System Transformation: What Does the Future Hold?

By Barry J. Jacobs, PsyD, Heidi Arthur, MSW, and Meggan Schillkie, MBA
Health Management Associates

We know that the mind and body are inseparable, so it’s no surprise that the evolution of behavioral health services will continue to be a story of convergence and consolidation, increasingly informed by science, financed by investments intentionally calibrated to drive progress, and guided by leaders prepared to meet the ever-changing needs of local communities. Here’s what we believe the future holds:

A bridged gap between professionals and communities: Integrating behavioral and physical healthcare is old news, but the inclusion of new partners able to attend to the “social determinants of health” by addressing issues like housing, food security, unemployment, and transportation will grow in sophistication and coordination. The interweaving of professionals and community supports will be increasingly seamless. Healthcare payers will align with funders from other systems to align resources and make investments that facilitate community wellness. Such cross-sector collaboration will engage public health, education, older adult services, law enforcement, housing, human services, criminal justice, child welfare, etc. in resource sharing to address mutual agendas using agreed metrics to measure and guide intervention.

Deconstructed supports: Behavioral health centers will increasingly direct comprehensive and multi-component services occurring in every milieu and neighborhood. Nearly all consumers will have access to peer specialists or community health workers working side by side with their licensed professionals. All treatment plans will include adjunctive interventions in the home, school and employment settings. All treatment outcomes will be measured not in de-contextualized DSM symptoms but in functional capacities and quality of life within specific environments and relationships. Service consumers will have options and their input and feedback will routinely and fluidly be elicited to inform service delivery design and facility improvements.

A real role for families: In the future, all healthcare will be “person-centered and family-engaged.” Privacy laws like HIPAA will be better understood and no longer used to marginalize consumers’ family members. Consumers will remain the focus of treatment but will be strongly encouraged to allow their family members to serve as partners in care with treatment teams, including defined roles and coaching to observe and report on treatment effects. Their own behavioral well-being, see The Future on page 24

Will “System Transformation” Transform the System?

Before We Celebrate: 20 Questions That Need Answers

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

System transformation is underway in New York State and throughout the United States through the development of elaborate financial structures such as accountable care organizations and health homes. No doubt these new structures will change the way business is done in the mental health system. But will they result in the kind of transformation called for early in this century by the President’s New Freedom Commission on Mental Health? Will they result in real and fundamental improvements in mental health care and in the mental health of the American population? Here are 20 questions that need answers before we celebrate the remodeling of how care is financed and managed.

1. Currently only about 40% people with mental disorders get treatment. Will this number increase substantially?
2. In most parts of the U.S. and in many counties in NYS, the capacity to treat people with mental illness is simply inadequate. Will service capacity increase significantly, especially in remote and high poverty areas?
3. Access to available care is often limited by cost, distance, inconvenient office hours and the like. Will mental health services become affordable? Will services be offered in places and at times that work for people who have real lives?
4. Many people do not seek or reject mental health services because of a sense of shame created by the still widespread stigma that surrounds mental illness and/or because they do not know that mental health services could help them or where to find it. Will these problems be addressed effectively?
5. Of those who get treatment, at most 1/3 get even minimally adequate treatment. Will the quality of mental health services improve appreciably?
6. One of the reasons for inadequate treatment is that so much of it is provided by primary care physicians who are not prepared to identify or treat mental disorders. Will primary care practices develop the capacity to provide effective care for people with mental disorders?
7. Most people with co-occurring mental and substance use disorders do not get treatment, and of those who do get treatment very few get treatment for both disorders and even fewer get integrated “dual-diagnosis” treatment. Will there be an appreciable increase in the use of integrated treatment approaches?
8. The mental health service system is fragmented, with inadequate coordination among mental health providers, between mental health and substance abuse providers, between behavioral and physical health providers, and with other human service providers. New managed care structures are specifically designed to reduce fragmentation. Will they succeed, not just from the standpoint of administrative and financial relationships but in the experience of people getting care?
9. Creating a mental health system that is “recovery-oriented” and “person-centered” was the major goal of the New Freedom Commission’s call for transformation. Will significantly more people with serious mental illness have lives that they find satisfying and meaningful? Will significantly more experience the mental health system as manageable and responsive to their needs and desires?
10. Many people who do not or cannot come to mental health programs are responsive to outreach efforts such as ACT teams and will use services in their homes or in local settings such as community centers and houses of worship. Will mental health services become less characterized by professionals waiting for patients/clients/consumers in offices and more characterized by active efforts to engage people in need where they are?

See 20 Questions on page 24
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Deadline: January 8, 2019

Spring 2019 Issue:
“Caring for Older Adults: Challenges and Solutions”
Deadline: April 1, 2019

Summer 2019 Issue:
“The Behavioral Health Workforce: On the Front Line of Behavioral Health Care”
Deadline: July 1, 2019

Fall 2019 Issue:
“Models of Integrated Care Across the Healthcare Sector”
Deadline: October 1, 2019

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Substance Use Disorder Measures and Preparing for Value-Based Purchasing

By Arlene González-Sánchez
Commissioner
NYS Office of Alcoholism and Substance Abuse Services

In a previous column, I wrote about the measures for value-based purchasing being developed together with the New York State Department of Health and the Center on Addictions, our partner on many projects. Our work to develop clear measures has set the foundation for insurance plans, providers and OASAS to assess how well substance use is being identified, how treatment is being initiated, and the effectiveness of how well people are engaged in treatment (see chart below for 2016 data on current measures) and cared for in New York through Medicaid and ultimately, all by all payers. As we move toward value-based purchasing, the next step for OASAS will be to help providers and payers understand the implication of these new measures.

Many providers are working together to form networks capable of looking at how people with SUD and mental health disorder are doing. They may aggregate and share the data they have and collectively identify practices and processes that can move the needle toward better performance on the measures. I am frequently asked why we chose these measures and how should programs be preparing to use them. The remainder of the article will focus on these two questions.

As measures were developed during the past two to three decades for physical health conditions to better track quality of care for health conditions, substance use disorder had only one Health Care Effectiveness Data and Information Set (HEDIS) endorsed measure to identify how well people were initiated into substance use disorder care (within 14 days of an initial diagnosis) and engaged (measured as a second visit within 30 days of initiation). This is an important measure of how well health care responds to diagnosed substance use disorder. This measure of quality is significant because, as we know, substance use, even when recognized is not always addressed and many people are not connected to care that can help, and even when they are, they may not be appropriately engaged. We will look at these rates for New York later in the article and I will pose the question, how would we react if these rates applied to individuals diagnosed with heart disease or diabetes?

OASAS recognized the need to go beyond these measures and was supported by the Department of Health to work toward additional measures for VBP pilots and quality performance measures for Medicaid Managed Care plans. During the past several decades, there have been many national conversations among substance use disorder experts. The Washington Circle developed the Initiation and Engagement measure and proposed and studied the feasibility of continuity and medication measures. The American Society of Addiction Medicine (ASAM) endorsed 9 potential measures of quality in a 2014 article*. However, none of these measures were endorsed or, at the time, moved toward endorsement.

OASAS and the Center on Addictions worked with a group of stakeholders to identify the measures that were most likely associated with outcomes in addition to those that were most feasible to develop quickly to identify a set that we could further develop and employ in New York. The measures include:

- continuity of care from withdrawal management (detox) to next level of care within 14 days of discharge;
- continuity of care from inpatient rehabilitation to next level of care within 14 days of discharge;
- initiation of medication for opioid use disorder within 30 days of diagnosis;
- utilization of medication for opioid use disorder – any medication prescribed during 12 months;
- initiation of medication for alcohol use disorder within 30 days of diagnosis;
- utilization of medication for alcohol use disorder – any prescription during 12 months; and
- continuation of engagement in treatment – 6 consecutive months with at least one visit with primary diagnosis of SUD.

Each of these measures has significant evidence from research that show a correlation to better SUD outcomes for individuals. The evidence is very strong for the continuity, engagement and opioid medication measures (there is less evidence for alcohol medication measure). This means that while we need to continue to identify more direct measures of outcome in treatment, improving these measures will very likely have a positive impact on SUD outcomes.

The next question from providers was what to do about these measures. Some of the measures can be tracked at a program level like initiation and utilization of medications and continuing engagement in treatment. Programs should be aware of how well they compare to the statewide and regional performance on these measures. Others will require data from other sources for a group of Medicaid members who are served by a network of providers and many Behavioral Health Collaborative Care (BHCC) groups are working to identify ways of following more system level measures.

Finally, programs must be able to identify ways of improving the measures. In a VBP environment, the responsibility for how well members do is shared with providers of health and mental health care. However, program level practices can lead to movement on these measures. During the past year, OASAS has focused on access, quality and integration. As a leader in your program, I recommend that you focus on practices that will help to reduce the time from the initial phone call to access to services in addition to those that improve retention in care and better integrated care. OASAS is committed to continuing to work with providers, plans, state sister agencies and others to contribute to the development of a robust set of measures that support quality, transparency and promote consumer choice and excellence in addiction treatment.


