our digital transformation journey, we are just getting started. Staff have already started sharing ideas of where they would like to see technology implemented to make their jobs easier. We have placed a large focus on implementing tools which are considered to be "low-code" or "no-code." This means that creating automations can be done by anyone within our organization, even without any coding or technology background. This has allowed us to utilize internal talent who understand the processes which are being automated and has created a new category of staff which are referred to as "citizen developers." Staff throughout every level of the organization have provided positive feedback and we are thrilled to be able to use technology to assist with providing excellent patient care.

To find about more about NYPCC, visit www.nypcc.org. Joshua Klein can be reached at jklein@nypcc.org.

Analyzing Behavioral and Health Data Together Holds the Potential for Improved Behavioral Treatment

By Andrew Shlesinger, MSW, LICSW
Director of Clinical Technology
Melmark, Inc.

The recording and analysis of behavioral data is a cornerstone of evidence-based behavioral health treatment. Over the past several years, data across a spectrum of health metrics collectively known as Health Informatics, has taken hold in the provider community. Health Informatics data can include any health related measures like weight, sleep, seizure activity and bowel movements. This article will review the promise of combining the two datasets – behavioral and health – to yield new client insights, discover functional connections between behavior and health, and ultimately guide practitioners to improved treatment protocols.

Andrew Shlesinger, MSW, LICSW

It All Starts with a Database

Where an organization stores their data is a key factor in their ability to mine the data to its fullest potential. Data stored on paper datasheets limits analysis to what's on the page. When transcribed into a spreadsheet like Excel, that same data can be recorded next to data from other similar measurements for increased cross-behavioral analysis. Spreadsheets, however, are not designed to efficiently store or link data across large sets of data.

The next level is a database, an application that stores all of your data in a structured format designed to ease the process of retrieving and making connections between vast amounts of data. Databases are designed to quickly and efficiently record, store, and report on a virtually limitless number of clients, variables, and connections between those variables. These connections, or *relationships*, are built between the sets of data to eliminate duplication and build a foundation for asking questions that span all the data. In this way, one can efficiently compare vast amounts of data to build potential connections and correlations, which, in turn, can be used to improve client treatment, setting-level treatment, or drive organizational-level improvement. For example, if a particular behavioral intervention is used across many clients, the database can be asked, or *queried*, for all the outcomes across all the clients using that intervention. Further, if many clients are treated by one clinician, one could query the database for all outcomes from that clinician using that intervention. If you imagine *all* the data being structured and related in this way, the possibilities are endless for asking questions that further your understanding and, ultimately, treatment protocols.

It is important to note that the "database" described above is the application in which the collection of data is stored. For users to record, query, and report on that data requires an application to be built for the users to interact with that database. Any modern software that collects data, from social media to electronic medical records have a database behind them. An organization can purchase off-the-shelf database applications that meet their requirements, or, if none exist, can develop their own. Our organization has developed all of our clinical recording and reporting applications in-house based on decades of evidence-based experience, protocols, and workflow.

Adding Health Informatics to the Mix

In addition to behavioral health applications, our organization has developed web-based database applications to record, process, and analyze health data including sleep, bowel movements, menses, weight, seizure activity, well-body checks and more. We have incorporated design features in each of these apps to streamline our workflow and get key information to the providers who need it, when they need it. For example, our weight tracking application automatically alerts nursing staff if a client's weight gain or loss exceeds predetermined thresholds over 30, 60 or 90 days.

Automated workflow, in combination with organizational policies that require scheduled data analysis by clinicians, results in a wraparound solution that ensures every client's data is given the attention required to optimize treatment outcomes.

see Data on page 37

Telehealth: Short and Long-Term Implications for Behavioral Health

By David Kamnitzer, LCSW, Chief Clinical Officer and Mindy Liss, VP for Strategic Communications ICL

David Kamnitzer, LCSW

Mindy Liss

Since the pandemic took hold just over a year ago, behavioral health entities had to adjust almost overnight to virtual care to ensure that services were not interrupted, especially for our most vulnerable populations. For many of these clients, in addition to the help they receive for their mental health challenges, ICL works closely with each individual client to address their physical health issues which are often significant for people living with mental illness.

So, we quickly got to work the weekend the shutdown began; the IT department preparing some 400 laptops so that on Monday morning, there was a seamless transition to virtual services.

We've learned a lot from this use of telehealth services. Beyond being an effective short-term solution for continuing care during a pandemic, use of telehealth this way has given clinicians another viable route to help more vulnerable clients in their recovery and achieving greater health and well-being. Of course, telehealth is one among a set of clinical tools -- vehicles that drive goal attainment for everyone we serve.

While it will take many months – and even years – to assess the full impact of the pandemic on behavioral health services, one thing is clear: our reliance on Zoom and other technologies for providing care for the provision of care is not disappearing. Use of telehealth will serve the field well as we confront the other pandemic – the tremendous rise in mental health challenges for much greater segments of the populations, particularly young people.

Even as we begin to return to some aspect of life as we knew it, there will be no going back to the pre-pandemic way of doing business – whether in providing mental health support or managing day-to-day operations of an organization or business.

Lessons of a Pandemic: Whether communicating virtually with clients or colleagues, we need to talk about it: what isn't working, and more importantly, what is. During the pandemic and beyond, we want to minimize the pitfalls and leverage the strengths of different forms of technology to accomplish our ultimate goal: Helping one another be better, feel better, and live better.

While we know the Zoom "revolution" could become a real force for change, it's critical that we understand the implications for practice as well as about access and suitability for different client populations. So too must we build in protections to ensure that the highest quality of care is offered through remote services. That includes collecting and carefully evaluating information and data on the efficacy of the use of remote video in behavioral health.

The implications for clinical practice are many. ICL is embarking on a training program for staff to understand and implement best practices in the context of offering care virtually.

It's critical that we not allow virtual services become a barrier to achieving the promising outcomes ICL has realized with the enhanced use of integrated care that has led to improvements in health and mental health for our clients and for the larger community, this use of whole health care has resulted in reduced hospitalizations for mental health and physical health reasons and enhancing the overall and longer term well-being of the people we serve.

While our shift to offering care virtually was quick, its continued use has been done very thoughtfully. From early on in the pandemic, we have been looking at how telehealth is impacting clients and services. Here are some of the early lessons for practice from the use of telehealth throughout our programs:

Creating safe spaces: In all ways of providing services, we know we must maintain confidentiality as well as comfort – professionalism while providing a sense of structure and warmth and an appropriate level of self-disclosure. Most challenging for the use of telehealth is the fact that clients cannot always log on to video or phone chat from spaces that are confidential or comfortable.

Practice suggestion: From the start, solicit client feedback about comfort and safety, and strategize together how to maximize these factors.

Cues and signals: On Zoom, if much of a client's body is out of frame, while we can focus on facial expressions, we're missing out on their body language and therefore much of the story. Facial cues themselves can be more difficult to discern; for example, we might not notice a client blinking back tears, or because of camera position, we might misinterpret shifts in a client's gaze. Auditory cues, such as sighs and sniffs, can also be more difficult to pick up on and interpret, perhaps more so than during telephone sessions where the auditory connection can feel more focused and intimate. Of course, we cannot pick up on olfactory cues on virtual sessions – at least not yet.

Practice suggestion: If you can't see (or hear) something, say something! It's okay and encouraged to ask: "How are you sitting right now?" Be candid about the fact that it's more difficult to pick up on certain cues on video chat. Check in often. It might be useful to ask how they are perceiving you, and to explore how your own non-verbal cues are experienced.

Staying present remotely: Scientific research shows that our brains have to work on overdrive to process what we communicate to one another via video-conference. This may make it more difficult to relax into the rhythm of a session. Many of us may feel a heightened awareness that we are being viewed on a video session, which can be distracting. There is also research showing that staring at a screen for long periods of time can lead to eyestrain, headache, and tension – all of which can significantly detract from the efficacy of the session.

Practice suggestion: Minimize your own image on Zoom if it's distracting, and if things feel labored or awkward, call this into the session. To encourage present-moment awareness for both practitioner and client, consider incorporating meditation or mindful movement, with eyes closed or looking away from the screen. If possible, try to structure workdays so that breaks in between client sessions need not all be spent looking at the computer.

At ICL, relationship-building is central to everything we do to support people on their road to recovery and leading a healthier and more productive life. These relationships can be healing and transformative for participant and practitioner. We know that in-person work will always retain a very important place in what is and must continue to be a person-centered field. At the same time, we are in an exciting juncture for the profession as all of us together as a community and individually as organizations, explore how we can sustain the benefits of relationship-building using nontraditional channels.

We've learned a lot from the use of virtual care provision. While it was first seen as a short-term change, the use of telehealth services has opened up new ways to reach our most vulnerable populations for the longer term while always recognizing the centrality of relationship-building and other longstanding approaches to helping us get people better

Survey Shows Acceptance and Success: The promise of telehealth is clear to many of us as clinicians; what was less expected was the extent to which our clients embraced virtual care. In May, 2020, individuals receiving services from ICL behavioral health programs were asked to participate in a survey, the results and its implications for the use of tele-psychiatry published in an article of APA Journal of Psychiatric Services. What we learned was that 80% of the almost 1,500 respondents reported satisfaction with care and interest in continuing these services in the future, even when the pandemic lifts. The majority of those feeling favorable toward telehealth wanted telehealth to be in combination with in-person services.

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ICL CONNECTS

Serving East New York and Brownsville communities

ICL

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Call us

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(646) 599-1329
ICLConnects@iclinc.net
at the ICL Health Hub
2581 Atlantic Avenue
bet. Georgia & Fulton Aves
(enter on Georgia)

A program of the Institute for Community Living
ICL offers a wide range of health and behavioral health services
Community Healthcare Network is our medical services partner in the Hub.
ICL Connects is generously supported by the Mother Cabrini Health Foundation.

Community Healthcare Network

Telehealth Is Critical for Our Behavioral Health During the Pandemic

By Jeffery, Trina, and Ephraim

This article is part of a quarterly series giving voice to the perspectives of individuals with lived experiences as they share their opinions on a particular topic. The authors are served by Services for the UnderServed (S:US), a New York City-based nonprofit that is committed to giving every New Yorker the tools that they can use to lead a life of purpose.

We are three New Yorkers who receive supported housing, mental health, case management, and substance use treatment and recovery services from Services for the UnderServed (S:US). Like everyone else, our lives have been full of upheaval over the last year because of the COVID-19 pandemic. We have embraced technology in different ways to help support our behavioral health and keep our lives moving forward during this time of isolation. S:US has helped us by using technology for telehealth and other services and by supporting their staff so they can safely help us meet our needs.

Barriers to Telehealth

When the pandemic first started, some of us had trouble with technology because we weren't familiar with how to use it. For example, one of us tried to do a video chat and couldn't get through so we just called on the phone instead. We've also experienced our video freezing or the internet cutting out, which makes it more difficult.

For parents with children still at home, they may help teach us technology but they also add challenges. A younger child doesn't understand when you can't pay attention to them. It's hard to find time to have calls, not be interrupted, and have our minds focus on one thing. "When you're in the office, you don't have to worry about these things. When you're at home, there's a whole world of stuff going on," said Trina.

Some of our peers have barriers to technology, they don't have smartphones, they're concerned about using up their data or minutes, they don't have laptops or they don't have WiFi. One of us reached out to our peers to show them how to use tools like Zoom and other things. This is something that S:US staff has helped us with too.

And one of us wishes that their primary care provider had more time to spend with patients instead of having an overwhelming workload and limited services.

The Convenience of Telehealth

Two of us really appreciate the convenience of telehealth. Once we learned how to use it, it's easy to make appointments and talk with our providers. We like not having to travel and take public transportation to get to our appointments.

"Before the pandemic, I'd come into the clinic from the subway, frustrated and stressed by the trip. Now when I log on, I have a clear mind for therapy," said Jeffery.

"My doctor is very nice. He Zooms with me every month. My therapist calls me every two weeks and checks on me. We talk about current events, vaccinations, family, work, my medication--everything that matters. I look up to them. If I have any problems, I can talk with them. I wish I could see them in person, but telehealth works fine for me," said Ephraim.

We like being able to get the support we need, when we need it. And one of us has also found that some things that are hard to discuss in person with our providers are easier to talk about over the phone.

Missing In-Person Interactions

We all enjoy being around people and we each consider ourselves as a "people person." In person you can tell a lot by someone's body language and that's missing in telehealth. We all think that it's good to see people face-to-face and that

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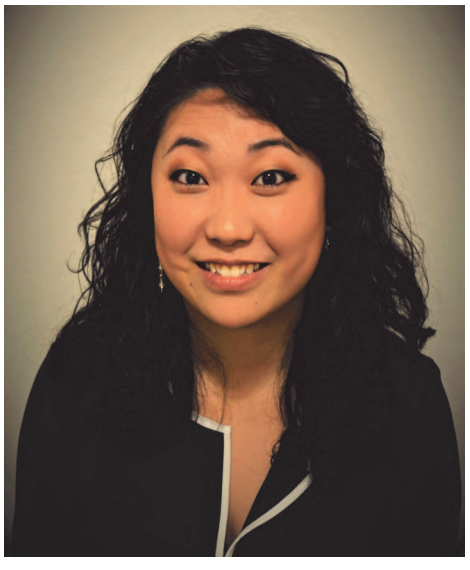
A Safe Space: Digital Tools Supporting Mental Health

By Ting Ting Lee
Coordinator, Clinical Technologies
National Suicide Prevention Lifeline

As the COVID-19 pandemic swept the globe last year, collectively, mental health challenges were intensified. With the pandemic, a series of lockdowns, restrictions, and preventative measures were put in place, forcing many of us into isolation, primarily interacting in digital spaces. We've also seen high rates of unemployment, food instability, and other barriers to emotional health throughout the pandemic. Moreover, while coping with all of this, we've experienced civil unrest throughout our country. There has been a lot weighing on our society over the last year. Elevated rates of suicidal ideation, substance abuse (Czeisler et al., 2020), intimate partner violence (Evans et al., 2020), and child abuse (Lawson et al., 2020) taxed our already stressed support systems. Facing these obstacles, many have turned to the digital supports that are available. But how do these tools actually work?

Even prior to the COVID-19 pandemic, our increasingly digital world created interpersonal distance, with some people increasingly interacting solely through social media, texting, and online spaces. These digital spaces gradually adapted to address the mental health issues faced by users, offering ways to report concerning posts, online behavior, and offer support (National Suicide Prevention Lifeline, n.d.). These tools are available to meet a variety of needs and, unlike many traditional forms of mental health support, have the ability to always be accessible. But do they work?



Ting Ting Lee

In the years since online crisis and mental health support services have become more common, research studies have shown that digital tools can supplement existing support systems and intervene for those who would otherwise not seek out professional support. A meta-analysis on digital interventions for suicidal ideation and self-harm found the tools to be effective compared to non-intervention control groups (Witt et al., 2017). A 2019 study out of Australia found that digital tools that target suicide were effective in reducing suicidal ideation and, the fact that they were digital, made them critical in helping those that might not choose to seek face-to-face treatment (Torok et al., 2019).

Built in collaboration with the national advisory committees of the National Suicide Prevention Lifeline (Lifeline), Safe Space is home to resources and tools to provide users with extra support in an emotionally safe environment. The intent of the Safe Space is to: (a) provide additional help to persons utilizing Lifeline Crisis Chat or the Lifeline; (b) provide helpful resources for persons to engage while waiting for Lifeline counselors to assist them (either chat or calls); and/or (c) engage and assist individuals in distress who are visiting the Lifeline site but are not inclined to use either the Lifeline call or Crisis Chat service.

Evidence-based self-help and peer support resources collected with the guidance of a custom rubric have created a space where users can connect to support through Lifeline Crisis Chat, find digital coping tools, or use distraction tools (Kuchuk & Gonzalez, 2020). This unique rubric was designed to measure the potential impact of a digital resource, assessing the resources' attributes on various categories of safety, best practices, interaction, and accessibility (Kuchuk, 2020).

Lifeline Chat is a service of the National Suicide Prevention Lifeline, connecting individuals with counselors for emotional support and other services via web chat. Available 24/7, Lifeline received over 91,000 chat visitors in the last month. Crisis Chat often reaches younger individuals discussing more intense subject matter who may not reach out for support otherwise (National Suicide Prevention Lifeline, 2020). Visitors to the Safe Space can utilize the tools available while waiting to speak with a chat counselor, much like a client awaiting a therapist in a quiet, calm waiting room. Since launching in March 2020, Safe Space has had over 190,000 visitors, with tens of thousands of users accessing resources every month.