<table>
<thead>
<tr>
<th>Measure – Medicaid</th>
<th>Description</th>
<th>NYS Result 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initiation and Engagement in Substance Use Disorder Treatment</td>
<td>Initiation of AOD Treatment: Percentage of members who have had a Substance Use Disorder treatment visit within 2 weeks of a first diagnosis. Engagement of AOD Treatment: Percentage of members who had two or more additional SUD treatment visits within 34 days of their initiation visit.</td>
<td>46% 20%</td>
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<tr>
<td>Continuity of Care from Inpatient Detox to Lower Level of Care</td>
<td>The percentage of members who receive follow-up to a lower level SUD visit within 2 weeks after discharge from detox.</td>
<td>47%</td>
</tr>
<tr>
<td>Continuity of Care from Inpatient Rehabilitation for Alcohol and Other Drug Abuse or Dependence Treatment to Lower Level of Care</td>
<td>The percentage of members who receive follow-up to a lower level SUD visit within 2 weeks after discharge from inpatient rehabilitation.</td>
<td>44%</td>
</tr>
<tr>
<td>Initiation of Pharmacotherapy upon New Episode of Opioid Dependence</td>
<td>The percentage of members who receive at least 1 MAT within 30 days of an opioid diagnosed visit.</td>
<td>33%</td>
</tr>
<tr>
<td>Utilization of Pharmacotherapy upon New Episode of Opioid Dependence</td>
<td>The percentage of opioid dependence diagnosed members who receive at least 1 MAT any time during the year.</td>
<td>58%</td>
</tr>
<tr>
<td>Treatment follow-up within 7 and 30 days from emergency department following a visit with a principle diagnosis or substance use.</td>
<td>The percentage of ED visits for which the member received follow-up within 30 days of the ED visit. The percentage of ED visits for which the member received follow-up within 7 days of the ED visit.</td>
<td>29% 22%</td>
</tr>
</tbody>
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Responding to the Mental Health Needs of the Aging

By Ann Marie Sullivan, MD Commissioner
NYS Office of Mental Health

Aging is an inevitable part of life. As we get older, we often think of physical problems such as an aching back or pain in our knees. But the elderly also have considerable mental health needs, as well.

Here at the Office of Mental Health (OMH), we’ve been looking at innovative interventions to address the mental health issues that New York State residents face as they age. And we are working to ensure that older New Yorkers who require services have access to appropriate treatment, whether they’re living independently in their community, require services in their homes, or need the care provided by a skilled nursing facility. In order to provide a continuum of care to patients as they age, OMH has been working to develop effective programs through the Intergency Geriatric Mental Health and Chemical Dependence Planning Council, and important demonstration projects such as Certified Community Behavioral Health Clinics and the Mental Health Aging in Place initiative.

Community-Based Care
OMH has been working to strengthen the resources available to support community caregivers. During the past five state fiscal years, the plan has been re-balancing the agency’s resources by developing community-based mental health services – focusing on prevention, early identification and intervention, and evidence-based clinical services and recovery supports.

Home and Community Based Services are designed to allow enrollees to participate in a vast array of habilitative services. Participants have been granted access to skill-building activities while having various necessary rehabilitative needs met. Services include: case coordination, skill building, family and caregiver support services, crisis and planned respite, pre- or post- discharge, and strategies used to increase access to home care and make aging-in-place possible. Ideas included:

- Cultivating relationships with home health agencies – use existing residential, behavioral health staff, and case managers to partner together to provide medical care and make aging-in-place possible. Ideas included:
  - Promoting “cluster care,” highlighting a home health/personal care agency’s ability to serve multiple clients within the same building.
  - Advocating for residents in need of (additional) home health and personal care help – leverage professionals in regular contact with residents to consult with physicians writing orders for home/personal care.
  - Providing efficient access to psychiatric, substance use treatment, and medical support onsite/co-located, nearby, telehealth/tele-psyche) enables people to age in-place and avoid (re) hospitalizations and unnecessary ER visits.
  - Reviewing care coordination and insurance plan options available to residents that may assist in more efficient access to psychiatric and medical care.

- Collaborating with managed care and community-based service providers to develop a value-based payment proposal that targets residents with complex or intense needs to help pay for needed services or building adaptations that address the social determinants of health.
- Connecting with informal caregivers and families, noting that when these trusted people were available, they were key members of the wrap-around support team needed for individuals living with mental illness to join, return, or remain in their communities.

Skilled Nursing Facility Care
For some individuals, care in the community or in their homes is not an option, and they require the care of a skilled nursing facility. OMH has found that, while skilled nursing facilities were quite able to provide quality medical care to clients, many were hesitant to address their behavioral health needs. These disorders represent significant public health challenges – including impaired quality of life, increased healthcare utilization, cost, morbidity, and mortality. However, specialty care for late-life psychiatric and memory disorders is associated with better outcomes and lower costs.

OMH is working with the University of Rochester to address this issue now, with an innovative program called the Extension of Community Healthcare Outcomes in Geriatric Mental Health in Long Term Care for Skilled Nursing Facilities, called “Project ECHO GEMH” for short.

Project ECHO GEMH provides training through a “virtual clinic” using video-conference technology. Best practices are shared through a combination of short didactic presentations and case-based discussions with content experts. The clinic sessions connect frontline nursing home staff with clinical experts at academic medical centers. Staff collaborate to identify patients to take part in the program, address physical health needs of residential clients, help prepare long-stay patients for discharge, and explore alternative strategies to placement.

Project ECHO GEMH and the allocation of 24 Community Mental Health Nurses are the major components of the OMH Skilled Nursing Facility Enhanced Support Project. The goals of the Skilled Nursing Facility Enhanced Support Project are to:
- Increase timely discharge of individuals in state-operated psychiatric centers who meet criteria for skilled nursing facility placement.
- Support the skilled nursing facilities to meet the psychiatric needs of individuals accepted from OMH facilities during the transition period.

Dr. Ann Sullivan

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Psychiatric Nurses as Change Agents in Mental Health Care and Recovery

Dr. Ann Sullivan, MD Commissioner, NYS Office of Mental Health

State Office for the Aging and other state agencies, and awards grants to programs such as Certified Community Behavioral Health Clinics and the Mental Health Aging in Place initiative.

Nurses are the major components of the Skilled Nursing Facility Enhanced Support Project. The goals of the Skilled Nursing Facility Enhanced Support Project are to:

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Managed Long Term Care is streamlining the delivery of long-term services to people who are chronically ill or disabled and who wish to stay in their homes and communities. These services, such as home care or adult day care, are provided through managed long-term care plans that are approved by the Department of Health.

Through its Partnership Innovation for Older Adults program, OMH has been working with mental health providers throughout the state to establish “triple partnerships” in their communities to help adults age 55 or older whose independent or survival is in jeopardy because of a mental health, substance use, or aging-related concern. Triple partnerships are designed to pull together the resources of mental health, substance use disorder, and aging services. The Partnership Innovation program is administered by OMH, the State Office for the Aging and other state agencies, and awards grants to providers in the areas of community integration, improving quality of treatment, integrating services, workforce, family support, finance, specialized populations, information, and staff training.

Help at Home
For seniors living with mental illness who are homebound, OMH has been working with OMH residential providers and with the home health care industry to gain insight into the type of needs that home care providers were encountering with residents, barriers to accessing services, and strategies used to increase access to home care and make aging-in-place possible. Ideas included:

- Cultivating relationships with home health agencies – use existing residential, behavioral health staff, and case managers to partner together to provide medical care and make aging-in-place possible. Ideas included:
  - Promoting “cluster care,” highlighting a home health/personal care agency’s ability to serve multiple clients within the same building.
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see Aging on page 29
The concept of system transformation in behavioral health is one that has garnered much attention in recent years. In New York State, this often refers to the evolving iterations of Medicaid managed care and value-based payment. This transformation is focused on the “triple aim” of better care, improved outcomes, and contained cost. At the same time, however, another transformation is taking place—the increased recognition of the impact of trauma on the lives of people with behavioral health needs, and its impact on those who serve them. If we are truly to achieve improved clinical and psychosocial outcomes through system transformation, increasing the efficiencies of program implementation and payment is not enough. Our goal as service providers, and as advocates who shape the system in which we work, should be to ensure that trauma-informed practices are central to program and policy development in New York State and beyond.

Wherever you are in the behavioral health system, you likely know something about the groundbreaking research on adverse childhood events (ACEs) that began in the 1990s and is ongoing. Because of this research, we know that traumatic childhood experiences are extremely common and that they are strongly associated with negative health and behavioral health outcomes. As the ACEs research demonstrates, trauma takes many forms. Domestic violence, sexual assault and child abuse and neglect are just a few kinds of experiences that are all too common in our society. It is also clear that environmental, as well as interpersonal, factors can be traumatic and that interpersonal traumas may be exacerbated under particularly difficult environmental circumstances. For example, poverty, homelessness, and community violence are all sources of trauma and are all social determinants associated with poor health and behavioral health outcomes.

The implications of this research are staggering. The ubiquity of trauma and its deleterious effects require us to design and deliver our programs in a manner that, if not directly treating the symptoms of trauma, recognizes its impact and, at minimum, does not exacerbate traumatic reactions or inadvertently re-traumatize the people we serve. Fortunately, it is becoming a widely-embraced standard for human service organizations and systems of care to embed a trauma-informed approach into their work in recognition of trauma’s impact on outcomes.

But we have to do more. The results of the largest study to date on adverse childhood events reveals significant disparities in traumatic experience across populations. People of color, disproportionately bear the burden of personal, historical and environmental trauma. This is reinforced and exacerbated by government reimbursement structures that engender deficit-based, reactive operations in the nonprofit organizations providing essential human services. It is a vicious cycle. Therefore, understanding the structural and environmental contributors to trauma see ACES on page 29.
By Jason Lippman
Interim President and CEO
The Coalition for Behavioral Health

Over the last several years, the community behavioral health landscape has changed. New York State is driving reforms toward achieving the Triple Aim for better care and improved health at lower costs. In doing so, the community-based behavioral health sector has been charged with undergoing several system transformations: moving from fee-for-service to managed care, integrating behavioral health care with physical health care, and participating in initiatives like the Delivery System Reform Incentive Payment (DSRIP) program and transitioning to Value Based Payment (VBP) arrangements.

All the reform puzzle pieces offer community-based providers opportunities for advancing whole health outcomes among individuals living with severe mental illness and substance use disorders. While maneuvering through the labyrinth of system transformation, community-based providers have changed people’s lives for good through providing stable housing, employment, education and care management services. At the same time, providers struggle with aligning policy with practice.

Care Integration
Integrating care is a desirable goal to ease the fragmentation of physical and behavioral health services. There is no one straight path to integration. In fact, there are several and they can be bumpy at an uneven. Total integration with a full service team that is holistic, interdisciplinary and person-centered is exemplified by the federally certified Community Behavioral Health Clinic (CCBHC). CCBHC’s provide a comprehensive range of addiction and mental health services, while meeting additional requirements related to staffing, governance, data and quality reporting and more. In return, CCBHC’s receive a Medicaid reimburse rate based on their anticipated costs of expanding services to meet the needs of these complex populations.

Other examples of integration include, collocating with another group of licensed specialists; sharing office space where mental health and substance use providers are dedicated partners with the state in holding up the safety-net up and keeping it intact. They go above and beyond their initial missions to ensure that services in the community are available to all who need them, despite fragmentation and persistent disparities and gaps in care throughout the service delivery system.

Care Outcomes
As the demand for mental health and substance use services increases, New York State (through its mid-level payers and community providers), is obliged to provide optimal care to the most vulnerable and complex populations. Nonprofit mental health and substance use providers are dedicated partners with the state in holding up the safety net and keeping it intact. They go above and beyond their initial missions to ensure that services in the community are available to all who need them, despite fragmentation and persistent disparities and gaps in care throughout the service delivery system.

Positive consumer outcomes are the center of the continuum of care provided by community-based behavioral health providers. This entails social support and preventative care through the entire life-cycle to increase independence and better health outcomes for people living with mental illness, who die on average of 25 years younger than the general population. In addition, ending the stigma surrounding mental illness, who die on average of 25 years younger than the general population. In addition, ending the stigma surrounding behavioral health so that people are comfortable seeking help before a crisis arises.

It is therefore necessary to ensure the sustainability and viability of the sector to guarantee that consumers have access to and receive the high quality, integrated care that they deserve as articulated under the goals of the Triple Aim: better care and improved health at lower costs.

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The Behavioral Health Community Today: Change, Challenge and Opportunity

The Coalition for Behavioral Health
Serving New York’s Behavioral Health Community

By Jason Lippman
Interim President and CEO
The Coalition for Behavioral Health

Jason Lippman

was intended to be an important step forward towards achieving the goal of integration. Community-based providers have devoted a lot of time and resources into DSRIP, but for them the hope has not been realized. The hospital-based PPSs have largely held on to DSRIP funding and the program is scheduled to conclude in 2020, with many PPSs transforming into ACOs or IPAs.

Health Homes are designed to be the linchpin of integration, providing care coordination that links behavioral health with primary care, addresses social determinants of health and avoidable use of hospitals. Yet Health Homes are not without their own engagement challenges and bureaucratic obstacles. For most enrollees, Health Home payments and care management functions are flowing through MCOs. As the program continues to evolve, Health Home leads and Care Management Agencies (CMAs) are looking to change their business models and engage in strategic partnerships to enlarge their network for referrals.

Value-based payments adds another critical dimension that will shape the system and the future. As a result, providers are now forming specialized networks to deliver care through ACOs, IPAs and BHCCs. To help behavioral health providers prepare for Value Based Payment arrangements, the NYS Behavioral Health Value Based Payment Readiness Program was launched with $60 million over three-years to fund selected BHCCs. The BHCCs are tasked with enhancing the collective quality of care by facilitating a shared infrastructure that is clinically and financially integrated with the use of community-based recovery supports, and utilization of service data to improve behavioral and physical health outcomes. Under the vision of value-based payments, plans will delegate some risk, network development and care management activities. But for VBP network contractors to be successful, access to real-time and actionable health plan and PPS data is fundamental, in addition to the capability to meaningfully partner with MCOs, and having opportunities to reinvest shared savings back into the collaborative.

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As the demand for mental health and substance use services increases, New York State (through its mid-level payers and community providers), is obliged to provide optimal care to the most vulnerable and complex populations. Nonprofit mental health and substance use providers are dedicated partners with the state in holding up the safety-net up and keeping it intact. They go above and beyond their initial missions to ensure that services in the community are available to all who need them, despite fragmentation and persistent disparities and gaps in care throughout the service delivery system.

For the Triple Aim to succeed, community-based providers must have the resources that are necessary to deliver high-quality, integrated, collaborative care. This includes investing in a high-quality, specialized workforce that is committed to achieving these ambitious goals. Furthermore, system transformation requires a thoughtful change management strategy. As it evolves, evaluation and assessment of the strategy need to occur with necessary modifications along the way.

Positive consumer outcomes are at the center of the continuum of care provided by community-based behavioral health providers. This entails social support and preventative care through the entire life-cycle to increase independence and better health outcomes for people living with mental illness, who die on average of 25 years younger than the general population. In addition, ending the stigma surrounding behavioral health so that people are comfortable seeking help before a crisis arises.

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A System in Transformation

By Andre, Derreck, Diomayra, Eugene, Isaiah, Rhonda, Robert

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 of this column facilitated a focus group of their peers to inform this writing. 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 they can use to lead a life of purpose.

There was something refreshing about talking through the way the delivery of care has transformed over the last few years. Through our lives, we have had to navigate not only systems of healthcare and services, but also our own resilience and strength. To some degree, everyone in our discussion group has experienced homelessness, trauma, mental illness, and other challenging circumstances.

While we may not have all been familiar with the term ‘system transformation’ or the exact names of each of the services we’ve been provided, our discussion made it clear that we have seen a significant change in the way we have received care over the years.

Our talk revealed a range of experiences: from confusion and continued frustration in working through the current structure, to life-altering revelations and realizations that have emerged from our interaction with the structure of care. Our needs are very individual, so each of us feels differently about what quality support and services mean. Still, when asked whether the system today has led to better care, more access, improved health, and better experiences for us, our collective answer was a definitive ‘yes.’

How System Transformation Has Impacted Us

Accessing services that can change our lives: For a few of us, after finding stability in our health and housing, for some time we still found it difficult to take full advantage of the services available to us. The assistance of Care Coordinators has been transformational in helping us to realize our deeper needs, find specialized primary care and mental health providers, and get the most out of available care.

“I was given housing at S:US because I have veteran status. I had housing but I still wasn’t settled. That’s when I got introduced to the Care Coordinators. I now have a Wellness Coach and a Care Coordinator, because my mind doesn’t remember the way that it used to. My psychiatrist told me that I need a special type of therapy called DBT (Dialectical Behavior Therapy), but I didn’t know how to find a list of people who specialize in DBT. My Care Coordinator helped me find someone and stayed on me to make sure that I kept that appointment, because there was a six month waiting list. My Care Coordinator has really helped me out. She had resources at her disposal that I could utilize.”

Staying on track in scheduling, keeping, and traveling to appointments: A big part of having full access to care involves following through on logistical tasks. These things may seem simple but can prove tedious when the system is confusing, when we have to juggle schedules, when we don’t have a way to travel to an appointment or meeting, or when we are simply feeling discouraged.

Care Coordination and the services that have become available over the last few years have helped us immensely with following through on appointments. From...
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few would dispute the assertion that our behavioral healthcare system and the many institutions on which it depends are in a state of transformation, if not upheaval. This transformation is characterized by manifold, overarching themes and trends, most of which aim to enhance the quality of care delivered to recipients of healthcare services and at lower costs. The Institute for Healthcare Improvement envisioned nothing less when it introduced the “Triple Aim” of healthcare reform in 2007, an ambitious plan that added improvement in overall population health to its goals for the new millennium (American Hospital Association, 2015). Subsequent developments, including the enactment of the Patient Protection and Affordable Care Act (ACA) and establishment of the Medicaid Redesign Team (MRT) and Delivery System Reform Incentive Payment (DSRIP) program, readily adopted the Triple Aim behaviors corollary initiatives. Foremost among these is the replacement of Fee-for-Service reimbursement systems with Alternative Payment Models (APMs) that recognize and reward quality in service delivery. Behavioral healthcare providers (and the many Community Based Organizations (CBOs) that provide ancillary support services to individuals with behavioral health needs) can no longer rely on payers to compensate them simply for the volume of services delivered. As envisioned in the New York State Roadmap for Medicaid Payment Reform, providers must demonstrate their “value” through measurable contributions to the attainment of the Triple Aim (New York State Department of Health, 2018). How does a provider, agency, or consortium of agencies demonstrate value? It is all in the measurement process. And therein lies great opportunity and tremendous peril.