The coping tools found on Safe Space include websites and apps connecting visitors to a host of coping, skills, and support for suicidal ideation and other mental health topics. Most of these tools provide a customizable experience for users to tailor to their own preferences and presenting issues. Through resources like the Virtual Hope Box, the Your Life Your Voice site, and the Now Matters Now site, visitors to the Safe Space can

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Putting Tech to Work: Adapting and Enhancing our Services

By Isobelle Surface
Senior Vice President and Director of Communications, Odyssey House

Putting advanced technology to work at Odyssey House was underway before COVID-19 disrupted our work and personal lives forcing us to change how we interact with each other. We have consistently invested in ways to make our administrative and program management tasks more efficient with remote meetings, online services, and cloud-based data management systems.

But what changed dramatically, in a year of so many unforeseen challenges, were rapid transitions of selected client services from in-person to virtual interactions and all-remote administrative functions.

Our ability to quickly set up virtual counseling, medical and court appointments, and other previously in-person-only services, made it possible for clients to progress in treatment while following public health directives on face coverings, physical distancing, and limiting exposure to others. And, of course, what worked to keep clients safe also protected our workforce.

When we implemented coronavirus containment measures, such as social distancing and reducing group sizes while continuing to provide essential services to clients, the role of virtual care expanded within the residential, outpatient, and housing programs.

Adapting Technology to Treatment

As the information technology (IT) staff worked in the background to provide remote technology, the clinical program and housing staff had to adapt quickly to the demands for infection control. This was an especially urgent need in residential programs and supportive housing programs, where hundreds of clients and tenants now had to be kept safe from a highly contagious virus while living in congregate living conditions.

For Jeremy King, Senior Manager, Director of OASAS Residential Programs, this meant incorporating telehealth into a treatment regime based on in-person peer support and group engagement. Mr. King explained this was particularly helpful for individuals new to treatment and not ready to leave the program unsupervised for extended periods.

"Telehealth technology allowed clients, where medically appropriate, to receive primary and specialty medical services, including psychiatric care and medication management, in the safety of the treatment program."

In future, when court-mandated child visits are required, Mr. King believes a responsible middle ground may be facilitating these visits remotely while the mother stabilizes in her recovery process.

"We use telehealth technology to facilitate Administration for Children's Services (ACS) conferences with judges, preventive workers, case managers, lawyers, and family advocates all present in the same digital space, which allows our clients to attend conferences without leaving the program.

"In the past, we wrote letters advocating for the rights of our clients, but secure virtual platforms allow us today to advocate for clients' parental rights and needs in real-time and to a live audience – an advance that clients have reviewed positively," added Mr. King.

And for individuals co-enrolled in external Opioid Treatment Programs (OTPs) while in residential care, telehealth technology can help clients receive individual counseling and medication management services within the facility, a benefit Mr. King believes could help a population that is at high risk for relapse and overdose.

Mr. King does, however, recognize there are some drawbacks to using technology in a therapeutic setting. One example he gives is in family services, where the connection a child and a mother develop while physically being together is a vital, tactile experience that cannot be replaced by technology. But he believes when used carefully in a therapeutic setting the benefits, such as enrolling clients in virtual adult basic education classes and vocational training, serve to enhance essential residential services.

Outpatient Services Online and Onboard

The impact of COVID-19 on outpatient services was immediate. Though some services, such as managing the medication-assisted treatment (MAT) program, needed to remain on-site, the bulk of individual and group treatment sessions transitioned to online and telehealth services. Not knowing how long the health crisis would last, the program and administrative teams moved quickly to ensure clients suffered minimal disruptions, stayed connected to their familiar support systems, and had 24/7 access to a crisis telephone hotline.

But the transition was not as smooth for clients without access to basic technology – a cell phone or Wi-Fi service. For these individuals and families, thanks to a grant funded by Columbia University School of Business, we were able to provide a low-cost data plan and cell phone that made it possible for them to connect with their counselors and recovery network.

According to Mary Callahan, Senior Director of Outpatient Services, the effort paid off – telehealth services are proving to be a hit with the clients. "Our daily numbers are better than we expected. The clients, and staff, are really latching onto this as a resource."

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The NYSPA Report: The Future of Telehealth in New York State

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

For many years, the New York State Psychiatric Association (NYSPA) has been advocating for mental health parity – equivalent coverage and reimbursement for the treatment of mental health and substance use disorders. In addition to Timothy's Law, New York's mental health mandate, and the federal Mental Health Parity and Addiction Equity Act, recent legislative successes have allowed New York to make great strides towards full parity implementation. The Behavioral Health Insurance Parity Reforms (BHIPR), a comprehensive overhaul of the New York Insurance Law included in the 2019-20 New York State Budget, mandated coverage for all mental health conditions, substance use disorders and autism spectrum disorders by individual plans, group plans and HMOs. Other recent victories include the Mental Health and Substance Use Disorder Parity Report Act, enacted in 2018, which requires plans to implement formal parity compliance plans along with regular reporting to the state. NYSPA's advocacy and support was critical in the enactment of these important measures.

The next frontier will be to guarantee parity for mental health and substance use disorder services provided by telehealth, both from a coverage and reimbursement perspective. NYSPA is committed to advocating for unrestricted access to telehealth and full parity in telehealth reimbursement from all payers.

In January 2021, Governor Cuomo included language in his Executive Budget proposals intended to expand access to telehealth for all New Yorkers. If adopted as part of the Fiscal Year 2022 Executive Budget, these proposals would codify reforms and relaxations previously authorized under gubernatorial executive orders issued in response to the COVID-19 public health emergency. The New York State Executive Budget must be enacted by April 1 and at the time of this writing, the following proposals are still pending.

Rachel A. Fernbach, Esq.

• Provisions confirming that individuals with Medicaid coverage may receive telehealth services wherever they are located. Although temporarily waived during the public health emergency, federal rules currently prohibit coverage of telehealth services to a patient not in an originating site (e.g., physician office, hospital or other health care facility). This proposal would seek to ensure that all individuals covered by the Medicaid program are eligible to participate in telehealth from the safety of their homes.

• An interstate licensure program with other contiguous states and states in the Northeast region to permit practitioners in other states to provide telehealth to individuals in need of services located in New York. Traditionally, New York has chosen not to participate in any interstate licensing compacts.

• A requirement that commercial health plans maintain an adequate network of professionals to provide access to telehealth for all services covered under the plan.

• A mandate that telehealth be reimbursed at rates that incentivize use, when medically appropriate.

• The requirement for Medicaid coverage for audio-only telehealth services, when medically appropriate.

NYSPA has been carefully monitoring the budget proposals and engaging with legislative members and their staff. While we support many of the initiatives and their intent, the proposals simply do not go far enough to ensure widespread access to telehealth and reimbursement parity for telemedicine services across all payers. Simply put, medical care and treatment provided via telehealth modalities should be reimbursed at the identical levels as those services provided in-office. This principle must be applied across the board with respect to commercial insurers, the Medicaid Fee-for-Service program and Medicaid Managed Care. According to budget testimony submitted by the Medical Society of the State of New York,[1] a survey of New York physicians conducted by one of its partner organizations revealed that only 23% of health plans reimburse telehealth visits at the same rate as in-person visits. Additional survey results indicated that audio-video telehealth visits are often reimbursed at only 30% of in-office visits while audio-only are reimbursed at 80% of their in-office counterparts. The failure to secure full reimbursement parity for telehealth will jeopardize access to necessary care for those communities that will likely benefit the most from remote access due to challenges in transportation, child-care and flexibility in scheduling.

We strongly support the ability of individuals covered by the Medicaid program to access treatment via telehealth while remaining in their homes. New York law already permits telehealth services covered by commercial health plans and insurers to be provided to patients in a location other than an originating site. Some individuals may have difficulties with transportation or do not feel comfortable leaving their homes as a result of the public health emergency. This expansion would permit individuals to receive necessary mental health care and treatment without the need to travel to a separate location.

With respect to the interstate licensure compact provisions, we strongly urge the state to prioritize quality of care and ensure that any out-of-state health care professionals providing care and treatment to New York residents provide those services in accordance with scope of practice requirements currently in place under New York law. Further, we support a further expansion of interstate reciprocity to permit physicians licensed in the State of New York to continue to provide care and treatment to their patients via telehealth when the patient may be traveling outside of New York for business, vacation or an extended stay, where clinically appropriate. An essential component of this initiative includes ensuring insurance coverage for services provided by New York physicians to their patients while temporarily outside of New York.

NYSPA supports the establishment of a telehealth provider network but would caution that establishment of an out of state network of providers authorized to provide services to New York residents cannot be a valid reason to limit the ability of New York-licensed physicians to provide covered telehealth services where needed.

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Mental Health News Education, Publisher of Behavioral Health News Welcomes David Minot as New Executive Director

By Staff Writer
Behavioral Health News

The Board of Directors of Mental Health News Education (MHNE), the nonprofit organization that publishes *Behavioral Health News* and *Autism Spectrum News*, announces important changes in Executive leadership and launches a planning initiative with an eye toward future development.

In a move designed to reflect the increase in technology and strengths of the leadership at MHNE, the father and son team of Ira H. Minot, LMSW, and David H. Minot, BA, will assume new titles effective immediately with Ira becoming Founder and David becoming Executive Director.

Since the creation of MHNE in 1999, Ira Minot, a survivor of mental illness, was the face and sole leadership of the organization. In 2008 Ira's son David Minot came on board to help launch Autism Spectrum News and develop the organization's website in its earliest form.

Times have changed and so has the technology driving MHNE and the website of Behavioral Health News and Autism Spectrum News. At the January 27th meeting, the MHNE Board of Directors conferred on Ira the permanent title of Founder and that he would continue as the publisher of *Behavioral Health News* and continue to contribute his exceptional vision to the organization. Simultaneously, the Board elevated David Minot to the position of Executive Director.

Ira H. Minot, LMSW, MHNE Founder and
David H. Minot, BA, MHNE Executive Director

"For the past year I have suggested this change in our titles because David has become the face of the organization and taken on new responsibilities including the redesign of both of our websites, developing our social media strategy, and recently launching webinars, which provide our readership direct access to leaders in the autism and behavioral health communities," Ira stated. "I am not retiring any time soon and will still be publishing Behavioral Health News while David continues to publish Autism Spectrum News."

"What most people don't know is that my father and I make up the entire staff of MHNE. Running this organization is a labor of love, and we couldn't do it without our wonderful Board of Directors," acknowledged David Minot. "Over the past few years, it became clear that we needed to modernize our content delivery strategy. Our websites have been completely redesigned from scratch, and now visitors are greeted by a media-rich

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Leaders of the Autism and Behavioral Health Community To Be Honored at May 12, 2021 Virtual Leadership Awards Reception

By Staff Writer
Behavioral Health News

Mental Health News Education, Inc. (MHNE), the nonprofit organization that publishes Autism Spectrum News and Behavioral Health News, will be honoring five outstanding champions of the autism and behavioral health communities at its Virtual Leadership Awards Reception on May 12, 2021 from 5:00 pm to 6:00 pm.

Debbie Pantin, MSW, MSHCM, President and CEO of Outreach and MHNE Board Chair, made the announcement stating, "MHNE has selected five prominent leaders from well-known New York organizations who represent some of the very best in the fields of autism and behavioral health. We are honored to pay tribute to them in recognition of their many years of dedicated service to the autism and behavioral health communities."

David Minot, Executive Director of MHNE, added, "We are so pleased to have this opportunity to recognize these champions who have dedicated their careers to making a different in people's lives."

Ira Minot, Founder of MHNE, remarked, "Due to COVID-19, this will be our first Virtual Leadership Awards Reception. This year's event will be an evening to remember as we pay tribute to our distinguished honorees. We cordially invite all colleagues, friends and family members to join in the celebration."

Proceeds from this event will go towards expanding and developing the nonprofit educational mission of Autism Spectrum News and Behavioral Health News. With these publications, MHNE aims to reduce stigma, promote awareness and disseminate evidence-based information that serves to improve the lives of individuals with mental illness, substance use disorders and autism spectrum disorders, their families, and the provider community that serves them.

Marco Damiani
Chief Executive Officer
AHRC New York City
Excellence in Autism Award

Marco Damiani joined AHRC New York City with a varied and progressive career in the field of intellectual and developmental disabilities (I/DD), behavioral health and general healthcare as a clinician, consultant and agency executive. Founded in 1949, AHRC NYC is one of the largest organizations in the nation supporting 20,000 people with I/DD and their families. AHRC NYC has over 5,500 dedicated staff, an annual budget well over $300 million and provides a broad range of programs, services and supports across the lifecycle. Marco's career began at FEGS as a direct support professional and clinician, shortly after the implementation of the landmark Willowbrook Consent Decree and progressed through the years with positions in New York State government to Executive Vice -President at YAI Network where he led a broad and expansive portfolio of health and behavioral healthcare, research/ program evaluation and a large community-based support, information and referral program, to Executive Vice President at Cerebral Palsy Associations of NYS, to his most previous position as CEO of Metro Community Health Centers, a network of 5 Federally-Qualified Health Centers in NYC devoted to supporting patients of all abilities.

In addition to his executive leadership positions, Marco was previously Chair of the Manhattan Developmental Disabilities Council and Chairman of the Alliance for Integrated Care of New York, the first Medicare Accountable Care Organization in the nation focused on individuals with I/DD. Marco is a Mayoral Appointee of the NYC Community Services Board I/ DD subcommittee, a Board member of both the Inter-Agency Council of I/DD Agencies and Care Design NY, an I/DD Health Home, and is also an Appointee to the New York University College of Dentistry Dean's Strategic Advisory Council. In recognition of Marco's contribution to the work of its school and to the field of oral health, and for his leadership and advocacy in promoting healthcare innovation models for people with disabilities, the NYU College of Dentistry awarded Marco with the College's highest honor, the Kriser Medal.

Marco earned a BS in Psychology from Manhattan College, a Master's Degree in Developmental Psychology from Columbia University and pursued doctoral studies in Educational Psychology at New York University. He attributes his success to the extraordinary collective work and shared vision of his many colleagues over the years, their enduring commitment to promoting social justice for people with disabilities and his never-ending quest to being more than just a so-so guitar player.

Tony Hannigan, LMSW
President and Chief Executive Officer
Center for Urban Community Services
Lifetime Achievement Award

Tony Hannigan, a licensed social worker, is the founder, President & Chief Executive Officer of the Center for Urban Community Services (CUCS). From 1983 -1993, Tony was responsible for the growth of Columbia University Community Services, an interdisciplinary project that developed various neighborhood-based programs for homeless and low-income individuals. Tony is a licensed social worker and was a staff member of

see Leaders on page 34

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Learning from Client Surveys About Telehealth and the Impact of COVID

By Kelly Daly, MS,
Shari Reiter, MA, Elana Spira, PhD
and William Mullane, PhD
WJCS

In the fall of 2019, as part of our effort to increase client accessibility to treatment, Westchester Jewish Community Services (WJCS) was preparing to launch a telehealth program. The plan had been to start a small pilot in the spring of 2020, with a few staff providing telehealth sessions, as well as feedback and guidance for a larger scale launch to follow. The onset of the global pandemic not only hastened our plans, it drastically changed the scale of our initiative. Indeed, today approximately 65% of our services are being rendered via video-based telehealth, and WJCS, the largest provider of licensed outpatient community-based mental health services, has delivered over 80,000 video-based telehealth services since the start of the COVID-19 public health crisis. Consistent with our original plan, WJCS assessed our clients' telehealth experiences during the fall of 2020, using both English and Spanish language survey methodology. The survey provided many important insights about our clients and the process of virtual data collection at a large community mental health agency. While some of the information garnered has become common knowledge, other findings came as a surprise, and several findings, although confirming what we anticipated, have been sobering.

The following information reflects data gleaned from a small sample of WJCS clients (n = 128). Survey results provided preliminary evidence that video-based telehealth has been well-received by our clients, with the majority of clients surveyed finding telehealth easy, convenient, private, and effective. Additionally, 97% of clients expressed a desire to continue with some proportion of video-based telehealth services, with 67% wanting exclusively remote services, at least until the conclusion of the pandemic. Further, of clients who received services before switching to telehealth, 30% confirmed that they had experienced significant barriers to accessing in-person treatment. These difficulties were primarily related to transportation, disability, and childcare. These results supported feedback from numerous clients who have expressed that telehealth, including video-based sessions, has been invaluable to them, helping them to get through the most challenging and isolating period of their lives. Further, these results highlighted how clients with access needs may receive services more equitably.

In addition to supporting clients' positive impressions of telehealth, the survey results also reinforced the devastating impact of the current pandemic for our client population. The most striking results of our survey are a startling confirmation of the disproportionate adverse impacts of COVID on our clients. Due to COVID, 45% of our respondents experienced a change in household income, 25% experienced a change in employment, 25% suffered the loss of someone close to them, 15% live with someone who has had COVID, and 6% had COVID themselves. A third of clients experienced more than one of these impacts. These figures become even more sobering in light of the timing of the survey. When the survey was administered, approximately 7 million people in the U.S. (approximately 2% of the total U.S. population) had contracted COVID; the cumulative total, as of February 2021, was over 28 million people. Comparing our figures to that of the general population, our estimates suggest that our clients were 3x more likely to have had COVID themselves, compared to the general population. If those estimates hold, it may be that as many as 24% of our clients have now had COVID at this point in the pandemic. The overall toll of COVID on our clients is truly incomprehensible.

Although the results of this survey provide promising support for the benefits of telehealth, we recognize the limitations of our survey. Chief among them is that those least comfortable with technology or without reliable access to the internet may have opted out of text message and email reminders to take the survey. As a result, we obtained a 30% response rate and sampled only a small proportion of our clients. Additionally, we have heard from a small handful of clients, most who have very complex concerns and challenging life circumstances, that telehealth has not worked for them. It is essential to understand more about their experiences and dissatisfaction with telehealth.

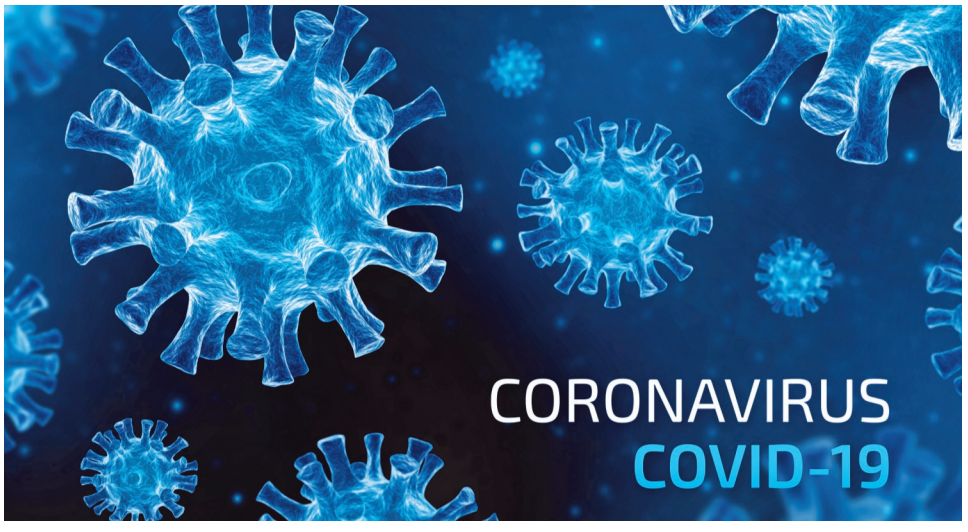
This project highlights the value of surveying our clients and has prompted us to think about how to better prepare to collect data from them going forward. Cognizant that we may wish to survey clients more frequently, we plan to modify questions around preferences for contact reminders during intake so that we do not exclude the option to text or email clients when necessary since both represent vital forms of communication. When asking clients about their preferences to be contacted by phone, email, and text, we also plan to ask clients to use that information to survey them about their treatment experiences.

Finally, this project has highlighted the invaluable role of technology in meeting the treatment and support needs of our clients. Although transitioning to remote services (in particular as rapidly and on as large a scale as we did) had its challenges, we know that telehealth has provided a lifeline for many of our clients. Our data on the impact of COVID has confirmed fears that our clients have been disproportionately impacted by the pandemic. It also reaffirms the importance of us being well-positioned to offer a variety of ways they can access services. The challenges posed by these unprecedented times impel us to continue to learn more about our clients and further develop our capabilities so that we may better meet their needs.

Kelly Daly, MS, is a Psychology Fellow, Shari Reiter, MA, is a Psychology Fellow, Elana Spira, PhD, is Director of Research, and William Mullane, PhD, is Director for Innovation, Integration, and Community Partnership at WJCS. Learn more about WJCS at www.wjcs.com.

COVID -19: Addressing Vaccine Reluctance

By Gregory Bunt, MD
Medical Director
Samaritan Daytop Village



The past year has been a time of great concern and anxiety acutely felt by our behavioral health workforce. Recently we have been overwhelmed by an influx of information about COVID 19 from its risks, testing procedures, and prevention and treatment as well. New and sometimes confusing information about the COVID 19 vaccination is available on the internet and questions and concerns arise from discussions with our behavioral health workforce colleagues.

The most common reasons for reluctance to getting the vaccine are concerns about safety and side effects as well as views that minimize the risk of COVID 19 infection and views of disapproval of vaccines in general.

In the field of medicine, doctors learn that one must weigh the risks of taking a medicine or vaccine against the risk of not taking a medicine or vaccine. In the case of the COVID 19 vaccine, the risk of not taking the vaccine far outweighs the risk of getting the vaccine. COVID-19 vaccines have been held to the same high standards as all other types of vaccines in the United States including the flu vaccine and the vaccine for polio. The COVID-19 vaccines available to us in the USA have been approved by the Food and Drug Administration (FDA) applying the strictest safety and efficacy standards. "The benefit of COVID-19 mRNA vaccines, like all vaccines, is those vaccinated gain protection without any risk of getting sick with COVID-19 from the vaccine" (CDC).

The clinical trials with many thousands of volunteers including elderly have demonstrated that the vaccine is very safe and no deaths have yet been observed or reported from the vaccine (compare that to the estimated 500,000 deaths in the USA from COVID 19). The only serious side effect for some very few individuals has been an allergic reaction which can occur with any new medication or vaccine and can usually be treated medically at the time of the vaccination.

Further, taking the vaccine not only protects that individual - although that alone, the health and well-being of our behavioral health worker is very important, but because COVID19 is a deadly highly contagious communicable disease, the COVID-19 vaccination will significantly reduce the risk of spreading the deadly COVID 19 virus to family, friends, co-workers and peers as well as the clients we interact with and serve.

COVID-19 mRNA vaccines are given in the upper arm muscle (deltoid). COVID -19 mRNA vaccines give instructions to our cells to make harmless pieces of what is called the "spike protein." The harmless spike protein is found on the surface of the virus that causes COVID-19. Next, the cell displays the protein pieces on its surface. Our immune systems recognize that the protein doesn't belong there and begin building an immune response and making antibodies, like what happens in natural infection against COVID-19. Our antibodies to the spike protein are then rapidly generated upon any exposure to the COVID virus and when they attack the surface protein they kill the virus. At the end of the process, our bodies have learned how to protect against future infection (for 6 months to a year) (CDC Center for Disease Control). Clinical trials have demonstrated that the vaccination protects over 90% of people from getting the infection when exposed, and for those small percentage who do get the COVID-19 infection it is much less severe.

We therefore urge all of our behavioral health workforce colleagues to inquire about opportunities to obtain the COVID-19 mRNA vaccine from their healthcare providers and to discuss any of their concerns or questions.

Gregory Bunt, MD, is Medical Director, Samaritan Daytop Village. He is Past President, New York Society of Addiction Medicine, and is Clinical Assistant Professor of Psychiatry, NYU School of Medicine.

MHNE Board Member and Psychiatrist Dr. Barry Perlman Publishes Memoirs in New Book "Rearview"

By Staff Writer
Behavioral Health News

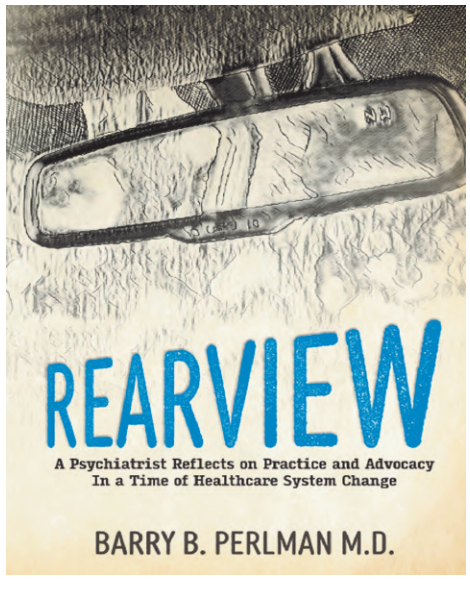
Barry B. Perlman a psychiatrist and longtime member of the board of Mental Health News Education, the sponsoring organization of Behavioral Health News and Autism Spectrum News has published a professional memoir. In Rearview: A Psychiatrist Reflects on Practice and Advocacy in a Time of Healthcare System Change. Perlman, a graduate of Yale Medical School, offers an overview of his career in medicine and personal commentary on the evolving mental health system. From his first inklings of interest in mental health issues tied to his grandmother's bouts of severe depression and his mother's volunteer work with persons discharged from psychiatric hospitals, to his summer jobs in hospitals, through to closing his practice and retirement, Perlman recounts the entire arc of his psychiatric and medical career.

Through recalled anecdotes Perlman brings readers along by writing about important experiences from medical school and his psychiatric residency. He describes his first professional experiences with dying, his cadaver, and clinical rotations such as neurosurgery and psychiatry. He experienced the English National

Barry B. Perlman, MD

Health Service when taking his OB/GYN clerkship in London. Readers will be introduced to several of his dedicated professors and their eccentricities.

Other chapters introduce topics central to the practice of psychiatry. They include consideration of suicide, violence, poverty, and electroconvulsive therapy. One chapter is revealingly illustrated with art done by patients and ponders the question of what makes art, art. Many of the chapters include interesting case presentations.



Dr. Perlman, an activist psychiatrist, served as president of the New York State Psychiatric Association and was appointed by NYS Governor George Pataki as chair of the NYS Mental Health services Council and as a member of the State Hospital Review and Planning Council. Based in participation, he describes the process and tensions involved in shaping public policy.

Dr. Jeffrey Borenstein, the creator and host of the Emmy Award nominated PBS series Healthy Minds and President and CEO of the Brain & Behavior Research Foundation, said "Rearview shares an activist psychiatrist's personal perspective on several aspects of his professional life. Readers will come away better appreciating their psychiatrists and the forces which impact their practices through Perlman's astute commentaries."

Mr. John J. Herman, formerly the editor-in-chief at Weidenfeld & Nicolson, wrote, "I enjoyed being in your company throughout your pages. Here is a battery of adjectives that occurred to me and seem entirely appropriate: Informed, intelligent, thoughtful, caring, humane, funny! All true, and not occasionally but present throughout."

Readers who delve into Rearview will be taken on a tour of the multidimensional life of a psychiatrist whose professional life encompassed provision of direct clinical care, running a psychiatric department under challenging circumstances, and trying to improve the lives of New Yorkers living with serious mental illness. As Dr. Perlman concludes, he feels grateful to those who encouraged and mentored him, the patients who sought his care, and diversity of professional experiences afforded him.

Rearview will be available for pre-publication purchase on Amazon beginning April 1, 2021 and for actual purchase of either the paperback or Kindle version on April 23, 2021.

The Emergence of Telehealth and a Deepening Digital Divide

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

In recent years it has become commonplace to reference "transformational" initiatives within our health and social service systems that have altered the manner in which care is delivered and reimbursed. A movement to replace "Fee-for-Service" models with "Value-Based" alternatives purports to bend an intractable cost curve that has defined the American healthcare system. An emergent recognition that Social Determinants of Health (SDoH) are dispositive of health outcomes (considerably more so than the quality or accessibility of healthcare and health-related services) has influenced the priorities of providers and payors alike. Authority over the publicly funded healthcare system continues to devolve from statehouses to the boardrooms of privately owned and operated payors, most of which operate under "Managed Care" arrangements with profound implications for their contracted providers and service recipients. The list continues. Perhaps none of these trends, however, has disrupted our systems of care as significantly as the sudden emergence of alternative methods of service delivery necessary to ensure public safety during the COVID-19 pandemic.

These methods couched under the overarching rubric of "telehealth," surely are not new, but they have been deployed on an exponential scale and all but upended our service delivery system. As the Chief Executive Officer of one telehealth company quipped, "There are generations when nothing happens. There are decades when nothing happens. And there are weeks when decades happen. And that's exactly what we've gone through." (Pifer, 2020). This latest transformation was enabled through a substantial relaxation of regulatory constraints that precludes the delivery of healthcare services via remote means under most circumstances. A byzantine patchwork of state and federal regulations has effectively relegated telehealth to the role of "exception to the rule," at least until recently. As the pandemic exerted its full force and effect in early 2020 and providers scrambled to deliver primary and behavioral healthcare services to vulnerable individuals (many made more so by the Coronavirus and its disproportionate impact on individuals with chronic and comorbid health conditions), telehealth quickly emerged as a means to mitigate risk while ensuring continuity of service delivery. Its widespread adoption also received nearly universal support from the provider community whose members experienced rapidly dwindling margins as traditional (i.e., "in-person") service volume evaporated.

The proverbial "barn door" to telehealth has been pushed open. Whether and to what extent it closes again will be subject to protracted debate among innumerable stakeholders in the months, and possibly years, to come. Questions whose answers remain elusive abound. Are services delivered remotely comparable in quality to those delivered via traditional means? Providers presumably incur fewer costs in delivering services remotely, so this should produce savings that accrue to payors and the general public. But will it? That is, will savings be realized or will the relative ease with which services may be delivered remotely lead to increased utilization and associated costs? Can patient confidentiality and privacy protections be assured amidst myriad videoconferencing platforms, a rapidly changing array of originating and distant sites, and enduring vulnerabilities in providers' Information Technology (IT) infrastructures? Will the extensive use of telehealth align with and support other transformative initiatives presently underway (e.g., Value-Based Care) to which the industry has already committed considerable resources?

Ashley Brody, MPA, CPRP

To invoke another frequently used (and arguably hackneyed) metaphor, the telehealth "plane" will be "built as it's flying," and answers to the foregoing questions must be answered in flight. And there are additional considerations and potential unintended consequences of this movement that should guide the plane's trajectory. For example, although our traditional modes of care are fraught with deficiencies, we now possess a wealth of information with which to direct quality improvement initiatives applicable to conventional care (many of which are already in effect and inform value-based contracting and delivery activities). A dearth of evidence concerning the efficacy of telehealth as a substitute for (or supplement to) conventional care could easily lead to a misallocation of scarce resources or impede providers' progress in achieving desired outcomes. In the event telehealth proves inferior by some measures it could be especially deleterious to individuals with behavioral health and chronic or comorbid physical health conditions, the economically disadvantaged, and other exceptionally vulnerable populations for which traditional healthcare, with its known and proven benefits, has often been ineffective. Moreover, disparate treatment of (and reimbursement for) primary and behavioral health treatment persists despite legislation designed to prevent it. Such disparities might deepen as a "digital divide" deprives many individuals of the reliable and affordable broadband technologies necessary to access healthcare services remotely. The senior and low-income populations, many of whose members are at greater risk of adverse outcomes associated with chronic, comorbid, or poorly managed health conditions, would be especially vulnerable to the digital divide should telehealth remain prevalent. Little more than half of Americans aged 65 or older own a smartphone or have broadband access, and low-income individuals have similarly low rates of smartphone ownership and broadband or internet access (Smith, 2020). Thus, policies that aim to codify telehealth as a permanent alternative or supplement to traditional modes of care must account for enduring disparities, lest the safety and "convenience" of remote care prove to be anything but for the less fortunate among us.

There is cause for guarded optimism despite the perils and inevitable disruptions that attend another "transformation" within the healthcare industry. The Governor's Executive Budget Proposal contains certain provisions that, if enacted, would enhance recipients' access to essential technologies and promote insurance coverage for services delivered remotely (Reimagine New York Commission, 2021). At the federal level, the Medicare Payment Advisory Commission (MedPAC) has indicated its willingness to grapple with various complexities and competing interests that accompany the expanded use of telehealth within the Medicare program. For instance, Commissioners have recognized the importance of "audio-only" (i.e., telephonic) technologies for individuals who lack broadband access necessary to support videoconferencing, but they have also acknowledged potential deficiencies in such technologies that merit further exploration lest they compromise the quality of care delivered to vulnerable individuals (Liss, 2020). The MedPAC has also recognized telehealth has significant implications for patient privacy and confidentiality that must be properly reconciled alongside imperatives to expand access.