Performance measurement is certainly not new to the healthcare industry nor is it unique to it. Frederick Winslow Taylor and his fellow progenitors of “scientific management” were among the first to apply the tools of the industrial efficiency movement to public school reform more than a century ago (Muller, 2018). Such “reforms” continue to abound, as manifest in the No Child Left Behind Act, the Common Core curriculum and myriad other initiatives of enduring influence and dubious merit. Other sectors including law enforcement, the military, business and finance have also been subject to various forms of performance measurement, most of which were borne of the seemingly noble intention to promote quality, efficiency, transparency and accountability in the name of a greater public good. The healthcare industry is another eminently logical target for reform inasmuch as it commands an ever-increasing share of our collective resources and produces uneven results, at best. By 2025 it is expected to consume a fifth of our nation’s GDP, nearly 50% of which will be shoul-dered by local, state and federal govern-
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T he Mental Health Association of Westchester (MHA) continues to actively transform the delivery of our expansive array of services, increasingly moving from a conceptual commitment to provide holistic services to operationalizing a unified fabric of existing and newly created services. Simultaneously, we maintain our unwavering focus on shared decision making and person-centered care. Our changes are more than incremental as we work to offer the “right care, at the right time, and in the right place” to the people that we serve whose health services are primarily covered by Medicaid and Medicare.

The goal is to address the full range of an individual’s health related challenges by offering an expanded array of services that work in concert with each other. Historically, challenges to this approach have derived from several factors, such as defined sets of services that did not address the full range of needs, including the impact of social determinants of health, limitations on the role of peer support, regulatory obstacles related to billable services, barriers to information sharing, and a workforce that was inadequately prepared to deal with the impact of complex trauma, substance use, and the intersection of physical and behavioral health. The following describes several initiatives now underway to achieve our goal of integrated care.

Integrating Medical Care

Care management services play a vital role in client care. Our work prioritizes both physical and behavioral health to improve quality of life and to avoid unnecessary emergency services. The work of care managers may include coordination of medical care, making connections to specialists, and managing successful transitions out of hospital settings. Though essential, much of this work was previously done in silos, with most clinical and care management services operating in parallel spaces. Embedding care managers into our main clinic settings was an essential first step towards integrating the two services. New workflows were established to insert care management services at several points of contact within the clinic, including at referral, intake, and throughout the course of treatment. Clinicians have been trained to provide more thorough medical assessments and screenings. These new workflows also enable us to pull out real-time information to our clinicians when we receive alerts from Healthlink, an alert system that provides easy access to Employment and Education services in other types of settings such as in primary care settings. Currently, we are looking at providing similar services in other types of settings such as homeless shelters.

Integrated Substance Use Disorder Services

Through new services and staff training, MHA is addressing the growing concern of opioid use and co-occurring substance and mental health conditions experienced by our clients. Select staff are being trained in Integrative Harm Reduction and Dialectical Behavior Therapy for Substance Use Disorders preparing them to integrate substance use approaches with more familiar clinical interventions. Staff accessing all services at multiple levels, peer professionals and support staff are trained in the use of NARCAN to provide emergency substance use first aid services if necessary. Once our pending application is approved, our psychiatric staff will begin to offer Medication Assisted Treatment (MAT). Along with establishing policies for MAT, our medical staff is creating a protocol to reduce the use of benzodiazepines and concomitantly increasing the use of alternative techniques such as mindfulness to manage anxiety.

Expanding Clinic Services

Our Intensive Outpatient Program (IOP) provides an array of intensive supports and services, particularly during times of crisis and transitions from hospital care. Clients in our IOP are supported by clinicians and peer professionals, who provide multiple points of contact and wrap around support during times of increased need. Frequency and length of contacts are dictated by individuals’ fluctuating levels of need. Furthermore, co-location at the Sterling Community Center provides easy access to Employment and Peer services.

Within MHA’s OnTrackNY program, which provides early intervention services to those experiencing a first episode, a new initiative offers social network meetings as an additional option. Social network meetings bring together the individual receiving services and members of his or her social circle, including family and/or other close relationships. Through the social network meetings, all participants are given the opportunity to express their thoughts and feelings in order to facilitate dialogue and understanding. The hope is that these meetings will enhance clinical and recovery outcomes while preserving and improving relationships.

Integrated Peer Support Services

MHA clients who have been high utilizers of intensive and expensive services due to histories of multiple psychiatric hospitalizations and/or periods of incarceration. The INSET program augments existing services with additional intensive supports, including mobile clinicians, care managers, and peer professionals. The INSET team supports these clients in the community, links them to needed social services, engages family supports, and coordinates care across MHA services.

Change Management

Initiating, implementing and sustaining significant change requires planning, ongoing monitoring and management. To that end, MHA employs proven change management techniques facilitated by designated staff and overseen by a dedicated Project Management team. Key Performance Measures are regularly reviewed to assess progress toward goals and drive changes in strategy. Our new integrated Electronic Health Record, with an expected go-live date of January 2019, is a key vehicle through which we will manage patient care.

Staff Support

As we work with a growing number of individuals with increasingly complex health and behavioral health needs, the toll on staff can be significant. We are implementing a protocol of enhanced staff support, activated particularly following a client death. Staff support includes a menu of HR, clinical, and peer support, drawing on our internal resources and staff expertise to assist our providers in managing the impact of client loss, tending to their emotional needs, reducing secondary traumatization, and increasing retention and staff satisfaction. Active endorsement by all levels of executive staff are essential for the success of this initiative.

Since its creation in 1946, MHA of Westchester has continued to evolve with and also to lead change in order to most effectively meet the needs of those to whom we provide services. Our current transformative initiatives continue that long tradition.

* Institute for Healthcare Improvement: http://www.ihi.org/resources/Pages/AudioandVideo/WIHI-Right-Care-Right-Setting-Right-Time-of-Hospital-Flow.aspx

About the authors. Ruthanne Becker, MA, is Senior Vice-President of Rehabilitation Services; Barbara Bernstein, PhD, is Chief Planning Officer; Cindy Peterson-Dana, LMHC, is Vice-President of Peer and Recovery Services; Stephen Smith, PhD, is Director of Training; and Jenna Velez, LCSW, is Vice-President of Behavioral Health Services at the Mental Health Association of Westchester.
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The East New York Health Hub: Realizing the Promise of Whole Health

By David Woodlock
President and CEO
Institute for Community Living

David Woodlock

Unver the last few decades, there has been an increasing focus on health care reform and the bending the cost curve through a combination of new approaches including social determinants of health, trauma-informed treatment, health equity, patient engagement and integrated care. While these elements have clearly found a place in the literature, few attempts to comprehensively address these issues have had significant impact. One program in East New York may soon change all of that and in an unprecedented way.

On Monday, September 24th, the ICL East New York Health Hub opened its doors. This milestone was the culmination of years of planning to bring a wide range of health and behavioral health services under one roof in a way that would be much more than co-locating programs or offer opportunities for sound referrals.

For ICL, this carefully designed, light-filled 45,000 square-foot space was the realization of a long-held dream. And we chose an equally committed and enthusiastic organization – Community Health Care Network – as our primary healthcare partner.

As the Hub officially opens, we are confident its success will out bear our long-held belief that you cannot separate health from mental health care nor from the social determinants of health. The Hub instead offers a unified model of care to address health and behavioral health and the larger social and economic factors that we know lead to significant health problems and disparities.

Whatever “door” a person enters at the Hub – a medical appointment for a chronic care program or a monthly appointment with their therapist for depression – our goal is for that person to feel after losing a child to violence and justice in their care. The Hub offers the most effective services and reach communities of color.

It is profoundly different than a simple co-location of services. ICL and CHN are firmly committed to a shared sense of responsibility for everyone who walks through its doors. The Hub offers a reimagining of what a neighborhood health center can and should be.

Throughout its 31-year history, ICL has been serving to saving New York City’s most vulnerable populations. At the core of our 110 programs throughout New York City – counseling, clinics and community and residential support – is a commitment to New Yorkers with respect for their experiences and engaging them on their terms.

I am proud that ICL was among the first behavioral health agencies to build into mental health treatment a specific, targeted consideration of health issues to help clients address their physical and mental health concerns. Thanks to a generous, multi-year SAMHSA grant in 2011, ICL instituted a Healthy Living initiative with a survey of all clients taken at six-month intervals to assess how individuals were doing – were they in fact getting better with us. Each year since starting the survey the answer has been a resounding yes. Over the past three years some 98% have said they feel more in control of their lives and connected to community as a result of their involvement with ICL services.

In 2017, SAMHSA chose ICL from around the entire country as one of only three organizations to receive its Pathways to Wellness award for impacting people with chronic health conditions.

The principles guiding the Hub reflect SAMHSA’s contention that the integration of mental health, substance abuse, and primary care services is the most effective approach for people with multiple healthcare needs and that care coordination across providers and disciplines increases efficiency and improves outcomes and satisfaction with care.

Other national policy groups support this shift to a whole health approach. A 2016 report by the Robert Wood Johnson Foundation contended that to promote a culture of health requires “health providers to fully understand the social determinants of health and take these determinants into account in its treatment of patients including collaborating with social services and other systems to provide necessary services outside the purview of the health care system.” RWJF defined the social determinants of health as “factors such as where we live, how much money we have, our education level, and the problems we struggle with that have been clearly linked to our well-being, the quality of our lives, our health, and how long we live.”