The digital transformation will undoubtedly generate its share of "winners" and "losers," and its impact on disparate populations might not be fully realized for years to come. Policymakers, regulators, and other key stakeholders must give serious consideration to the needs of the most vulnerable among us in order for this transformation to align with and support others presently underway. True "value" in healthcare cannot be achieved unless it extends to disadvantaged and marginalized populations. Economy and equity demand nothing less.

The author, Ashley Brody may be reached at (914) 428-5600 (x9228), and by email to abrody@searchforchange.org.

How EHR's Are Responding to the Need for Virtual Client Care

By Staff Writer
Behavioral Health News

The past year has been challenging for every single one of us and unprecedented in so many ways. Agencies that provide mental health services have been hit particularly hard. They have had to pivot in order to provide therapy to clients online or over the phone, and problem solve so that those who are most in need of services are still able to receive them. The communities that these agencies serve are often the communities that have been hit the hardest by COVID-19. Mental health agencies have done an amazing job of finding a way to continue to serve their clients; EHR technology is adapting to this changing environment so that virtual client care is easier for agencies to provide.

Another significant factor that is increasing the need for virtual client care and document exchange is the 21st Century CURES Act. The CURES Act includes Information Blocking requirements which now requires mental health agencies have to make client information available to those who have the right to access it. The information has to be easy to access and must be provided in a timely manner. EHR's need to make it easy for agencies to share the necessary information they want to so that they can comply with the requirements of the CURES Act.

Exym Behavioral Health EHR's Chief Product Officer, Paolo Bettoni, describes these new needs best; "For many years, care was provided by therapists meeting clients in person. You'd walk into the building, say hi to the receptionist, enter the therapist's office and have a conversation. If you needed to sign any paperwork, you were handed a pen. If you wanted a printed copy of your medications, you just asked for it. Today expectations and regulation are changing, and EHR's need to guarantee people have the same quality of service. For example, you should be able to have a conversation with your therapist via chat, or telehealth without going to the office. You should be able to sign paperwork from anywhere in the world. You should be able to receive a copy of relevant documentation without having to go anywhere. That's how EHR's need to change to address the needs in our country."

Exym Behavioral Health EHR has solved this problem with Exym Engage. Exym Engage is a set of thoughtfully curated tools designed to support remote work and virtual client care. The product facilitates the execution of electronic signatures, secure document exchange, and unlimited telehealth engagement with clients. Exym Engage is fully HIPAA compliant and provides the mental health professional with the tools they need to comply with the 21st Century CURES Act. It is easy for agencies, clinicians and clients to use, and can replaces some of the cumbersome process agencies have been using to provide care this past year by centralizing those processes into one simple to use solution.

Bettoni's response when asked what made Exym realize there was a need for the development of Exym Engage; "Two main forces: COVID and the CURES act. Covid drastically accelerated the need to provide care beyond physical locations, and the CURES act is a push to make medical information accessible and easily interchangeable. Once we saw the change in culture, we saw an opportunity to look at things in a new light and build an experience that would allow everybody involved to focus on the most important thing: receiving and delivering care."

Exym is committed to making this new solution easy for clinicians and agencies to use, especially in light of the lengths they have gone to in order to make sure clients have continuity of care while maintaining security and regulatory compliance this past year. Exym has a long history of working with provider partners to design a system that does not just meet compliance requirements but identifies opportunities to help clinicians and staff deliver the best outcomes possible for clients. With the Engage solution, Exym is offering remote trainings for agencies and staff, as well as phone and chat support in English and Spanish for clients who may need additional support. Importantly, Exym Engage is designed to be extremely intuitive and easy-to-use.

Bettoni said one thing he has learned

see Virtual on page 35

Innovative Disrupters in Behavioral Health

By Courtney Beach, PCMH, CCE, Chief Innovation Officer, and Echo Shumaker-Pruitt, MSW, Vice-President of Innovation, The Mental Health Association of Westchester

Courtney Beach, PCMH, CCE

Echo Shumaker-Pruitt, MSW

Innovation – the new buzzword in behavioral health. What is it and do you need this in your organization? Why is everyone discussing the need for it in behavioral health? If we look at the definition of innovation by the Merriam-Webster dictionary it's "a new idea, method, or device; the introduction of something new". The healthcare landscape is rapidly changing, and in order to succeed, behavioral health organizations need to embrace innovation at all levels. You need a group of innovative disrupters who can look at the organization through a different lens and provide solutions that move you forward.

The Mental Health Association of Westchester (MHA) created a division dedicated to innovation a little more than two years ago. The team's mission is to increase engagement, facilitate integration with primary and multi-specialty care, and increase quality. We are responsible for leading the identification and cultivation of new data-driven technology solutions that support differentiation and growth, which align with and leverage MHA's predictive analytics to help drive value and innovation within the agency. Although technology is important for innovation, innovation is more than just that, it's a philosophy or way of doing things that can be incorporated into all departments and at all levels.

Our team is currently led by three individuals who oversee several departments within this division. Under the leadership of our Chief Innovation Officer, Vice President of Innovation and Director of Special Projects, the department oversees Practice Management, Clinical Informatics, Compliance and Privacy, and Quality Improvement.

What MHA's Innovation has accomplished: Interoperability has been a new concept for the agency culture. We have recently enhanced our workflows to, with consent, share essential clinical information with members of the MHA care team and other providers to ensure continuity of medical and behavioral health care. To non-behavioral health providers, these processes may not seem innovative, but the rollout of interoperability in our world takes longer as we breakdown traditional silos of care and navigate challenges related to regulation and privacy laws. This technology will allow us to improve our client's experience, save documentation time, reduce errors, and lower costs.

Automatic appointment reminders are one way in which we are utilizing technology to better communicate with our clients, increase engagement and better leverage staff resources. Historically, front desk staff would personally call all clients to remind them of appointments – a time consuming and ineffective task. The benefits experienced since incorporating automatic reminders have been plentiful and are a reminder of how innovating standard practices keeps us moving forward. Clients are able to opt in (or out) for phone, text and email reminders in either English or Spanish. At the end of the reminder, clients are able to either confirm or cancel the appointment. Front desk staff can now better utilize their time by logging into a portal and rescheduling appointments as needed. This combination of new technology and practice management has been crucial to ensuring a successful innovation implementation.

We introduced myStrength™, a digital health platform that promotes mental and physical wellness, which we offer to our clients, their family members, staff, and the larger community. All members have access to an extensive digital library of self-care resources to manage and overcome challenges with depression, stress, substance abuse, and a myriad of other conditions. myStrength™ allows users to track their moods, provides resources for managing feelings, and offers access to hundreds of articles and activities, such as guided meditations. Our clients and staff have found this to be a helpful resource to use between visits, and we are working on how to further incorporate this into our day-to-day workflows.

In 2020, we implemented a client portal, allowing clients to access their clinical record 24/7, request medication refills, request appointments, set individual notifications and message their care team. The portal is available to clients through a web browser or via a smartphone app. The client portal utilizes technology to increase client engagement and has also increased staff efficiency, allowing them to focus on assisting with their clients' most urgent care needs.

What MHA hopes to accomplish moving forward: MHA is in the process of incorporating measurement-based care (MBC) into our existing core values of providing the highest quality of person-centered and trauma informed care. MBC is the practice of basing clinical care on client data collected throughout treatment – or more simply, incorporating data into the treatment process. Up until now, MBC has primarily focused on assessing symptoms (e.g., depression, anxiety), but MBC can also be used to assess valuable information about functioning and satisfaction with life; stages of/readiness to change; and encourages the active involvement of clients in the treatment process (e.g., session feedback, working alliance). One way in which we are operationalizing measurement-based care is by piloting a client facing app where clients can enter data that is utilized by their clinician.

We are also working on launching a data warehouse, i.e. a data management system that centralizes and consolidates large amounts of data from multiple sources, allowing MHA to make more strategic decisions with real time data and provide more opportunities for measurement-base care. As we share more data, we hope to empower the care team to have all of the information needed to assist them in identifying potential issues before they become exacerbated. This will also allow the team to have a comprehensive view on the client's health status, social determinants of health and other influencing factors that could pose a risk.

"While the benefits of introducing innovative practices are extensive, it is important to be mindful of the potential risks." Our team often asks two questions when working on an identified problem: do we understand the need of clients and staff, and does the solution we have created address those needs? If we fail to understand those questions then the product, workflow, or solution we are proposing will ultimately fail. It's important to take the time to listen and ask questions of what is being asked before investing time into developing a plan to appropriately address the need.

Additionally, an organization needs to be mindful of what we affectionally call "Innovation Overload". This occurs when numerous solutions or workflows are rolled out without allowing the client or staff to have time to react and adjust. The MHA team is aware of this and has recently created an Innovation Think-tank Team, which will help us determine the schedule of roll outs, as well as provide a

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Computerized Screening May Help Identify Youth at Risk for Suicide

By The National Institutes of Health Research Matters Newsletter

Researchers have developed a fast, computerized screening test to identify youth at risk for attempting suicide. The test could help emergency departments quickly get supportive services to those who need it.

Suicide rates for adolescents have risen over the past two decades. In 2019, nearly 1,600 adolescents between the ages of 12 and 17 died by suicide. Only about 40% of adolescents who die by suicide have been treated for a mental health concern. To help ensure that at-risk youth receive help, it is important to screen broadly for suicide risk.

Emergency departments are a common place where youth access emergency care. This makes it is an optimal place to implement universal screening for suicide risk. But emergency rooms face many challenges to screening, including lack of time and budgetary restrictions. A tool that could quickly and accurately identify suicide risk would help providers implement universal screening in these settings.

A team of scientists led by Dr. Cheryl A. King at the University of Michigan, Ann Arbor developed a computerized suicide screener. The screener, called the computerized adaptive screen for suicidal youth (CASSY), asks a series of questions—11 on average—and takes between 1 to 2 minutes to complete.

In collaboration with emergency departments across the U.S., the team recruited youth between the ages of 12 and 17 to help develop and test the screener. The study was funded in part by NIH'S National Institute of Mental Health (NIMH). Results were published on February 3, 2021 in JAMA Psychiatry.

In the first phase of the study, youth who were admitted to an emergency department at the study sites were randomly selected to complete self-report questionnaires (92 main questions and up to 27 additional questions). More than 2,000 youth answered questions on a computer tablet. Questions assessed factors related to suicide risk, including suicidal thoughts; history of suicide attempts; self-injury; depression; hopelessness; alcohol and drug misuse; family, school, and social connectedness; and physical and sexual abuse.

The youth and their parents then received follow-up calls three months after this initial screening to learn if the youth had tried to end their life in the intervening months. The researchers used these data to create the CASSY. They found that using 11 items from the questionnaires could provide nearly the same predictive value as 72 of the questions.

In the second phase of the study, the team tested the ability of CASSY to predict suicide risk in a new set of more than 2,700 youth, aged 12 to17, at 15 emergency departments. Youth completed the CASSY. Similar to phase 1, families were contacted three months later to learn whether the youth had tried to end their life.

In this second phase of the study, 6% of participants attempted suicide in the three months between initial screening and follow-up. CASSY correctly identified 82% of the youth who had attempted suicide.

"No young person should die by suicide, which is why we have made bending the curve in suicide rates a priority area of research for our institute," says Dr. Joshua A. Gordon, director of NIMH. "The CASSY screener represents an important advance in identifying those adolescents who are at risk for suicide, so they can be connected with the critical support services they need."

Concert Health: Using Technology to Support Safer Suicide Care

By Virna Little, PsyD, LCSWr, SAP, CCM Co-Founder and Chief Operating Officer Concert Health

Dr. Virna Little

Since 2018, Concert Health has been using technology to make high-quality behavioral health services available at the primary care level using the Collaborative Care Management (CoCm) model. CoCm has been proven to significantly improve depression and anxiety outcomes compared with traditional primary care. Concert's team of Behavioral Care Managers and psychiatrists provides patients immediate access to evidence-based behavioral health support as part of their primary care team and supports providers in effectively diagnosing and treating these conditions to improve both physical and mental health.

Patients are typically identified for CoCm through the use of the Patient Health Questionnaire-9 (PHQ-9), a depression screening tool that asks about recent suicidal ideation in Question 9. As a result of implementing this screening tool, many patients at risk for suicide are identified in primary care settings, necessitating further assessment, care, safety planning, resources, and treatment.

Primary care providers are uniquely positioned to identify suicide risk and intervene. Roughly 45 percent of people who die by suicide visit a primary care provider in the month before their death, while only 20 percent have contact with mental health services. Primary care providers have access to patients at risk for suicide during a crucial window for intervention and can capitalize on longstanding, trusted relationships with their patients.

Concert Health developed and utilizes

see Suicide on page 35

Fentanyl Test Strips as a Form of Harm Reduction: Study Outcomes

Dr. Nadeen Makhlouf, PharmD, MPH, Director, Clinical Engagement, and Salvatore Volpe, MD, FAA, FACP, ABP-CI, Chief Medical Officer, Staten Island Performing Providers System

Nadeen Makhlouf, PharmD, MPH

Salvatore Volpe, MD, FAA, FACP

Every seven hours someone dies of a drug overdose in New York City, opioids-involved deaths comprise more than 80% of all overdose deaths, and fentanyl; a highly potent opioid is involved in approximately half of all overdose deaths. The Drug Enforcement Agency (DEA) issued a nationwide alert in 2015 acknowledging that fentanyl is a threat to public health and safety. Staten Island is a community of approximately 500, 000 residents and one of the 5 boroughs of NYC. In 2017, the overdose death rate on Staten Island (SI) was 27.3 per 100,000 residents, the highest per capita of all of NYC and significantly higher than the national rate of 21.7 per 100,000. According to our local DA who with NYPD monitors the substances at the scenes of OD Fentanyl was presumed present in 35% of OD in 2017.

Fentanyl is a synthetic opioid that is fifty times more potent than heroin and 100 times more potent than morphine. Prescribed fentanyl is often reserved for chronic pain and end of life pain management. In its prescribed form is available in dermal patches, tablets, lozenges or as a nasal spray. Illicitly manufactured fentanyl is illegally sold for its heroin like effects and is pressed into pills or mixed with heroin or cocaine without the user's knowledge. Fentanyl test strips are used to test for the presence of fentanyl and its analogs in the urine. They have been used as an off-label harm reduction approach to test for the presence of Fentanyl and its analogs in street bought drugs. A recent report published by John Hopkins University found the BTNX Fentanyl test strips had the lowest detection limit and the highest sensitivity and specificity for Fentanyl when compared to two other technologies. That study found that most individuals surveyed (85% of respondents) had a desire to know about the presence of Fentanyl before using drugs and seventy percent reported that knowing their drugs contained Fentanyl would lead them to modify their behavior (FORECAST study, 2018).

A pilot program was launched by Community Health Action of Staten Island (CHASI) at their local harm reduction site on Staten Island to test for potential change in behavior of those about to inject heroin based upon their knowledge of fentanyl presence in the drug supply. Harm reduction is a public health approach that aims to reduce harms related to substance use through various approaches, by meeting people where they are at and not forcing treatment decisions. CHASI is a non-profit organization that provides behavioral health and social support services. Their services encompass HIV/HEP C, harm reduction and overdose emergency, food pantry and assistance, domestic violence, and trauma services, as well as addiction and substance use. The Pilot was funded by the Staten Island Performing Providers System (SI PPS) and implemented at CHASI. The SI PPS is a non-profit focusing on improving the population health and overall health for Staten Island's Medicaid and uninsured populations which include more than 180,000 residents. This pilot program was implemented at the CHASI harm reduction location. It provided active drug users with education and counseling about safer drug use practices as well as fatal opioid overdose prevention strategies.

The program began issuing fentanyl test strips to harm reduction clients on April 2019 through November 2019. All opioid using clients enrolled in the harm

see Test Strips on page 34

Bringing Together Data to Improve Health Outcomes

By Mathew Smith, Khushi Shah, and Jorge R. Petit, MD

Access to actionable data makes for smarter decisions and leads to better outcomes. Healthcare providers readily acknowledge that more targeted services are possible when armed with real-time, client specific information. There are many sources of data, including but not limited to electronic health records (EHRs), health information exchanges (HIEs), payers, government partners, strategic vendors offering client facing services (e.g., client transportation), and a multitude of agency developed tracking forms. Arguably, the challenge is not lack of data but, to the contrary, too much data stored and presented in a disorganized and ultimately unusable format. IMSNY's core product, DABI (standing for Data Analytics Business Intelligence) solves for this in a groundbreaking manner, leveraging the powerful analytics capability of Arcadia[1] combined with subject matter experts from two of the largest behavioral health Independent Practice Associations (IPA) in New York.