Research by the Kaiser Family Foundation shows that social determinants of health account for at least 60% of a person’s health.

The problems inherent in a siloed system were underscored in a 2016 report by the Eugene S. Farley Health Policy Center, “Creating a Culture of Whole Health: Recommendations for Integrating Behavioral Health and Primary Care.” Researchers attributed the “fragmentation in healthcare delivery” to “the artificial separation of ‘mental’ health from ‘physical’ health” that “almost always comes back to a need for intentional integration at all levels to achieve a foundation for better health.” They argued that “primary care cannot adequately address mental health concerns, and all attempts to do so result in inferior care.” The research showed where integrated care was introduced, “it appears to improve health and healthcare and contain costs.”

A Continuing Commitment to Integrated Care

Through more than 30 years working in distressed communities, ICL had come to understand that changing health outcomes is just about improving medical services or “behavioralizing” but a fully ecological approach.

So guided by the research and our own client outcomes, ICL went to work to develop new models in New York City. We considered what community residents could come to have the complexity of their needs better met. We knew it would not be an easy road but were determined to overcome bureaucratic and financial hurdles. We felt compelled to do what we knew could significantly impact the lives of the people of East New York, one of the most distressed communities in the United States.

In addition to offering clinical and support services for adults living with mental illness and substance abuse, helping families is a major focus. The Hub will be home to ICL’s Family Resource Center (FRC), giving people access to this highly sought-after family support program; at the same time, FRC’s 500 family members have the chance to get their medical care there.

With our understanding of the benefits of intervening early and effectively, we will offer wellness programs, access to healthy food, counseling, and other support services.

For our plans for the Hub better prepare us to fulfill New York State’s five-year plan for Value-Based Payment to improve outcomes, reduce skyrocketing costs, and improve patient experience. The Hub could become a model for moving from fee-for-service to a whole health approach to comply with the state’s plan requiring 80% of Medicaid spending be in a Value-Based arrangement by 2020. We believe the Hub offers one of the most promising ways to help turn around an out-of-control system unprepared to meet basic health care needs, particularly for the high-needs, high-cost populations we see every day in our programs.

In recent years we have come to better understand the “gaps” in our community’s healthcare costs and the need to address causes. One reality is that 5% of the US population spends 40% of health care monies, predominantly in disadvantaged communities.

The Hub is also in sync with state and city initiatives to combat poverty, violence and poor health in severely underserved and disadvantaged communities by creating a sustainable network of community resources to bring better health care to the people of East New York.

Joining Forces to Enhance Health

ICL was very deliberate in our choice of Community Healthcare Network (CHN) as our medical services partner in the Hub. An outstanding provider of primary care, mental health care, and children, CHN is a Federally Qualified Health Center (FQHC) with 15 sites throughout New York City and a highly respected leader in comprehensive community medical care for underserved New York City residents.

Early on, we knew this would be a very successful partnership. In talking about the Hub, Bob Hayes, CHN CEO, says that “it is inspiring to work with the ICL team. We share a common vision to bring the finest care to people in distressed communities long ignored by traditional service systems. Our integration of physical and mental health care will make a huge difference for the people of East New York. One day soon we will wonder why there were ever separate systems for health and behavioral healthcare.”

ICL and CHN met regularly prior to the move to explore how we could enhance communication and service delivery.

An Altman Foundation grant is allowing us to create a manual of standard operating procedures culturally responsive to the health needs of Black/African American and Hispanic/Latino communities in East New York to be used by both organizations. A grant from the New York Community Trust further supports a shared service framework for a whole-person care approach to health and wellness.

Community at the Core

To make inroads into the seemingly intractable health disparities of the social determinants of health, research continually underscores the importance of patient engagement and patient activation. At ICL we apply these individual constructs to engaging the community as a whole.

From the start, we recognized the importance of working closely with local community organizations, service providers, churches, businesses and schools to offer the most effective services and reach communities of color.

We engaged two leading community development organizations – Local Initiatives Support Corporation NYC (LISC NYC) and Hester Street Collaborative – to conduct a comprehensive planning study to identify unmet needs and make the Hub inclusive and inviting. Over a two-year period, virtually every group they met with expressed excitement; the Hub vision clearly resonated with local residents.

Cruz Fuchsia, a community outreach worker who has lived in East New York her entire life and is a member of our East New York Health Advisory Council, made a commitment at a focus group this last time I stayed with me. “I’ve lived in this community all my life and we’ve always

see Hub on page 28
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Turn and Face the Change: Children’s Medicaid Redesign

By Ryan Logan, LMSW
Director, Children & Family Services
WellLife Network

The transition of behavioral health benefits has been a long and complex process. In 2015, the Children’s Mental Health System, which serves children and their families, underwent a significant redesign. This transition marked a dramatic shift from comprehensive, unified programs to coordinated, individualized services. The intention behind this shift was to focus on prevention, early intervention, and flexibility, giving providers the ability to identify the needs and challenges of youth and their families early. The hope was that this approach would help providers match those needs with appropriate services, thereby improving outcomes.

WellLife Network, an organization that has been serving children and families for over 25 years, has been at the forefront of this change. In 2015, Sherry Tucker was appointed as the Chief Executive Officer of WellLife Network. Sherry, who had previously served as the Chief Financial Officer, brought a wealth of knowledge and experience to the role.

Prevention and Early Intervention

The sweeping change that the Children’s Mental Health System is currently experiencing consists of several major initiatives: Health Homes, Children and Family Treatments and Supports (CFTS), and an expanded array of Home and Community Based Services (HCBS). These changes have begun and will continue to redefine service delivery within the Children’s Mental Health System, marking a dramatic shift from comprehensive, unified programs to coordinated, individualized services.

The intention behind this shift is to focus on prevention, early intervention, and flexibility, giving providers the ability to identify the needs and challenges of youth and their families. This approach aims to help providers match those needs with appropriate services, thereby improving outcomes.

Re-Education Challenges

Facing Parents and Network Providers

While it is easy to focus on the benefits of this change, it is important to acknowledge that there are also challenges. Parents and network providers may feel overwhelmed by the changes, and they may have questions and concerns about how to best support the children in their care. It is crucial for providers to communicate clearly and effectively with parents, ensuring that they understand the goals and benefits of the new system of care.

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Building an Integrated Delivery System Through Community Collaborations

By Jorge R. Petit, MD
President and CEO
Coordinated Behavioral Care (CBC)

C oordinated Behavioral Care (CBC) was launched in 2011 by a committed group of NYC not-for-profit behavioral health organizations to meaningfully participate in NYS’s Medicaid Redesign and Value Based Purchasing initiatives. CBC is dedicated to improving the quality of care for New Yorkers with serious mental illness, chronic health conditions and/or substance use disorders. CBC has developed a citywide Health Home, which is currently the largest of its type in NYC providing care coordination services to tens of thousands of New Yorkers of all ages, through 50+ community-based Care Management agencies located in all five boroughs. CBC has launched innovative community-based programs that build on the expertise of older community-based agencies; organized as an Independent Practice Association (IPA) that includes a citywide network of primary care, mental health and substance use treatment providers, thousands of units of supportive housing, recovery and support services, and assistance with concrete needs such as food, employment and housing. The CBC IPA Network “knits together” programs to holistically address individuals’ treatment and recovery needs, while assressing community deficiencies and connecting individuals to needed supports.

Over the years, CBC has worked closely with multiple stakeholder groups and developed strong relationships and collaborations to fulfill its mission of leveraging community partnerships toward the goal of integrated medical and behavioral health interventions that, coupled with a specialized emphasis on social determinants of health, promote a healthier New York. These collaborative efforts serve as the foundational underpinning of a clinically integrated delivery system that allow CBC and our partner agencies to participate in the healthcare system transformation underway as we move toward Value Based Payment.

One such example of an effective collaboration with amazing outcomes is the CBC, Bronx Partnership for Healthy Communities (BPHC) SBH Health System’s Providing Provider System (PPS), and Project Renewal innovative care transition partnership. This PPS initiative, including three other provider groups, was intended to provide a six-month Pathway Home/Critical Time Intervention (CTI) program to support individuals with serious mental illness as they transitioned from a hospital setting back to a homeless shelter or a precariously housed living situation. Based on first year data (2017) this model resulted in a reduction in hospital utilization, an increase in primary care and outpatient utilization, and increased access to housing and employment services. The initial goal was a 25% reduction in hospital days measured by a 6 month pre- and post-intervention review. The impact was far greater than expected with a 62% reduction in hospital days for the cohort and a 57% reduction in inpatient admissions. The CBC/Project Renewal Bronx Pathway Home Team had an even more extraordinary impact with an 85% reduction in inpatient and emergency utilization.

Another successful collaborative effort is exemplified by the Staten Island PPS (SI PPS) partnering with CBC and Project Hospitality on an innovative intensive care management program providing targeted outreach, engagement and support to individuals with a goal of reducing their reliance on emergency settings by connecting them to community-based services. The project, Helping, Engaging, and Linking to Health interventions (HEALTHi), modeled on the successful Camden Coalition’s Healthcare Hot-Spotting Initiative, uses data analytics to identify high utilizers and focuses on providing a safety net of resources to individuals with complex chronic conditions who are also affected by the social determinants of health.