Before diving into the solution, it is important to clearly identify why analyzing data is important. The quadruple aim is the guiding principle for healthcare delivery, and focuses on improving the client experience, achieving better total health for the entire population, reducing the cost of healthcare, and optimizing the well-being of the "care team." Without clearly presented data detailing what is happening with the client population, progress is difficult to measure. Conversely, if a service provider has the data to predict when a client is at risk, timely intervention is possible. For example, an expensive inpatient stay could be avoided by implementing an effective community intervention at the right time, thereby improving the client's life and reducing cost to the system.[2]

For a data analytics solution to be useful, it needs to have the ability to perform complex analysis with customized algorithms. The information returned to the network or to the provider must be easy to digest and speak to the needs of the population served. For example, knowing the percentage of a specific population that speaks Spanish as their primary language offers insight that a behavioral health provider can react to and make decisions based on (like hiring more Spanish speaking therapists). IMSNY and Arcadia have access to a huge set of publicly available data that can greatly impact care delivery, and when matched with specific client data sourced from **Figure 1** a 360° view of a client is possible. This leads to better point of care decisions as well as a coordinated network response to more pronounced population health needs.

Healthcare networks all share the same overarching goal of improving the health of their clients. There is a host of specific measures to track, each requiring a different intervention. An IPA or similar provider network is required to build out a set of behaviors or health targets that it wants to improve, determine interventions that impact outcomes, and then track how effective the interventions are over time. IMSNY's two founding IPA networks chose to focus on eighteen specific priority health measures, each one with a specific "target track." A target track, in this case, is a structured map of activities that a provider network uses to guide activities to impact a specific measure. By using a consistent intervention, or "track," fidelity to a specific process is maintained allowing for better cause and effect analysis. See ***Figure 3***, which shows the target track for *Follow Up: Post Inpatient Hospitalization*. This and seventeen other measures were chosen in partnership with the CBC and CBHS IPA clinical quality committees, comprised of representatives from 80+ agencies. By tracking, reporting, and building interventions around many of these, the network expects to see health improvements and reduction in negative health outcomes (e.g., avoidable emergency department use).

A useful exercise when putting together a system for data analytics is to carefully review a target track and determine how to secure data for each node on the map. Using ***Figure 3*** as an example, the first data point for DABI to track is the occurrence of an inpatient hospital stay, which IMSNY learns of through its partnership with a Health Information Exchange (HIE).[3] As this track is focused exclusively on whether a client attends a follow-up appointment, the subsequent nodes are tracked through direct connections to network agencies' electronic health record or billing files, which contain details regarding appointment status. IMSNY ingests this data and reports gaps in care. By following an agreed upon, standardized intervention and pulling this information into DABI, the network can effectively track progress on each measure and share associated data with agencies providing point of care services.

DABI – Our Solution

Innovative Management Solutions of New York (IMSNY), a joint venture between two of the largest behavioral health

see Outcomes on page 38

Sampling of Data Sources:

- Admission, Discharge, Transfer (Health Information Exchange)
- Services Delivered (837 billing files)
- Claims Data (Payer/MCO/SDOH)
- Demographic and Care Delivery details (Agency Electronic Health Records/EHRs)
- PSYCKES
- Other Health Information Technology Solutions, such as a care management documentation platform, closed loop referral tools, etc.

Figure 1: Data Points and Sources

Sampling of Priority Measures (HEDIS):

- Follow-Up after Hospitalization (FUH): 7/30 day to make sure of engagement
- Utilization/Access: high utilization of emergency department services
- Care Coordination: % of members enrolled in Health Home
- Medication Adherence

Figure 2: IMSNY BH Priority Measures

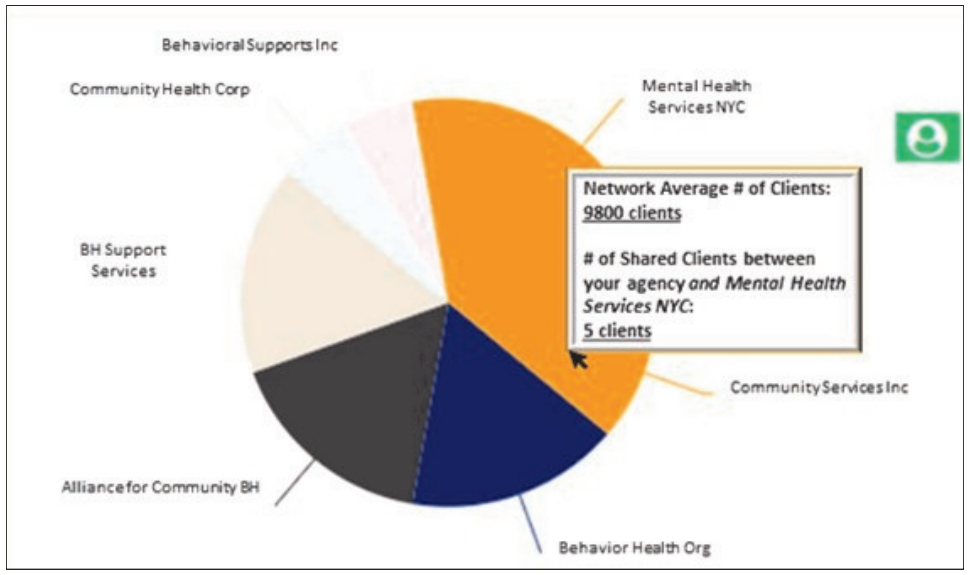

Figure 4: Clients Shared Among Network Agencies

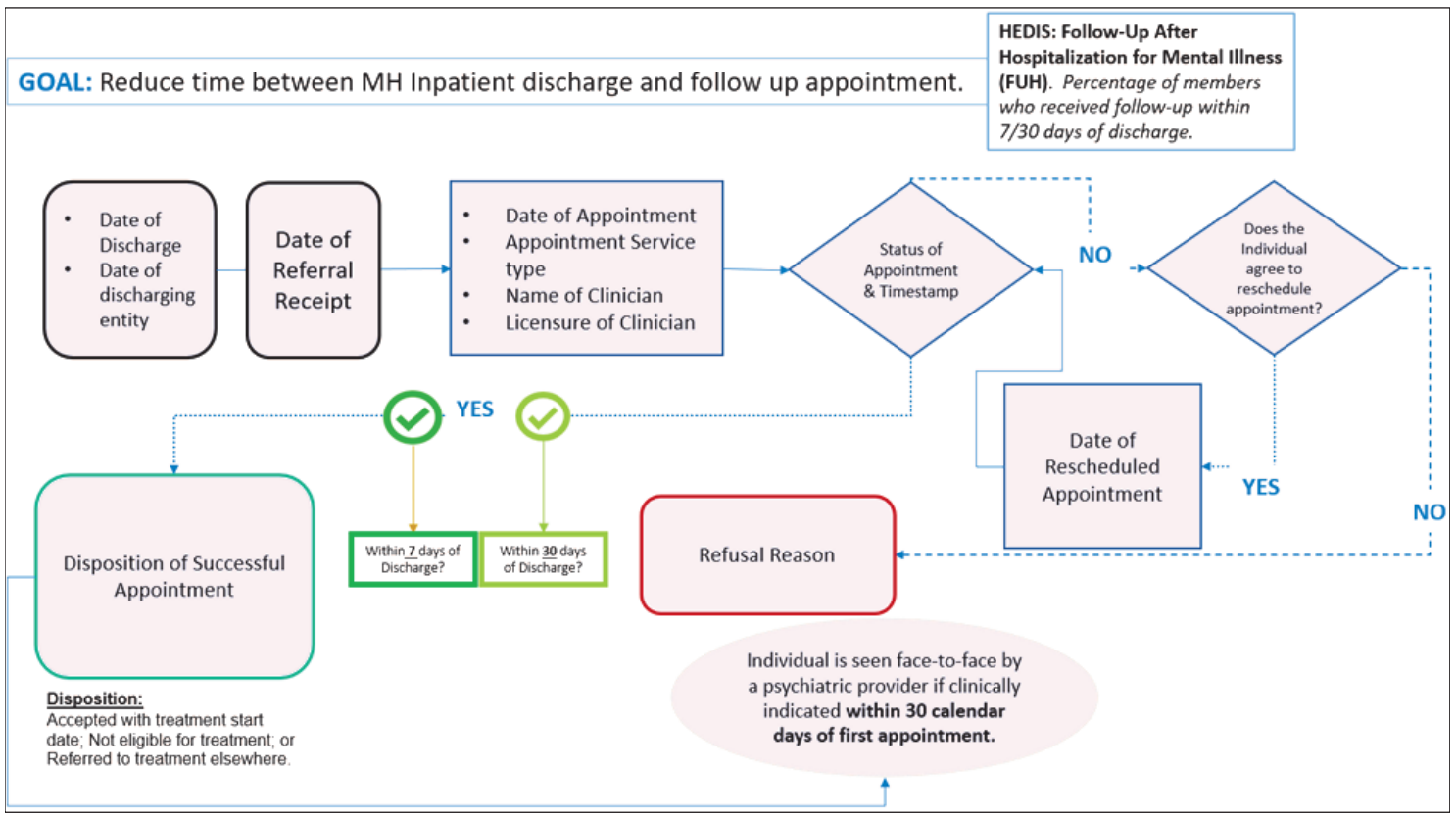

Figure 3: Target Track - FUH 7/30 day

Workforce Training in the Age of COVID-19 and Zoom

By Alex Wolff, MPH, Emily Grossman, MA, CPRP, Jorge R. Petit, MD and Mark Graham, LCSW, Coordinated Behavioral Care (CBC)

Since its launch in 2018, Coordinated Behavioral Care's (CBC) Training Institute (TI) has embodied a versatility befitting the evolving behavioral health landscape in which it operates. This ability to reflect both the training content and format necessary to resonate with its broad audience of New York State behavioral health providers has played no small role in the exponential growth it has experienced in the past year.

The TI began by developing an array of trainings designed to support frontline behavioral health workers in programs run by the citywide community-based providers within the CBC network. The menu of training opportunities has evolved over the years to include applied material designed to help behavioral health service providers work directly with their clients (Person-Centered Engagement, De-escalation, Building Effective Relationships with Participants), to holistic, mindfulness strategies for service providers to practice with themselves and their service recipients (Coping Skills, Building Effective Relationships with Participants and Self Care).

CBC's TI has employed a wide array of learning formats informed by adult learning theory. In-person sessions often stray from traditional lecture-style presentations, instead favoring a more interactive format that fosters engagement through break-out groups, video content and games. CBC TI's goal was to cater to all learning styles and support the emotional wellbeing of the behavioral health workforce, empowering them with the necessary tools to improve community care. An emphasis was placed on localized in-person learning—CBC secured training locations across the city so that long commutes to facilities were no obstacle to attendance.

Naturally, COVID-19 presented unforeseen challenges to the TI's well-oiled training operations. Scheduled trainings were immediately canceled, given the need to maintain social distance and limit in-person gatherings. However, CBC recognized in the pandemic's early weeks that the behavioral health workforce required the regular cadence of their training experiences—not just to continue refining their practice, but as a means of communication, peer support and normalcy in an unprecedented time. CBC TI quickly pivoted to repurpose all trainings for an online/virtual format, and attendance rose significantly as a result. Whereas previously TI trainings were primarily held at CBC's commercial offices in NYC's Financial District, now providers were afforded accessibility to these trainings from the (necessary) comfort of their own home office. By leveraging the same remote/virtual telemental health platforms that providers were fast becoming acquainted with in their everyday work, CBC TI was able to improve access to its own services without sacrificing quality. With MCTAC (a part of the McSilver Institute) hosting and providing technological support, the TI was able to focus on building content for a broad online audience. Trainings were shortened from whole-day programs to shorter 60–90-minute sessions, with a sensitivity to "Zoom fatigue" and lower attention spans when training online. The TI also quickly learned how to use these platforms' built-in engagement tools, including video, polling and prompts that encourage liberal use of the chat-box feature.

In late March 2020, CBC published its April Training Calendar, featuring a variety of online trainings that had been developed to meet the unique challenges of working amid a pandemic. Offerings included traditional trainings that centered quality care and professional development, as well as more intentionally therapeutic opportunities for self-care—with content cast through a mid-pandemic lens and repurposed to account for the potent uncertainty of the moment. In the following months, CBC TI continued to develop unique COVID-19 response trainings that supported the fluid and challenging work and social climate. The response from the workforce to these trainings was encouraging—attendance increased dramatically, showing a desire and demand for trainings that offered guidance, reassurance and "virtual hugs" during a time of heightened anxiety and isolation. By the end of 2020, CBC TI was serving upwards of fifty attendees at each training and successfully marketing its product to dozens of community-based provider agencies across NYC.

A large part of the behavioral health workforce is essential frontline workers. While they do not often receive the recognition of hospital staff, they too have had to continue providing community-based services throughout the pandemic. From retaining food pantries to administering medication to providing residential support, this workforce has risen to the challenge of continued in-person work and ensured quality care endures despite COVID-19. However, their heroic work has had a heavy emotional impact, ranging from heightened anxiety to grief and loss in the wake of a client's death. CBC recognized the importance of supporting the workforce around these issues and partnered with OMH and OASAS to apply for COVID-19 emergency grant funding via the Substance Abuse & Mental Health Services Administration (SAMHSA) just as the pandemic's impact on CBC member agencies and their clients was coming into sharp focus. CBC and its IPA partner Coordinated Behavioral Health Services secured a multi-million-dollar award to develop a program that mitigates the negative impacts of the COVID-19 crisis on the emotional wellbeing of New Yorkers in hard-hit NYS counties and communities therein. By providing timely services and person-centered care to address the depression, stress, trauma, bereavement, substance use and other behavioral health concerns that have surfaced during the pandemic, CBC is empowering New Yorkers to resume happy, productive lives once the crisis abates.

CBC TI's role in this award's programming has been to recognize the pandemic's toll on not only the mental health of vulnerable community members but the behavioral health workforce itself. Accordingly, CBC TI developed and marketed an array of supportive offerings in its COVID-19 Self-Care Training Series by and for behavioral health staff across the entire state, many of whom need support to address COVID-19's impact on their personal and professional experiences over the past year. To deliver content that met this unique and growing need, CBC TI identified lead trainers with clear expertise amongst its IPA network and partnered to develop trainings on topics that tackled urgent matters that the pandemic had made more commonplace, ranging from grieving the loss of a client to physically returning to the workplace and managing anxiety therein. Each training both explores the topic in a sensitive and empathetic way and offers concrete tools for trainees to manage each difficult aspect of the pandemic.

CBC TI has also sought subject matter experts outside its network, partnering with the Kripalu Center for Yoga & Health to integrate a six-week yoga and mindfulness course into its COVID-19 Self-Care Training Series for behavioral health staff. The initial six-week offering was fully booked in a matter of hours—CBC added a second opportunity which has also reached capacity. Future Kripalu trainings are planned for later this year. Finally, the COVID-19 Self-Care Training Series has also engaged a nationally renowned epidemiologist to hold COVID-19 "Town Hall" sessions with behavioral health staff. These sessions provide a platform for behavioral health staff to pose practical questions about the virus directly to an expert. To date, the Town Halls have provided clear guidance on questions ranging from the relative safety of various public transportation methods to facial covering best practices to social behaviors in which vaccinated populations can safely re-engage. In advance of each Town Hall, behavioral health staff across the State are invited to submit questions on areas of concern and these are broadcast live in a podcast-style interview held over Zoom. Each session caters to a particular subject matter, such as vaccine hesitancy, and questions from staff are interwoven over the course of the session.

The COVID-19 Self Care Training Series has established itself as a silver lining of the COVID-19 pandemic for the behavioral health workforce. In merely two months since launch, the program has trained 807 behavioral health staff employed by 219 community-based provider agencies across New York State. This remarkable reach has been highlighted in Crain's Health Pulse New York and prompted further funding from SAMSHA to continue programming into 2022. The trainings are recorded and subsequently uploaded to CBC's YouTube channel for on-demand viewing.

Click here to receive CBC TI's SAMHSA-sponsored Self-Care training offerings direct to your inbox each month and consider joining CBC's Independent Practice Association for universal access to CBC TI. Please email CBC Director of Training Emily Grossman (egrossman@cbcare.org) for further questions.

Alex Wolff, MPH, is Project Manager, Emily Grossman, MA, CPRP, is Training Director, Jorge R. Petit, MD is President and Chief Executive Officer, and Mark Graham, LCSW, is Vice President, Program Services, at CBC.

Read MHNE Founder's Inspiring Story: "From the Depths of Despair to a Mission of Advocacy"

https://behavioralhealthnews.org/from-the-publisher-a-personal-journey-from-a-survivor-of-suicide-from-the-depths-of-despair-to-a-mission-of-advocacy/

AsOne LEADS from page 6

upfront from each of our partners, we still found some critical missing data variables during our validation efforts.

As an example, we found that some of AsOne's selected quality measures required providers to explicitly label appropriate clinicians as "Mental Health Practitioners", a categorical tag that was either missing or not ingested across our partners. By using the lineage process to map measure specifications to partner EMR submissions, we found specific taxonomy codes needed to be placed into the extract to appropriately activate the follow-up measures. This method significantly reduces the time from problem identification to solution, without the multi-layered steps traditional data gap efforts take.

Similarly, the way our partners collect, and record deceased data was not standardized, which presented a major area of concern for us. After all, what good is a population health platform if you can't filter by patients who are still alive? Some of our partners reported "death" in the reason for discharge; others noted that a patient had died in the free text of progress notes which did not map to be ingested by our platform, and others recorded a properly formatted (and hopefully accurate) date. After surveying other colleagues in the field who reported similar challenges with deceased data but few solutions, we took an individualized approach with each partner to ensure dates of death were being captured and input into the correct EHR field which is then mapped to deceased status in LEADS.

While this approach may seem counterintuitive as we are taught to "measure twice and cut once" and scrutinize every data point before depositing it into a pristine data warehouse, without this 'road less taken' approach, most population health initiatives do not make it very far as it is impractical to examine every single variable prior to activation. AsOne focused instead on the vital few data sets important to the business today and not the many that we may need in the future. By highlighting the key functional areas of the LEADS platform useful to executives, clinical, and quality stakeholders today, we were able to prioritize data quality efforts in areas that had the largest value.

Data Security

A key functionality of a mature population health platform is the ability to reconcile disparate data points and link them back to an individual. The aspiration of AsOne in providing whole-person care requires blending primary care, mental health, substance use, hospitalization, and other datasets to create a composite record. However, this enhanced record cannot simply be shared with all AsOne partners, even when a treating relationship exists with more than one provider, due to HIPAA, 42 CFR Part II, state-based mental health laws and other regulatory rules which among many things, require blinding substance use-related data from those caregivers not specifically privileged to access that information.

To this end, undergirding the LEADS platform is the Master Patient Index (MPI) which not only unifies data but facilitates access rights. At the widest level is the AsOne perspective which can see the entirety of the patient records where duplicate patients' records have the data merged together; at the narrowest level, is a single network partners' view of their patients' data merged with other external sources such as hospitalization data. Through this multi-tiered MPI, we can facilitate access to right driven views of the correct information to the specific provider(s) at the right time.

Knowledge Sharing for Improved Data

We believe that providers, networks and organizations working to aggregate, analyze and share data, should work to publish and share lessons learned and how to troubleshoot common and less-than common challenges. We were surprised at the vast obstacles and nuances we came up against during this process and leaned heavily on the AsOne and network member staffs' experience and expertise in this field, legal and technical consultants, s and published best practices from other networks and organizations who had engaged in similar endeavors to offer guidance and a pathway forward through each challenge we encountered.

About AsOne

AsOne is a healthcare Independent Practice Association (IPA) that exists to facilitate value-based payment contracts with payers, including managed care organizations, on behalf of its clinically integrated provider network to provide health care and related social services. Currently, AsOne's 19 network providers serve over 250,000 children, adults, and families with complex physical, mental, and social needs throughout the five boroughs of New York City. AsOne is one of several Behavioral Health Care Collaboratives that was launched and funded through the NYS Behavioral Health Value -Based Payment Readiness Grant, a multi-year initiative to help increase provider readiness to operate in value-based payment (VBP) environment.

Caroline Heindrichs, MA, is Executive Director at AsOne; Jawad Sartaj, MBA, is CEO of Informd; Jessica Frisco, RN, BSN, MPH, is Director of Quality and Compliance at AsOne; and McKenzie Pickett, MPH, is Manager of Program Operations, at AsOne Healthcare IPA.

For more information on AsOne Healthcare IPA, please visit www.myasone.org or send an email to McKenzie Pickett, Manager of Program Operations at AsOne at Mckenzie.Pickett@myasone.org.

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build coping plans and strategies to last them long after their interaction with the site.

An empirically validated component of CBT and DBT, distraction can help visitors in crisis gain control, decrease symptom severity, and help in grounding. The digital distraction tools on Safe Space range from soothing, interactive art creation with Silk (the top-rated resource on Safe Space) to simple breathing videos and ambient soundscapes in Calmsound. These distraction tools can be utilized while waiting to connect with a chat counselor on the Lifeline Chat service or revisited later when the same distressing feelings arise.

Providing connection and mental health support during a public health crisis requires an understanding and an ability to meet people's needs, whereever they may be. As many are already active online, the Safe Space website is a prime example of the importance of offering digital support tools to address a variety of needs for users dealing with mental health challenges. Visitors to the site have praised its ability to deescalate their crisis state, sharing that "this immediately got my mind off of the negative thoughts I was having." Others reported that "this helped me off the ledge several times while waiting for a helpline" and noting that the site "was very soothing for my mental and physical wellbeing."

If you are interested in connecting yourself or linking others to Safe Space, please visit www.Vibrant.org/SafeSpace.

For immediate support in a crisis for yourself or someone you know, call the National Suicide Prevention Lifeline at 1-800-273-8255 (TALK).

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References

Czeisler, M. E., Lane, R. I., Petrosky, E., Wiley, J. F., Christensen, A., Njai, R., Weaver, M. D., Robbins, R., Facer-Childs, E. R., Barger, L. K., Czeisler, C. A., Howard, M. E., & Rajaratnam, S. M. W. (2020). Mental health, substance use, and suicidal ideation during the COVID-19 pandemic - United States. Morbidity and Mortality Weekly Report, 69(32), 1049-1057. https://www.cdc.gov/mmwr/volumes/69/wr/mm6932a1.htm

Evans, M. L., Lindauer, M., & Farrell, M. E. (2020). A pandemic within a pandemic - Intimate partner violence during Covid-19. The New England Journal of Medicine, 383, 2302-2304. https://www.nejm.org/doi/full/10.1056/NEJMp2024046

Kuchuk, M. (2020, May 7). Offering a Safe Space. Lifeline Crisis Centers. https://medium.com/@CrisisCenters/offering-a-safe-space-1647fe899248

Kuchuk, M. & Gonzalez, F. (2020). Digital tools to help ourselves and each other. Vibrant Annual Report 2020. https://annualreport2020.webflow.io/digital-support

Lawson, M., Piel, M. H., & Simon, M. (2020). Child maltreatment during the COVID-19 pandemic: Consequences of parental job loss on psychological and physical abuse towards children. Child Abuse & Neglect, 110(2), 104709. https://doi.org/10.1016/j.chiabu.2020.104709

National Suicide Prevention Lifeline (n.d.). Support on Social Media. https://suicidepreventionlifeline.org/help-someone-else/safety-and-support-on-social-media/

Torok, M., Han, J., Baker, S., Werner-Seidler, A., Wong, I., Larsen, M. E., & Christensen, H. (2019) Suicide prevention using self-guided digital interventions: a systematic review and meta-analysis of randomised controlled trials. The Lancet Digital Health, 2(1), 25-36. https://doi.org/10.1016/S2589-7500(19)30199-2

Witt, K., Spittal, M. J., Carter, G., Pirkis, J., Hetrick, S., Currier, D., Robinson, J., & Milner, A. (2017) Effectiveness of online and mobile telephone applications ('apps') for the self-management of suicidal ideation and self-harm: a systematic review and meta-analysis. BMC Psychiatry, 17, 297. https://doi.org/10.1186/s12888-017-1458-0

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Doing all this was, of course, time-consuming and expensive, so it seemed great to me when E-mail came along making rapid mass communication possible without spending a penny. In fact, we could save money on paper, stamps, and clerical time. And telephone tag gradually became almost a thing of the past as we came to understand that E-mail is "asynchronous communication." And I didn't need a secretary to take dictation, type up drafts, retype them, and take them to the post office. I could just whip off a response on the computer, edit it on the screen, and press the send button. We didn't need to make a million phone calls to find a date for a meeting—just a few e-mails. And I could do my filing right there on the computer. Less and less paper sitting in piles in my office. A golden age had arrived.

Without doubt the new technology helped enormously with organizing. It was easy to reach a lot of people, sign them up, set up meetings, have them put their names on sample letters and press a button to send the letters via E-mail.

But I wonder whether the technology has really made advocacy more effective. As it has been used more and more, it's become a cacophony of competing causes seeking our affection, affiliation, and contributions. Years ago, for example, it occurred to me that we should get our message out on Facebook. At that time, 500 million people would see it. How long could it be before mental health became a major world-wide cause? Of course, every other social advocate had the same thought at the same time. A very few of their messages rose above the others. Ours? Not so much.

Don't get me wrong. I think it is very useful to have websites that provide lots of data and information about policy matters, advocacy groups, etc. And it is terrific to be able to do research using search engines instead of by going to dusty libraries and leafing through journals or wandering around the Capitol to get my hands on bill copy. And word processing improves writing because it's easy to edit. And it's certainly useful to be able to reach a lot of people who are interested in mental health with a single push of a button. And I guess the speed of communication offers some real advantages.

But there are more than a few speedy communications I wish I had never sent. A day's reflection would have really

Michael B. Friedman, LMSW

helped. And an awful lot of E-mail goes unanswered or filed in "folders" in "the cloud." I frankly have no idea where the cloud is, and my files are no more accessible to me there than in the piles of paper that used to clutter my office because I can't remember file names or usernames or passwords. I keep those in another file—when I remember.

And I really doubt that the E-mail I send to the powers-that-be calling for a better world have as much impact as pleas sent on paper.

And every day, as I wade through E-mail from advocates trying to get my attention in the way I am trying to get theirs, I have the sense that I am fighting just to keep my head above water, making it difficult to spend time doing real work.

So, I guess, like everything else, technology is a mixed bag.

Of course, the reality is that policy gets made now just like it did before the new technology—through relationships between real people. Person-to-person. Not computer-to-computer. At least not so far. Maybe someday policy will be made by Artificial Intelligence. Hopefully, I'll be gone by then.

Michael Friedman is a retired social worker who moved to Baltimore after 60 years in New York to be near his grandchildren. He continues to be an active mental health advocate as volunteer Chair of the Brain and Behavioral Health Advocacy Team of AARP of Maryland.

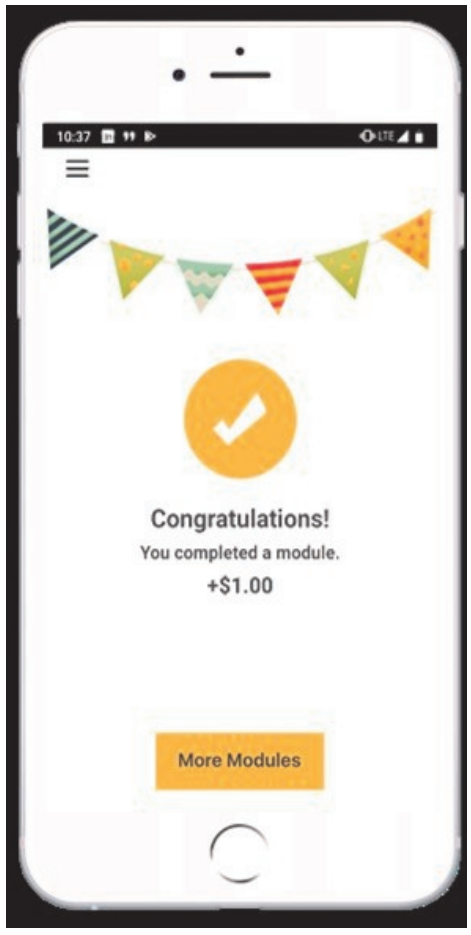
Secret Weapon from page 9

DynamiCare Health, also provides our members with breath and saliva testing devices so that they can perform substance tests remotely, verified over selfie video. Negative tests earn our members financial incentives on a debit card. The debit card, however, is "smart" — it blocks access to bars, liquor stores, and cash withdrawals.

This system implements CM in a way that's true to the research, since it creates strong accountability through true-witnessed, true random testing (even evenings, weekends, and holidays). It's more rigorous than usual testing, but because it's in exchange for prompt, frequent, financial rewards that members care about, satisfaction ratings are surprisingly high. We have demonstrated in 3 clinical trials that our system, similar to the previous research, has been able to increase abstinence rates by 2-3x across drugs, alcohol, and tobacco. There's a bottom line benefit fo providers, too — elevated attendance rates. We've dramatically simplified the delivery of CM through technology, while maintaining its effectiveness.

Technology is now driving a "CM Renaissance," breaking the sound barrier for adoption by getting commercial and Medicaid health plans to start offering CM to their insureds. The public is taking notice, too; the adoption of CM through technology has been covered in the New York Times, Wall Street Journal, and CBS News. Health systems and addiction treatment providers around the country are starting to integrate CM technology platforms into their practice. And where adoption has lagged behind, families have begun paying out-of-pocket for CM programs for their loved ones.

At DynamiCare, we believe that CM is a critical component of a continuing care program, but not a silver bullet. That's why we've designed a 12-month program that uses CM to help stabilize and anchor the member, with help from a supportive telehealth Recovery Coach, as they work together to build the skills for long-term recovery. Our digital care program is often used to complement Medication Assisted Treatment (MAT) and other treatment modalities. Within DynamiCare, we've built upon CM and integrated it with Cognitive Behavioral Therapy (CBT), Motivational Interviewing (MI), Community Reinforcement and Family



DynamiCare Health CM Smartphone App

Therapy (CRAFT), and other evidence-based interventions.

Treatment programs can license DynamiCare's technology to integrate it into their practice, or resell the program directly to patients and families. If you're interested in using DynamiCare's platform in your treatment program or practice, please reach out to us at info@dynamicarehealth.com, (855) 539-6264, or please visit us online at www.DynamicareHealth.com.

Bibliography

1. Dutra L, Stathopoulou G, Basden SL, Leyro TM, Powers MB, Otto MW. A meta-analytic review of psychosocial interventions for substance use disorders. *Am J Psychiatry*. 2008;165(2):179-187. doi:10.1176/appi.ajp.2007.06111851

2. Petry NM. Contingency management: what it is and why psychiatrists should want to use it. *Psychiatrist.* 2011;35(5):161-163. doi:10.1192/pb.bp.110.031831

Leaders from page 19

the Manhattan Borough President's Office and later the NYS Office of Mental Health.

In 1993, Tony led the spin-off of CUCS from Columbia University. With an annual budget that exceeds $80 million, CUCS currently works with 50,000 individuals through its housing, psychiatric, medical and social services programs in New York as well as its national staff training institute.

Tony has co-authored numerous professional articles and is a board member of Homeless Services United, Coordinated Behavioral Care, the Supported Housing Network of New York, a member of the NYC Human Services Strategy Council, and has chaired various mayoral and gubernatorial select committees on homelessness.

Hillary Kunins, MD, MPH, MS
Executive Deputy Commissioner of Mental Hygiene, NYC Department of Health and Mental Hygiene
Healthcare Hero Award

Dr. Hillary Kunins is the Executive Deputy Commissioner of Mental Hygiene at the New York City Department of Health and Mental Hygiene (DOHMH), leading New York City's public health strategic and equity-driven initiatives to improve the behavioral health of all New Yorkers, including for children, adults, people affected by criminal justice involvement, experiencing homelessness, developmental challenges, or use drugs. In her prior role as DOHMH's Assistant Commissioner for the Bureau of Alcohol and Drug Use, Dr. Kunins led the reimagining of New York City's public health approach to substance use, including overdose, rapidly implementing and scaling up programs in public health surveillance, naloxone distribution, peer-delivered overdose support, and buprenorphine treatment in primary care and harm reduction settings. Dr. Kunins has dedicated her career to promoting equitable health for people with substance use and other behavioral health concerns through science-based public health and healthcare programs and policies.