The HEALTHi project is aligned with the other initiatives funded by SI PPS under the Delivery System Reform Incentive Payment (DSRIP) Program, and overall goals of the Medicaid Redesign. The HEALTHi project locates and actively engages individuals who have serious mental health conditions to improve quality outcomes while reducing their reliance on emergency settings by connecting them to community-based services.

The BHCC Steering Committee Member (photo details at end of this article)

Two New York Behavioral Health IPAs Merge

By Aley Weidman, Intern
Health Management Associates

C oordinated Behavioral Health Services (CBHS) and Comprehensive Care Network of the Hudson Valley (CCN), two Independent Practice Associations (IPAs) serving individuals in the lower Hudson River valley, are merging. Both organizations are recipients of state Value Based Payment (VBP) Readiness Program grants, which enabled them to form Behavioral Health Care Collaboratives (BHCCs).

During the process of developing their BHCC work plans, both organizations recognized that gaps in their networks could be filled by the other IPA. CBHS’s network lacked sufficient capacity for substance use disorder services, while CCN’s had insufficient mental health services available. When leadership of the two organizations recognized the extent to which their networks were compatible, and the almost complete overlap in their service geographies, they decided that a merger between the two IPAs was the wisest way to proceed.

This merger is consonant with national trends in mergers among providers at all levels, resulting from the move to VBP, and the infrastructure demands that result. While some in the state have utilized the $8.4b Delivery System Reform Incentive Payment (DSRIP) program in order to facilitate their transition to accountable care, behavioral health providers have had very limited access to those funds. The $60m that state policymakers were able to secure for BHCs enables some of the work needed for integration, but in order to develop the necessary infrastructure, and build a sustainable model, these two IPAs chose to bring their networks, and their BHCC funds, together. Both CCN and CBHS understood the overlap in their client bases, and sought to eliminate duplication, increase outreach, and provide more cost-effective, high quality care. In an effort to improve the health outcomes of the individuals they serve, enhance their quality of care, and generate economies of scale, they chose to merge their IPAs.

CBHS is made up of ten not-for-profit provider organizations, and one IPA (which is comprised of seven agencies) and covers seven counties. Shortly after the organization formed as a nonprofit in 2012, it became an IPA. The IPA allowed CBHS to provide integrated care solutions for individuals with complex healthcare needs. Partnering allowed these organizations to improve quality outcomes while working with various other healthcare entities including, MCOs, FQHCs, and hospital systems. In addition CBHS’s BHCC has 47 affiliates, including the largest hospital, FQHC, and health home providers in the region.

CCN is a not-for-profit IPA comprised of thirteen behavioral health providers serving Medicaid beneficiaries in five counties in the Hudson River region. While their focus is primarily substance use, services, CCN members also offer mental health services in Westchester and Rockland counties. CCN also partners with twenty-six health, housing, and prevention affiliates in an effort to provide solid supports to its growing client base.

When interviewed, leaders of both CBHS and CCN agreed that partnerships among behavioral health providers and between the specialty behavioral health community and the greater healthcare system were critical in delivering cost-effective quality care, and that adding value for primary care and hospital system providers will be essential to serving their community going forward. CBHS Co-Chair Liz Kadatz, Director of Operations of RSS, said about the merger: “We want to do the very best we can for these populations. We are committed and serious about building solutions. We expect we can do this through implementing ideas that work and learning from those that do not.” Likewise, CCN Co-Chair Adrienne Marcus, CEO of the Lexington Center for Recovery said that they “have
By Richard Gallo and Rachel Fernbach, Esq.
New York State Psychiatric Association

If signed into law by Governor Cuomo, New York’s parity reporting bill (A.3694-C/S.1156-C) will be among the most comprehensive laws of its kind in the country. The bill was passed by both the New York State Senate and New York State Assembly in the final week of the 2017/2018 Legislative Session, which concluded this past June. The passage of this legislation represents a major step forward in advancing parity compliance by health insurers and health plans.

The bill, called the “Mental Health and Substance Use Disorder Parity Report Act” would amend Section 210 of the Insurance Law, which requires the state to annually publish a Consumer Guide to Health Insurers. The Consumer Guide provides a ranking of insurance companies from best to worst based upon claim processing or medical payments made during the preceding calendar year. The new legislation would require insurers, health plans and behavioral health management companies to submit data to the state and information on parity compliance, including:

- Rates of utilization review for medical and mental health and substance use disorder (MH/SUD) claims and rates of approvals and denials, compared to medical and surgical claims
- Number of prior or concurrent authorization requests for MH/SUD services and number of denials compared to medical and surgical services
- Rates of appeal of adverse determinations for MH/SUD claims including rate of appeals upheld or overturned, compared to similar rates for medical and surgical claims
- Percentage of claims paid for in-network MH/SUD services, compared with the percentage of claims paid for in-network medical and surgical services
- Percentage of claims paid for out-of-network MH/SUD services, compared with the percentage of claims paid for out-of-network medical and surgical services
- The number of behavioral health advocates or staff available to assist policyholders with MH/SUD benefits
- A comparison of cost sharing requirements (co-pays and coinsurance) and benefit limitations (limitations on the scope and duration of coverage)
- Number of providers licensed to practice in New York State that provide MH/SUD treatment and diagnosis who are in-network (by type)
- The percentage of providers of MH/SUD services who remained participating providers

Any other data or metric the Superintendent deems necessary to measure compliance with MH/SUD parity including (i) capacity of the company’s in-network MH/SUD provider panels and (ii) reimbursement for in-network and out-of-network MH/SUD services compared to reimbursement for in-network and out-of-network medical and surgical services.

The state will evaluate the data collected to verify compliance with parity laws and publish its findings in a parity report. If the bill is enacted into law, the first such parity report would be published in September 2019.

Background on Parity

New York already has strong parity laws in place. Timothy’s Law, New York’s mental health parity law which was enacted in 2006, requires all group health plans to provide coverage for a minimum of 20 outpatient visits and 30 inpatient treatment days per year for the treatment of mental illness. Timothy’s Law also provides for unlimited coverage for adults with schizophrenia/psychotic disorders, major depression, bipolar disorder, obsessive-compulsive disorder, delusional disorders, panic disorder, bulimia and anorexia. The federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, expanded New York’s 30/20 benefit to a full parity benefit, requiring full coverage of all medically necessary treatment for mental health or substance use disorders.

Despite strong parity laws on the federal and state level, full implementation and enforcement of these laws has yet to be achieved. As evidenced by investigations conducted by the New York State Office of the Attorney General, health insurers and health plans continue to exhibit non-compliance, impeding implementation and inhibiting access to care.

To date, the Attorney General’s office has entered into settlement agreements with eight insurers in connection with policies and procedures that violate the parity statutes. As described in the settlement agreements, certain insurers continue to apply more stringent and frequent utilization review standards to MH/SUD benefits than to medical/surgical benefits and to deny care and treatment for MH/SUD benefits at a higher rate than medical/surgical benefits. In addition, insurers continue to apply medically necessary criteria and models inconsistent with applicable law and regulation, resulting in adverse coverage determinations and reduced access to care.

Advocacy Efforts

The original concept of an annual parity evaluation and report was advanced by NYSIPA’s Committee on Legislation and further developed in conjunction with representatives from organized psychology and organized social work with an intent to focus in large part on the most common areas of non-compliance identified by the Attorney General’s office. NYSIPA leadership engaged Senator Rob Ort (R-North Tonawanda) and Assemblymember Alice Smith (D-Scranton), the Chairs of the Senate and Assembly Mental Health Committees, respectively, to sponsor the legislation.

The original version of the reporting bill was introduced at the end of the 2016 legislative session, laying the groundwork for further advocacy in the following session. Upon further discussions and consultation, the legislation was amended in 2017 to add requirements for submission of additional data elements. In late May 2018, the bill was further refined to include an evaluation of network adequacy and in-network and out-of-network reimbursement as well as any other metric the Department of Financial Services deems necessary. The legislation was vigorously opposed by health insurers, health plans and behavioral health management companies who argued against increased reporting requirements.

However, as a result of advocacy on the part of mental health provider and consumer groups, on June 18, 2018, the NYS Assembly passed the legislation by a vote of 137-1. Two days later, on June 20th, the NYS Senate passed the bill by a vote of 60-0, in one of its final acts of the Legislative Session. Clearly, there was significant bipartisan support for this significant piece of legislation.

This success would not have been possible without the support of 22 different organizations, including organized psychology, organized social work, the Medical Society of the State of New York, other medical specialty societies and many consumer and provider advocacy organizations. Also essential were the individual grassroots efforts of providers who took the time to call and write their legislators, Senate and Assembly leadership and the bill sponsors in support of the legislation.

NYSIPA is very proud to have played an integral part in legislation that will have a significant role in improving parity enforcement and compliance and will positively impact consumers, families and providers across the state. Barry B. Perlman, M.D., longstanding chair of NYSIPA’s Committee on Legislation, was quoted in a Psychiatric News article on parity enforcement: “This is clearly one of the most consequential pieces of legislation undertaken by NYSIPA, and one that will advance the goal of fully implementing the spirit and intent of the federal and New York’s parity law that we all fought so hard to enact twelve years ago.”