As a general internist and addiction medicine physician, Dr. Kunins previously worked in the Bronx providing primary and addiction-related care to patients in both community health centers and in substance use disorder treatment programs. During her tenure at Montefiore Health System/Einstein College of Medicine, Dr. Kunins held a number of leadership roles, including medical director of a methadone maintenance treatment program; founder and director of an HIV prevention for women with substance use disorders; and Director of the Primary Care/Social Internal Medicine Residency Program at Montefiore Medical Center/Albert Einstein College of Medicine. She has been a Principal or Co-Investigator of numerous foundation and federal grants related to care of people with substance use disorders, medical education and training to reduce health disparities, and public health interventions for behavioral health. Dr. Kunins received her MD and MPH from Columbia University and her MS in Clinical Research from Einstein College of Medicine. Dr. Kunins is a Clinical Professor of Medicine, Psychiatry & Behavioral Sciences and Family & Social Medicine at Einstein College of Medicine, Fellow of American College of Physicians, and Fellow of American Society of Addiction Medicine.

Allison Sesso, MPA
Executive Director
RIP Medical Debt
Behavioral Health Advocacy Award

Allison Sesso became the Executive Director of RIP Medical Debt in January of 2020. RIP Medical Debt was established for the sole purpose of reducing the medical debt burdens of low-income individuals with limited capacity to pay their medical bills by leveraging donations from people across the country. They have abolished over $2 billion to date and anticipate that number growing to at least $3 billion this year.

Under Allison's leadership and in response to the COVID-19 pandemic, RIP Medical Debt launched the "Helping COVID Heroes Fund" focused on relieving the medical debts of healthcare workers and emergency responders like nurses, home health aids, pharmacists, social workers, hospital technicians, the National Guard and others working on the front lines of the pandemic. It also benefits service workers and others facing financial hardship resulting from the COVID induced economic downturn.

Through this effort RIP has abolished over $100 million in medical debt.

Prior to joining RIP Medical Debt, Allison served as the Executive Director of the Human Services Council of New York (HSC), an association of 170 nonprofits delivering 90% of human services in New York City.

Under her leadership HSC pioneered the development of nationally recognized tools designed to illuminate risks associated with government contracts, including an RFP rater and government agency grading system. She led negotiations with New York City and State government on behalf of the sector and successfully pushed for over $500 million in investments to address the nonprofit fiscal crisis.

During her tenure at HSC, Allison also led a commission of experts focused on social determinants of health and value-based-payment structures and published the report, Integrating Health and Human Services: a Blueprint for Partnership and Action, that examines the challenges of operationalizing relationships between health and human services providers, offering several recommendations. She also served on the New York State Department of Health's Social Determinants and Community Based Organizations (CBO) Subcommittee helping to formulate recommendations around the integration of CBOs into Medicaid managed care.

Allison's work on behalf of the human services sector led City & State to recognize her as a top nonprofit leader in 2018 and 2019, one of the 25 most influential leaders in Manhattan in 2017, and one of New York City's 100 "Most Responsible" in 2016.

Allison also serves as the Board Chair of the nonprofit Hollaback!, a global movement working to end harassment through bystander intervention training and storytelling.

see Leaders on page 36

Test Strips on page 29

reduction services were eligible to receive fentanyl test strips due to heightened concerns about possible fentanyl-related overdose. Harm reduction services available at the site included a syringe access program, counseling and group services, and buprenorphine treatment. Clients received fentanyl strips from April 2019 – November 2019 (n=110), half received the test strips one time (n=55). Fourteen accepted four or more kits and 10 regularly received strips over the entire pilot period. 99 clients provided feedback regarding their actions after using the strips and identifying fentanyl in their supply.

A total of 93 clients refused kits offered during 282 encounters, 73% of those refusing kits stated that they were not interested, and 25% reported not needing fentanyl strips because they believed that they knew fentanyl was present.

The fentanyl test strip pilot funded by the SI PPS as part of the population health efforts to help decrease opioid overdose deaths and was the first of its kind in the borough. Preliminary results indicated that there is a benefit in providing the strips to clients as a form of harm reduction. Further investigation is warranted due to some limitations which included: lack of pre survey questions, interviewing clients on their perception of fentanyl danger, experience with post fentanyl exposure, personal drug use patterns, demographics and socioeconomic status. The overwhelming majority of clients (73%) were not interested in receiving a kit. This requires further investigation of what the perceived barriers to obtaining a strip may be. Fentanyl test strips used off label to test the drug supply is a new pilot in the borough and staff identified that clients may have found this to be a tedious and difficult task or may have had fears around criminal implications if their supply tested positive.

"So What?" This pilot program is the first of its kind in Staten Island as a comparable program was not found in the borough. Of the 100 participating clients the pilot's results indicate that 29 clients (29%) reported not using the product upon testing positive for fentanyl or reported using overdose prevention strategies such as:

1. keeping an extra naloxone kit nearby
2. using the drug slower
3. using the drug with a friend.

These findings strongly support that having the strips widely available as an additional harm reduction strategy can potentially save many lives and decrease the number of opioid overdose deaths.

Implications from page 12

As we continue to track clients receiving support via telehealth, there will be much more to learn and share with the community, just as their experiences can help us moving forward. We all share the goal of making these services as effective as possible.

Advocacy is Key to Future of Telehealth: Virtual forms of care were immediately put into place by agencies across the five boroughs. But at the same time, it was clear that making this shift – and other needed adjustments to the pandemic – was going to be very costly to our organizations. And while telehealth showed great promise for the care of the people we serve; government would have to make more permanent changes around reimbursement and regulations for behavioral health organizations to effectively use telehealth longer term.

In their Budget Priorities for FY22, the Coalition for Behavioral Health said that Covid-19 "is an unprecedented financial threat to community service providers."

The Coalition supported the executive proposal to "maximize movement to telehealth, allowing individuals to receive care where they are located." But advocates also made clear two key ways the executive proposal fell short: rate parity and the need to cover telehealth at the same rate as in-person services and peers: making those peers eligible for reimbursement for in-person series eligible for telehealth reimbursement; they have proven to be an important part of treatment and recovery and should not be treated differently from other professionals.

All of us in the behavioral health field will watch closely as the state budget negotiation process moves on these issues and legislators and the governor agree to a final budget; by law it is to be finalized by April 1st. Stay tuned.

Suicide from page 28

an innovative population health suicide risk registry to identify and manage suicide risk among approximately 3,700 primary care patients enrolled in CoCm across seven states. Approximately seven percent of patients at Concert Health meet criteria for inclusion on the registry. Inclusion criteria include endorsement of suicidal thoughts or behaviors on the PHQ's Question 9, Columbia- Suicide Severity Rating Scale (C-SSRS), or spontaneous report. Variables include:

• Date of first, highest, and most recent PHQ-9 administration and scores, including how the patient answered question 9

• If a positive screening for suicide risk resulted in appropriate assessment using the Columbia-Suicide Severity Rating Scale (C-SSRS)

• Provision of evidence-based interventions for suicide including the Safety Planning Intervention and Lethal Means Counseling

• Date of last safety plan review and/or update

• Date of last consultation with psychiatric provider

• If a member of the care team has connected with the patient in the past seven days

The registry's use allows for substantially higher access to needed services through CoCm than would be received as part of a traditional mental health referral. It facilitates more flexible and comprehensive follow up than treatment as usual, despite outpatient mental health being viewed traditionally as a "higher level of care."

Behavioral care managers can utilize the registry to manage their panel of at-risk patients and managers can report by patients assigned to their supervisees, practice, or larger geographic area to ensure the care provided is consistent with the organization's suicide safe care practices and policies.

References

i Archer, J., Bower, P., Gilbody, S., Lovell, K., Richards, D., Gask, L., Dickens, C., & Coventry, P. (2012). Collaborative care for depression and anxiety problems. The Cochrane database of systematic reviews, 10, CD006525. https://doi.org/10.1002/14651858.CD006525.pub2

ii Luoma JB, Martin CE, Pearson JL. Contact with mental health and primary care providers before suicide: a review of the evidence. Am J Psychiatry. 2002;159:909-916

Virtual from page 26

while creating this solution was that he would "come to appreciate the service our customers provide to their clients even more. Despite the challenges of COVID people were able to find a way. Did you know that agencies often use couriers that go house to house? They have these huge, sanitized, zip-lock style bags that they prepare. They visit their patients, drop of the package, let the patient read and sign, then pick up the package again and bring it back to the office. The complexities and overhead of this type of logistic is really an indication of how committed agencies are to the important work they are doing. That was an eye opener for us and we said to ourselves 'We have to give them something better that makes their life easier.'"

Behavioral Health EHR companies need to support the important work that mental health agencies do so that they can deliver the best possible client care. Exym Engage empowers clinicians to do the work that matters with an easy-to-use solution for virtual client care and compliance.

Exym is a leader in EHR software for behavioral health agencies. We proudly serve agencies across California with our intuitive, robust behavioral health EHR system. 45,000+ clients per month are served by clinicians who use Exym's EHR software to simplify their billing, documenting, and case management needs. As an EHR company in California, Exym is built to meet California's unique needs and regulations. For more information, visit www.exym.com.

Executive Director from page 19

experience that is much more accessible with thousands of articles now available to read, search and share on social media. We are now also able to publish additional website-only content that can address timely issues such as COVID-19 and better serve the needs of our readership. I am excited to lead the organization into our next phase as a growing media presence providing vital information and education to the autism and behavioral health communities."

Debra Pantin, MSW, MS-HCM, MHNE Board Chair and President and CEO of Outreach, remarked, "We applaud Ira for the effort it took to create an organization and run it almost single-handedly for over 20 years and at the same time recognize David as the new face of the organization to support his new roles in technology and networking."

About MHNE

Mental Health News Education (MHNE), publisher of Autism Spectrum News and Behavioral Health News, is a 501(c)(3) non-profit organization that provides a trusted source of education, information and community resources on mental illness, substance use disorders, and autism spectrum disorders to consumers, families, and the professional community. As two of the nation's leading evidence-based resources for the behavioral health and autism communities, both publications provide an affordable and cost-effective opportunity to reach a large, targeted audience now estimated at over 200,000 readers.

Innovative on page 27

safe space to bring ideas, feedback and solutions to the table.

The question is no longer whether technology will change the behavioral health field, but rather when and how it will occur. The need for innovation has been exacerbated by the pandemic; its repercussions will require further innovation.

Suicide Prevention Survey: WellLife Network Needs Your Help

By Staff Writer
Behavioral Health News

Suicide rates in America were continuing to increase at alarming rates even before COVID-19. However, the economic and sociopolitical landscape as well as the increased turmoil, stress due to uncertainty, and disruption in people's lives since COVID-19 has caused tragic changes in the lives of many. This has not only resulted in dramatic loss of lives due to COVID-19 but also suicide and profound increases in rates of depression and anxiety as well as exasperation of other medical and mental/emotional conditions.

Suicide Prevention is everyone's business. This tragic loss of lives impact many thousands of families and inflict permanent physical and emotional damage in the lives of more than million more who attempt suicide and continue to live among us. Addressing the stigma and knowing and learning how to discuss our worries with those whom we may be concerned about not only can be taught but is clearly proven to SAVE LIVES.

The suicide epidemic in our society necessitates prevention approaches both at the micro and macro levels reaching all sectors of the community. Knowing what is being done in this regard by the different groups (youth and adults) and what is missing in education and training goes far in understanding the educational and training needs of the different entities in our communities in suicide prevention With this in mind WellLife Network (WLN) has developed this survey to gather important information and assess the needs of the community in this regard.

WellLife Network is asking for your input, guidance and feedback in obtaining information from the community about suicide prevention, intervention and postvention. Please take a few moments to complete this survey so that we may more accurately develop future education and trainings for you, your agency and the community at large. Thank you.

Take the Survey Now!

https://www.surveymonkey.com/r/HLJRPRN

Services from page 17

Tech Supports for Housing

Supportive housing at Odyssey House ranges from transitional housing with on-site counseling and medication management services, to scattered-site independent housing. Integration of technology within these services prior to COVID-19 focused on managing tenants' entitlements, funder reporting requirements, and staff assignments.

For Janice Glenn-Slaughter, VP, Director of Mental Health & Housing Services, the impact of COVID-19 brought home the essential role on-site staffing has in supportive housing. "The majority of our tenants live alone and the challenges they face living with mental and physical health disorders require hands-on support. COVID-19 presented a real threat to their lives.

"Key for their survival," she added, "was keeping our essential employees safe with personal protective equipment and outfitting them with access to online services so they could work remotely, as appropriate.

"Nothing will replace the need for in-person care, but extending what we can do with technology gives us flexibility."

IT Investment Pays Off

For several years, we have invested in digital client and administrative management systems. With data and administration functions already secured on the cloud, our priority over the past year was clear: ensure staff could access these systems remotely.

While essential program staff worked on maintaining contact with clients, reassuring them the recovery services they rely on will continue, Renas Tili, Director of Information Systems and Technology, worked behind the scenes to ensure each staff member was quickly set up for remote work. He provided employees with a virtual private network (VPN), equipped them with remote desktop services (RDS), and installed high-level security protocols.

According to Jeff Savoy, VP, Director of Clinical Support Services, while there have been some barriers to facilitating remote services, such as ensuring the treatment experience is not distorted by technology; complying with confidentiality and regulatory guidelines; and training staff in providing virtual treatment, he sees "the flexibility and connectivity that technology provides for patient-centered care paying off and continuing as we pivot from this public health crisis."

As a human services organization, while nothing will replace hands-on care, we see a growing role for technology in supporting client services, arming staff with the resources they need to succeed in their roles and helping us stay prepared for future health and economic challenges.

Consumers from page 14

eye contact is essential when you have conversations with people. That makes in-person conversations more comfortable for us. Video chats are helpful, but the phone is more impersonal. Trina said, "On the phone, I don't know what the other person is doing or if they're listening to me." And there are some things that can't be done via telehealth -- like hip replacements!

One of us belongs to the Brooklyn Clubhouse, which is a program that supports people living with mental illness, offers GED and basic computer training, as well as skills development in food service, facilities management, computer applications, and office work. The Clubhouse provides valuable social and vocational opportunities, support from peer advocates, and assistance in developing critical life coping skills and employment readiness.

"The Clubhouse is vital for us because it gives us structure and keeps us functioning, so we don't get bored or stressed or relapse. We help each other. It's a wonderful place. Now we use Zoom, which helps us keep our focus on our health and communicate with one another. It's not the same as when I'm there in person, but I still get to see a lot of members. It makes me feel good and helps me with my quality of life. But I miss being around people. Being around people makes me feel happy," said Ephraim.

Learning to Use Technology

All three of us are older and didn't really use social media or video chat tools before the pandemic. We had to learn how to use these tools. Fortunately, for one of us, the internet speed has improved during the pandemic.

"I learned how to use technology better in the past year. I did not know how to Zoom before. I understand technology better and I don't have to go to my son for every little thing. I've been able to do things for myself, like set up appointments and check information in my online medical chart, which has been a great help. I also understand the medical terminology better because while I'm looking at it, I can look up the terms online," said Trina.

Using Technology to Connect

One of us mostly uses video chat to help her children with school and keeps them busy with online activities. "Online activities are fun for the kids and keeps them occupied. But I haven't done many myself. I don't find it interesting. Sometimes I tell myself to try it out, but if it's not hands-on, I just watch it," said Trina.

In addition to outpatient treatment, wellness and recovery sessions, and self-improvement workshops, one of us is applying for a Credentialed Alcoholism and Substance Abuse Counselor (CASAC) certification and plans to do the training online. "I have a history of substance use and have been recovering for a long time. It's time for me to use my life history to be able to help other people. At my age, as a senior citizen, I still struggle with mental illness and other things. I've been through it so I want to help other people going through it," said Jeffery.

Ephraim said, "It's very important that we have Zoom. This way, we can be together as a Clubhouse community and talk about important things. We laugh and have fun and talk about our lives, our homes, our health, cooking, gardening, and also about improving our quality of life. This group helps me to be myself, to be a better person. They also helped me get a job through the Transitional Employment Program that operates out of Clubhouse. I've seen myself flourish--I've come a long way."

Survey on COVID-19 Impact

In November, S:US sent an anonymous survey to us and other people they serve that focused on the impact of COVID-19. S:US staff and members of the Clubhouse helped create questions about potential needs that we have faced during the pandemic and potential barriers to video conferencing. S:US received 3,458 responses, which is 60% of people served.

The key findings from the survey generally support what we have shared about our experiences in this article.

Barriers to video conferencing:

° 32% of people surveyed stated they had no barriers or concerns.

° 1 in 4 people stated they needed a device (smart phone, tablet, or laptop).

° 1 in 5 stated poor or no internet or WiFi.

° 26% stated they need to learn how to use video conferencing apps like Zoom.

° Only 13% stated they are uncomfortable being on camera.

° Only 9% stated they don't have a private space.

° On average, people stated they have two barriers (out of eight possible options).

• Statistically significant trends with age:

° Younger clients stated greater needs, particularly in meeting education/vocational goals and support with food.

° Older clients stated greater barriers to video conferencing, including needing a device, more data plans, and learning to use the apps. This was most true for individuals 55 years old and older.

° The preference to meet in person increased with age.

Statistically significant trends with gender:

° Men stated a more negative emotional impact from COVID-19 than women; on average, men stated having more needs and more barriers compared to women.

General emotional impact of COVID-19 trends:

° The more impacted by COVID-19 an individual was, the more needs they faced and barriers to video conferencing they presented.

° Conversely, individuals who were less negatively impacted by COVID-19, felt they had greater support from S:US and were comfortable meeting with S:US staff and medical providers via video conferencing.

Looking Forward

As spring blooms in New York City, we see hope on the horizon. We appreciate the support from S:US and are glad that we've gained some new skills and better understand technology. We're also really looking forward to seeing people in person again!

"Everything I've said is from the heart. These times are very serious. Life is serious--I never take things for granted. I'm grateful that I can sit here and talk to you," said Ephraim.

Outsourcing from page 8

Unidine clients have suppliers that are local favorites. If a local supplier is requested, Unidine Supply Chain will initiate a vetting/approval process to ensure that the supplier complies with quality standards, safe food handling practices, competitive pricing and delivery requirements.

What is the "typical" term of service agreement? The standard minimum contract term is 3 years.

How do you manage the transition? Your only get one opportunity to make a first impression. The transition and opening of your facility is Unidine's first impression, and will last with you for the entire life of our partnership. Because we understand this, it has been and will always be our goal to ensure we have resources on the ground from day one. To ensure your transition runs smoothly, we have adopted a methodology for transitioning new locations that includes accomplishing a number of key tasks: Managing the transition of employees with respect and dignity, ensuring adequate training before and during opening; Implementing the programs and standards that are core to mutual success; Creating a communication process by which expectations are clearly defined feedback is full -circle and proactive measures are taken to address questions and concerns; Ensure rigor around following a proven, standardized process

Throughout each phase of our transition playbook, our team will make every necessary effort to ensure we have the right people, tools and systems to effectively transition your dining program without service interruption. At each step, our team will circle back with you to provide detailed progress reports and understand your feedback. We look forward to a long partnership and great dining program that all starts on day one.

How would you describe the difference between Unidine and other providers in one concise statement? Unidine's approach is customer-first-we craft invigorating dining moments for discerning clients and their clientele

About Unidine

Unidine operates in over 400 facilities and is the leading provider of food and dining management services for discerning clients throughout the United States. Since its founding in 2001 by President and CEO Richard B. Schenkel, Unidine's success derives from consistent execution in four key areas – and exclusive focus on food and dining management services, a commitment to seasonal, fresh-from-scratch cooking, exceptional customer service and a corporate culture enlivened by each team member's passion for culinary and service excellence. Unidine's network of dietitians and culinarians leverage the latest research to support cultural enrichment and wellness strategies for hospitals and behavioral health facilities, and also exceptional service for senior living communities and corporations.

Leaders from page 34

Ian Shaffer, MD, MMM, CPE
Former Vice President and
Executive Medical Director
Healthfirst - Behavioral Health (Retd.)
Corporate Leadership Award

Ian Shaffer, MD, MMM, CPE was Vice President and Executive Medical Director, Behavioral Health for Health first responsible for behavioral health program management. He retired from this position in January 2020 and currently provides consulting services on managing and providing behavioral health care. Prior to this he was Vice President Behavioral Health Program Design and Research for Health Net Federal Services responsible for behavioral health program design and research with a specific focus on the military and veteran populations and their families. Previously at Health Net, Inc. Shaffer was MHN's Chief Medical Officer, responsible for setting the company's clinical policies and guidelines and ensuring clinical excellence. Dr. Shaffer oversaw MHN's quality improvement and disease management units and was accountable for the coordination and quality assurance of clinical care.

In addition, Dr. Shaffer has overseen quality and outcomes monitoring for the Military & Family Life Consultant Program services and collaborated with his Health Net Federal Services colleagues to ensure optimal care and service delivery for TRICARE beneficiaries.

Prior to joining MHN in 2003, Dr. Shaffer served as executive vice president and chief medical officer of a national managed behavioral health organization, working closely with several Fortune 100 companies. He three times served as chairman of the Association for Behavioral Health and Wellness (ABHW) (formerly the American Managed Behavioral Healthcare Association – AMBHA), and he has also served on several federal government committees, including a three-year term on the National Advisory Committee for the Center for Mental Health Services arm of SAMHSA. He remains involved in national behavioral health policy issues, including parity and autism.

For more information and to register, visit www.behavioralhealthnews.org/2021awards reception.

The Future from page 18

NYSPA also strongly supports a mandate that audio-only services provided to Medicaid beneficiaries be reimbursed at the same rate as all other telehealth services. This is a true access issue. During the pandemic, audio-only care was often the only option for those patients who could not engage in audio and video telehealth because they lacked the required video technology or lived in an area without reliable internet access. As noted by a coalition of state-wide physician groups in a joint letter on the budget proposals: "Across specialties, providers report that during the pandemic, audio only communications was often the difference between care and no care."[2] In order to ensure full and widespread access to care, mandates for coverage of audio-only services must apply to all payers, including Medicaid Managed Care plans and commercial insurer and health plans doing business in New York.

On the federal level, the American Psychiatric Association has advocated that audio-only psychiatric services be considered complete telehealth encounters and paid at the same rate as an in-person visit. Last Spring, the Centers for Medicare and Medicaid Services (CMS) ruled that audio-only telephone care would be covered for a significant portion of psychiatry services during the COVID-19 public health emergency. CMS further confirmed that it would provide coverage for psychotherapy add-on codes paired with evaluation and management telephone codes (99441, 99442, and 99443). Payment for the telephone codes was increased to match payments for similarly timed office and outpatient visits. NYSPA strongly supports continued coverage for audio-only services, both on a federal and state level, particularly after the end of the current public health emergency.

We are also very pleased to report that bills mandating parity in coverage and reimbursement for telehealth (S5505/A6256) have been introduced by the Chairs of the Senate and Assembly Health Committees Gustavo Rivera (D-Bronx) and Richard Gottfried (D-Manhattan), respectively, in both the New York State Senate and Assembly and are currently under committee review. NYSPA staff was closely involved in the development of these bills. The legislation would require health plans to reimburse a treating or consulting provider for telehealth services "on the same basis, at the same rate and to the same extent that the health care plan reimburses for the services when provided through in-person diagnosis, consultation or treatment." Further, the bills confirm that copayments, coinsurance and deductibles may be applied to telehealth services only if they are at least as favorable as those applied to services not provided via telehealth. If signed into law, either as part of the FY 2022 State Budget or in separate legislation, these bills would confirm, once and for all, full parity in reimbursement for services provided by telehealth in New York State.

In addition to the pending legislation, NYSPA is also advocating for legislative action to ensure a uniform definition of telehealth in both the Public Health Law (which applies to Medicaid and HMOs) and the Insurance Law (which applies to commercial health insurers). At present, the definitions are slightly different. The Medicaid definition of telehealth includes audio-only services while the other laws do not. This is an important clarification to avoid confusion or potential inequalities that might arise from inconsistent statutory definitions. Finally, NYSPA supports legislation that would mandate that all payers permit beneficiaries to use of out-of-network benefits in connection with telehealth services.

The future success of telehealth and telemedicine in New York depends primarily on two factors, access and payment parity. In order to confirm that telehealth is a long-term and viable option for care, we must work together to ensure that government and third-party payers provide reimbursement for telehealth commensurate with reimbursement for in-office services. Audio-only services must be covered at the same rates to ensure that those with limited technology resources have the same access to quality care. Finally, we must remove the Medicaid originating site requirement and any other previously imposed barriers to care that prevent comprehensive access to necessary care and treatment.

Rachel Fernbach is the Deputy Director and Assistant General Counsel of the New York State Psychiatric Association, a division of the American Psychiatric Association and the medical specialty society of psychiatrists practicing in New York State. Ms. Fernbach is also a Partner at Moritt Hock & Hamroff LLP where she concentrates her practice in not-for-profit and mental health law. Ms. Fernbach also serves as Vice-Chair of the MHNE Board of Directors, publisher of Behavioral Health News.

Footnotes

1. www.nysenate.gov/sites/default/files/medical_society_of_the_state_of_new_york_mssny.pdf

2. Joint comments submitted by the Medical Society of the State of New York and other state-wide medical specialty societies, including NYSPA, regarding the Executive Budget proposals.

Data from page 11

All of this health data is stored in the same database alongside the behavioral health data, like frequency and durations of targeted behaviors, and learning progress. Combining both sets of data in the same database simplifies the cross-analysis process by having a common understanding of who the clients are, a similar structure to the data, and a single database to extract the data.

Joining data across domains yields a virtually unlimited potential to ask and answer questions that unravel the function of behaviors and discover new opportunities for improvement at both the client level and organizational levels. For example, by combining sleep and behavioral data, research at our organization has shown a correlation between poor sleep quality and increased behavioral activity the following day. Insights such as this can be used to fine-tune an individual's behavior support plan to factor-in poor sleep nights, for example. At an organizational level, this finding can inform changes in the overnight environment, bedtimes, light and noise levels, and more. Training can be implemented with outside providers, parents and guardians as to the importance of proper sleep to their client.

Similarly, other health variables on their own or in combination can significantly impact behavioral health and are often distant or immediate antecedents to behavioral episodes. As the dataset grows, so does the potential for discovery. When all of an organization's client behavior and health data are accessible together, even cross-client findings can be discovered. For example, you may discover that an antecedent of one client's behavior is a combination of less than four hours of sleep and a loud vocalization behavior from another client across the hall.

Methods of Analyzation

Databases store the data. Database queries are statements which ask, or query, the database to return the data you need for your particular analysis. That data, in turn, can be prepared as tabular reports, charts, or graphs for analysis. It is common for a database application to have reporting features which run common queries automatically and present results in tables, charts or graphs.

Regular visual inspection and interpretation of the data by clinicians remains a cornerstone of any treatment protocol. At our organization, we have programmed these reports into our web-based applications for retrieval at the push of a button. Standard graphs of progress, rates of behaviors, trends are a click away in real-time, providing the information a clinician needs when they need it. Many advanced reports, including many filters, are also available.

In addition to visual inspection, the data can be analyzed statistically using one of dozens of statistical software packages like the SPSS, RStudio Cloud, and MiniTab. Statistical engines can also be added directly into your custom application to do the work behind-the-scenes. Statistical analysis promises advantages in precision and volume: causation or correlation can be determined with confidence and accuracy across a vast number of variables. This level of analysis has the best chance of discovering connections between seemingly unrelated variables, like in the example of one client impacting another from a different room. The disadvantage is the relatively high level of complexity required to set up the analyses to ensure trustworthy and clinically useful results.

The Promise of Adding Health Data to Your Organization's Data Profile

As practitioners and behavioral health organizations adopt new technologies, consideration should be given to developing or purchasing database applications which bring data together that traditionally would be recorded individually. Behavioral data and health data, as this article shows, can be combined discover useful, actionable information to optimize client treatment and bring continuous improvement at the organizational level.

Outcomes from page 30

IPAs in New York, aggregates and analyzes data from sources that have been historically challenging to access, allowing for insights that impact how care is delivered. Substance use disorders and mental health conditions play critical roles in overall population health but are often underrepresented through the lens of claims data alone. Our solution includes not only claims data, but ADT (admission, discharge, transfer) feeds from Health Information Exchanges (HIE), Electronic Health Records (EHRs), and social determinants of health data sources, allowing for a full understanding of what is "happening" to the clients served through either an agency-specific or total-network view.

DABI aggregates, normalizes, and analyzes data, with clinical experts overseeing the quality and outputs to ensure that they result in actionable insights that lead to improved workflows, processes, and consequent health and quality of life outcomes. What makes the platform unique is its focus on behavioral health and social determinants of health-related measures, viewing these factors as critical drivers of optimal total health in a value-based payment context.

Once data sources are normalized (i.e., made to conform to a format that can be understood by an analytics platform), they are fed to Arcadia. By hooking into Arcadia's engine, IMSNY's IPA networks can seamlessly track and make decisions based not only on the sum of contributed data sets, but also leveraging a multitude of layered-on databases (e.g., census data) and proprietary algorithms that allow for risk stratification.

While the Arcadia solution represents the most pronounced value to participating networks, there are intermediary tools developed by IMSNY to support participating networks immediately. In partnership with MD Health, IMSNY created a tool to organize and present data from billing files. Using this tool, IMSNY aggregated files from 30+ agencies in NYC and the Hudson Valley with the goal of delivering immediate insights about not only their individual billing files, but how they compare to others in the network. A While the Arcadia solution represents the most pronounced value to participating networks, there are intermediary tools developed by IMSNY to support participating networks immediately. In partnership with MD Health, IMSNY created a tool to organize and present data from billing files. Using this tool, IMSNY aggregated files from 30+ agencies in NYC and the Hudson Valley with the goal of delivering immediate insights about not only their individual billing files, but how they compare to others in the network. Whether their mix of diagnoses is aligned with the rest of the network, or if they are treating a different mix of clients. Using this data, an agency can determine whether to further customize service offerings to meet the unique needs of their clients.

Additionally, the solution shows agencies which other in-network agencies they are sharing clients with, giving valuable intelligence around which agencies they could more closely partner with. (***see Figure 4***)

Looking Ahead

With the availability of data, made possible by the advent of electronic health records and other technology platforms, failing to make decisions informed by all accessible information is increasingly irresponsible. Furthermore, in a value based contracting environment, payers may cease to contract with networks that do not have a sound method for tracking network activities and consequent health outcomes. With DABI, IMSNY has developed a system for combining complex data into a singular, easily reportable data warehouse. More importantly, IMSNY is breaking ground with Arcadia by jointly developing behavioral health functionality, as most analytics platforms have only designed their algorithms for physical health outcomes. Through this partnership, IMSNY and its affiliated networks will continue to advance the mission of improving access to health data, and helping providers make better decisions to improve population health.

IMSNY's affiliated networks include over 80 agencies serving nearly 160,000 people in the Hudson Valley and NYC, all of which are committed to supporting this solution and are looking to DABI to improve the system of care and engage in meaningful VBP contracting with payers.

IMSNY's Parent Companies

CBC was launched in 2011 by innovative NYC not-for-profit behavioral health agencies to meaningfully participate in NYS's Medicaid redesign and Value Based Purchasing initiatives. In the following years CBC developed a citywide Health Home, which is currently the largest of its type in New York State. CBC has launched effective gap-filling service programs for low-income New Yorkers that build on the expertise of its community-based service network. CBC "knits together" affiliated agencies to holistically address treatment and recovery needs, while assessing community deficiencies and connecting clients to needed support.

CBHS realizes the need for nimble, responsive, cost effective ways to serve people with behavioral health other related challenges. To accelerate their knowledge and preparation for value-based contracting, CBHS partners with healthcare agencies, health homes, and managed care companies to achieve the outcomes needed for a healthier future. CBHS is creating an array of innovative services that are financially viable and responsive to the needs of the clients served. CBHS has been a leader in New York State's transformation to a person-centered model of care and is recognized for its recovery services, which are outcome-driven and incorporate peer and natural supports. CBHS utilizes strength-based planning in the behavioral health and child welfare services that draws heavily upon community supports to promote positive outcomes.

Jorge R. Petit, MD (Co-CEO), Mathew Smith (COO), and Khushi Shah (Data Solutions Manager) are at IMSNY, focused on supporting behavioral health networks. To connect, reach out to msmith@imsnyhealth.com.

Footnotes

1. Arcadia is a healthcare data and software company dedicated to healthcare organizations achieving financial success in value-based care. Arcadia Analytics, their purpose-built population health platform, delivers enterprise-level transformational healthcare outcomes.

2. To learn more about CBC's Pathway Home program: Pathway Home™ – CBC (cbcare.org)

3. IMSNY partnered with HealtheConnections, see press release

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