At the time of publication, the bill had not yet been sent to the Governor’s office for consideration. Once it is sent, the Governor will have ten days to either sign or veto the legislation. It is essential that proponents of the bill reach out to the Governor’s office by phone, email or direct mail to express their support and urge him to sign the parity reporting bill into law.

To contact the Governor’s office regarding the legislation, please use the following link: https://www.governor.ny.gov/content/governor-contact-form.

Richard Gallo is the Government Relations Advocate for the New York State Psychiatric Association. Rachel Fernbach, Esq. is Deputy Director and Assistant General Counsel of the New York State Psychiatric Association.
The last few months have seen major advancements of TMS in the treatment of psychiatric illness. In August TMS was approved by the FDA for the treatment of Obsessive Compulsive Disorder, a third indication after depression in 2008 and migraine with aura in 2013 (this approval was broadened in September 2017 to include prevention of migraine). The FDA’s announcement included the following statement by Carlos Peña, PhD, MS, and director of the Division of Neurological and Physical Medicine Devices in the FDA’s Center for Devices and Radiological Health, “Transcranial magnetic stimulation has shown its potential to help patients suffering from depression and headaches; with today’s marketing authorization, patients with OCD who have not responded to traditional treatments now have another option.” The specific device approved is Brainsway’s H7 coil which targets the medial prefrontal and anterior cingulate cortices. The treatment takes 30 minutes and is administered five times a week for 6 weeks. One month follow-up outcomes showed significant benefit in active vs sham subjects. Because of Brainsway’s unique H-coil design, it may be some time before other FDA-approved TMS devices utilizing the traditional figure-8 coil receive approval for OCD. August also saw the FDA’s approval of a newer, much quicker TMS treatment for depression. Whereas traditional TMS depression treatments have relied on a 10-20Hz protocol taking anywhere from 18-40 minutes to administer, the new protocol utilizes a different pattern of TMS known as Theta Burst Stimulation (TBS). TBS protocols take as little as three minutes to administer and have been known in research circles for years as a faster and equally effective method of administering TMS. Currently, the only device to have received this approval is Magventure’s MagVita TMS Therapy system, though as the Magventure system employs the traditional figure-8 coil, it will likely not be long before other manufacturers receive this approval as well. Whether or not the faster TMS treatment will have an impact on insurance reimbursement remains to be seen - a treatment that used to take half an hour now takes three minutes, with some speculateing insurers will mandate patients first fail treatment with TBS to then receive other TMS protocols. There are numerous studies continuously being published that add to the growing body of literature supporting TMS as an effective treatment for psychiatric and neurological conditions, including just recently Tobacco Use Disorder, Parkinson’s, Somatic Symptom Disorder, and stroke. But one study published this summer in JAMA Psychiatry has received a lot of attention for being one of the few TMS studies that did not find a difference between active and sham treatment groups. The study, ‘Effect of Repetitive Transcranial Magnetic Stimulation on Treatment-Resistant Major Depression in US Veterans; A Randomized Clinical Trial,’ was an effectiveness trial and not an efficacy trial - participants with PTSD, previous Substance Abuse, and multiple medical comorbidities were allowed to participate as long as when asked by screeners reported depression as being their primary psychiatric problem as opposed to any other psychiatric condition. There was a mathematical difference of outcome in participants who had MDD without PTSD, which would have reached significance if this study was able to double the number of participants thus increasing its power. What might be more interesting though than how effective the treatment was for the active treatment group – 41% of active treatment participants achieved remission, is that the sham treatment group also reported such a high remission rate, 37%. Compare this to the 5% sham remission rate in the OPT-TMS trial (the study that lead to FDA approval of TMS for depression) as well as the 7% sham remission rate in the Neuronetics manufacturer’s trial, and one must wonder what is behind this discrepancy. This is not the first time a randomized clinical trial involving military veterans with psychiatric disorders in the VA system has failed to show efficacy for a treatment that had been effective in initial studies. Earlier this year, a VA study found no difference between Prazosin and placebo in the treatment of PTSD-associated nightmares. There was a negative randomized trial of sertraline for see TMS on page 27
Treatment Works! The Recipe to Recovery and Storytelling as Medicine

By Tom Wright, MD
Senior Vice President of Medical Affairs and Chief Medical Officer
Rosecrance Health Network

When I was training to be a child psychiatrist many years ago, I had a mentor who was one of the most well-known and beloved child psychiatrists in Illinois: Jay Hirsch, MD. Jay had many sayings, quotes, and “clinical pearls” he taught all of us and I continue to use today. One of my favorites was that he believed everyone had a story about their lives and why they were coming for help. He said that it was our job to find a way for our patients to feel safe to tell that story, and for us to hear it. He said that if we could do that, we’d be great psychiatrists. Recently, I was reflecting on these words: Storytelling can change the world.

There’s a lot of truth there. Storytelling acts as a sort of medicine and a rudder when all else feels directionless: stories we tell at the end of a long day; stories that bring people together over a meal and stories we turn to during our darkest of times. With that in mind and in the spirit of recovery month, I begin with a story of recovery from a Rosecrance client…

At Rosecrance we see over 30,000 clients annually and we hear a lot of inspiring stories along the way. Kristin I. recently shared her experience with Medication Assisted Treatment. After 20 years of abusing opioids, Kristin had lost nearly everything. However, she began actively working towards recovery and receiving monthly injections of Vivitrol to help control her cravings. It changed her life.

“I feel like everything I’ve tried to do to stay clean is finally working,” says Kristin. “I feel like I’m succeeding at something for the first time in my life.”

After treatment with Rosecrance Kristin now has more than a year of sobriety and begins school next month to become a substance abuse counselor. Her inspirational story certainly deserves celebrating, although it’s not altogether unique. Many of us have known or loved someone experiencing a mental health or substance use disorder. In fact, one in five Americans is living with mental health conditions according to National Alliance on Mental Illness (NAMI), and 21 million Americans experience substance use disorders, according to Substance Abuse and Mental Health Services Administration (SAMHSA).

The good news is…treatment works! Millions of Americans have transformed their lives through recovery. At Rosecrance, we experience that truth every day. We see individuals transform and lead productive, rewarding lives; we witness families being restored and communities working towards healing and wholeness.

As we celebrate recovery this month, we call attention to individuals, like Kristin, who have achieved and maintained their hard-earned recovery, but also inform and educate others on the level of commitment recovery really takes.

I like to think of recovery as a recipe that needs the right combination of ingredients. What does that recipe look like?

This year’s recovery month theme “Join the Voices of Recovery” focuses on four distinct pillars, health, home, community and purpose, which, very simply, serve as a basic recipe for recovery.

Health- Investing in physical, mental and emotional health and well-being is paramount to recovery. In many cases, health begins with successful treatment and establishing healthier lifestyle habits.

Home- Even after successful treatment, individuals still have to integrate back into their everyday lives and routines. This can be scary as recovery is often a complete lifestyle change. The ‘home’ ingredient includes establishing new routines, new people, places, things and support, new coping skills and new ways of thinking.

Community- Staying involved in the recovery community is integral to overall success. It provides an individual with a support network where they can receive helpful feedback and encouragement; stay connected and be held responsible for their actions and decisions.

Purpose- Purpose helps sustain and maintain recovery. Individuals may experience a new found life purpose through their recovery, which motivates and drives them to continue moving forward. For many, this includes giving back and sharing their story.

Transition at NYTC – Stay’n Out Programs

By Staff Writer
Behavioral Health News

Ronald Williams, Founder and the President/CEO announced his retirement, effective July 2018 – after which he will continue in a part time capacity, and subsequently a member of the NYTC Board of Directors. NYTC, Inc was founded in 1977, and has over forty years of experience providing substance abuse treatment to adults in the criminal justice system. They operate community-based programs utilizing a therapeutic community (TC) model. The mission is to help participants effect changes in behavior and attitude that will enable them to make those choices appropriate to a healthy, positive lifestyle. Since its inception in 1977, NYTC has successfully treated thousands of men and women, helping them to lead productive lives, free of involvement with drugs and crime.

Mr. Williams began his career in the substance abuse field over 50 years ago as one of the founders and first graduates of the Phoenix House organization, where he held clinical and administrative positions. During his many years of involvement in this field he has served as an expert in demand reduction and as a technical assistant advisor and trainer for the US Department of State.

Mr. Williams is the Founder of the NYTC, Inc., Stay’n Out in-prison Therapeutic Community that served male and female inmates of the NYS Department of Corrections for over 30 years. The Stay’n Out program was the first such in-prison therapeutic community (TC) program that was independently researched from inception and whose impressive success rate attracted National and International attention and replication. Mr. Williams also implemented the Serendipity Community-based TC program or criminal justice clients returning from incarceration and, also as an alternative to incarceration. Participants of NYTC programs are currently served in both residential and outpatient modalities.

Mr. Williams has assisted in the implementation of the NYS Residential Treatment Centers in 32 states and several foreign countries, including, Malaysia, Thailand, Columbia and Italy. Mr. Williams has served as Vice President of Therapeutic Community- Criminal Justice Task Force of that association. In this position he led the successful effort to develop and implement accreditation standards for in-prison Therapeutic Communities through the American Correctional Association. These standards have also been adopted by the Federal Government.

Ronald Williams has received numerous awards including commendation by the NYS Bar Association for outstanding contributions to the Rule of Law and the Administration of Justice. He has also been awarded the Saint Bonaventure College Award for excellence in Public Service and the NYS Governors Lifetime Service Award for extraordinary dedication and years of service in the field of addiction.

Mr. Williams states, “As Founder and Developer of this landmark program, I take great pride in having served as its President/CEO for the 41 years of its existence. I am pleased to announce that a friend and colleague, who has served as my Executive Vice President, will assume the position of President/CEO. This is more than well deserved. I wish to thank my Board of Directors for their ongoing support, our exceptional funding source, OASAS, and the OASAS Sister Agencies, and the outstanding Staff of NYTC Inc., who have made this magnificent journey possible. Above all, my thanks and admiration to the clients that we have served throughout the years and who by their success, proved that NYTC, Inc. is an exemplary program.”

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By Amanda Semidey, LCSW, and Kathleen Rivera, LCSW  
CBC and JCCA

C ommunity-based care management (CM) services, in general, and specifically those geared toward children and families, have historically been fragmented. Prior to the Patient Protection and Affordable Care Act (ACA), New York State had a wide array of disparate CM services, including Targeted Case Management (TCM) serving children with severe emotional disturbances, Voluntary Foster Care Agencies (VFCA) providing case management to children separated from their caregivers, State Plan Services, and 1915c Waiver Programs to name a few. In 2012, New York State opted to implement Health Home (HH) under Medicaid Redesign (MRT). Health Home was thus defined as the mechanism/vehicle to address health care fragmentation and ballooning population health concerns (Thomas E. Smith, Matthew D. Erlich, & Lloyd I. Sederer, 2013), intended to support a more integrated model of service delivery shifting the practice standard from siloed to collaborative practices (Mechanic, 2013). The health home model’s whole-person approach — encompassing comprehensive care management and coordination, integration of physical and mental/behavioral care, and links to non-clinical supports — thus has the potential to improve the overall health and quality of life for some of the most vulnerable Medicaid beneficiaries” (U.S. Department of Health & Human Services Assistant Secretary for Planning & Evaluation Office of Disability, 2017).

In New York State the Health Home was identified as the hub and gateway to Community-Based Care Management (CBC) services and the Health Home Serving Children (HHSC) model was expected to provide “no wrong door” access to an array of critical Care Management services for children beginning in December 2016. By linking individuals to behavioral health and medical providers, Children’s and Community-Based Care Management is expected to monitor and more successfully transition children and families to appropriate needed services. Despite this, many medical providers remain unfamiliar with the process of enrolling children and are reluctant to make referrals to Health Home Serving Children programs (Citizens Budget, 2018). This fact remains true even when providers recognize that comprehensive care management is needed and will result having in social determinants of health needs addressed, and behavioral health services offered to some of the youngest and most vulnerable patients they serve. The challenge for many medical providers has been in understanding how they can refer their patients, while parents and caregivers may continue to have difficulties accessing the right services at the needed intervals due to “separate social-service realms and divergent funding streams” (Center for New York City Affairs, 2018).

Coordinated Behavioral Care (CBC), a member-led organization, established in 2011 by many of New York City’s behavioral health and human services providers, offers a vast array of medical, behavioral health, rehabilitation and supportive housing services across the 5 boroughs, was designated a Lead Health Home in 2012. CBC’s Health Home provides city-wide

By Ilene Lainer  
Co-Founder and President  
NEXT for AUTISM

S ince 2003, NEXT for AUTISM has launched an average of 1.5 programs per year, a pace that matched the urgent needs of individuals and families living with autism and our own desire to help grow the field of autism services. As proud as we are of this pace, we could not have achieved it alone. We wanted to go fast, and we also wanted to go far.

NEXT for AUTISM has understood that in order to accelerate change, we had to build partnerships. Rather than reinvent the wheel, we chose to enhance quality services that already existed, particularly for people with developmental disabilities other than autism, and adopt them to meet the specific needs of the autism population with evidence-based strategies. We rely on data to assess the needs, then build on best-in-class solutions to transform the landscape of autism services for people with autism.

Our partnerships involve public and private entities, as well as collaborations among not-for-profit organizations. They succeed in affecting systems transformation in large part, due to a high level of commitment at the leadership level of each partner organization; a shared institutional drive towards innovation and a comfort with program iteration; the dedication and professionalism of the founding staff at each newly launched entity; and the continued support provided by each partner to the new entities at critical stages of growth.

Large-Scale Partnerships

The NYC Autism Charter School in Harlem opened after several years of collaboration among three key partners: NEXT for AUTISM, which identified the need for evidence-based education for children with autism in New York City, originated the idea for the school, and recruited private donors; the New York State Board of Regents, which issued the charter; and the New York City Department of Education, which operates the school. This public-private partnership resulted in high-quality, evidence-based public education options for families in the five boroughs of New York. Among the innovations were community-based instruction, work internships, and peer mentoring programs. The school has since been replicated in the Bronx, fulfilling NEXT for AUTISM’s wider transformational goal – in this case, creating capacity in a large, metropolitan school system to rethink education for children with autism and create two specialized autism schools inside of already existing public schools located in underserved communities.

The Center for Autism and the Developing Brain (CADB) was conceived at a time when families facing an autism diagnosis often had to coordinate disparate services while simultaneously trying to understand what a diagnosis of autism truly meant for their child and their family. NEXT for AUTISM, whose founders and board members are parents themselves, approached NewYork-Presbyterian Hospital and its partner medical schools, Columbia Vagelos and Weill Cornell, as partners to address this immediate need for a more rationalized approach. Our vision was to create a family focused diagnostic and treatment center offering comprehensive and coordinated treatment by clinicians from multiple disciplines. We also sought to build capacity for autism research within a major metropolitan hospital system.

Throughout several years of planning, the partners formulated details that ranged from CADB’s clinical approach, to leadership recruitment, affordability of services, and the bricks and mortar renovation of a dedicated building on the Westchester campus of NewYork-Presbyterian. The outcome was a state-of-the art center, led by one of the country’s foremost experts in autism, Founding Director Dr. Catherine Lord. Since 2013, CADB has

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Building Partnerships to Transform Autism Services

By Ilene Lainer  
Co-Founder and President  
NEXT for AUTISM

Ilene Lainer
Leaders Join Mental Health News Education Board

By Staff Writer  
Behavioral Health News

Mental Health News Education, Inc. (MHNE), the nonprofit organization which publishes Behavioral Health News and Autism Spectrum News, is pleased to announced three leaders who will be joining the organization’s Board of Directors this fall. Debbie Pantin, MSW, MS-HCM, MHNE Board Chair and President and CEO of Outreach, remarked, “We are delighted to welcome three new outstanding leaders to MHNE’s Board of Directors. They represent vital sectors of the nonprofit and corporate community that support the behavioral health and autism education mission of our organization.”

Roy Kearse, LCSW, Vice President for Recovery and Community Partnerships  
Samaritan Daytop Village

Mr. Kearse stated, “I am honored to join the MHNE Board of Directors and will endeavor to help this vital organization further its’ behavioral health and autism education mission.”

Matthew Loper  
CEO and Founder  
Wellth

Matthew Loper has long been interested in scalable approaches to improve the health and wellbeing of people. He studied biological engineering at MIT in the hopes of someday developing novel therapeutic treatments for those who suffer from previously untreatable conditions. But after experiencing the realities of academic research, he strived to get exposure to the healthcare industry from more of a commercial and entrepreneurial point of view and headed to Wall Street. After working in the Healthcare Investment Banking Division of Goldman Sachs, he headed to OrbiMed Advisors, a healthcare focused investment firm that manages $14 billion and has funded some of the most impactful pharmaceutical, biotech, and healthcare services companies in its 20-year existence.

In 2014, while at OrbiMed, he was struck by the idea of using scalable digital interventions and behavioral economics to improve the behaviors and outcomes for individuals with chronic conditions. He started Wellth to accomplish that goal and has raised $7.5 million of venture financing from strategic investors including large insurance companies like AAX and NY Life as well as large pharma companies like Boehringer Ingelheim.

Mr. Loper stated, “I am excited by the mission of Mental Health News Education, and its’ important focus on mental health issues that has been overlooked by our health system, society, and government for too long.”

Keri Primack, CFP, Managing Director, Senior Vice President and Client Advisor  
Gerstein Fisher

Keri Primack, CFP, joined Gerstein Fisher, an investment management and advisory firm, in March 1998 and is currently a Senior Vice President, Senior Client Advisor. Before joining Gerstein Fisher, Ms. Primack worked in the property casualty division of the insurance department for the BWD Group Ltd, and in the life insurance department for Nathan & Lewis Securities. She started her career at IDS, as an assistant to a financial advisor.

Ms. Primack is a Certified Financial Planner (series 7 and 63 registered), and a graduate of the State University of New York, Oneonta with a Bachelor of Science degree in business economics.

A native New Yorker, Ms. Primack lives on Long Island with her husband, Adam, and their two children, Ian and Blake.

Ms. Primack stated, “I am very dedicated to the autism treatment, advocacy, and education mission of MHNE’s publication, Autism Spectrum News, and look forward to assisting in MHNE’s vital efforts to help families learn about and cope with children on the autism spectrum.”

MHNE Founder and Executive Director, Ira Minot, LMSW and Associated Director, David Minot, stated, “We are both so honored and excited to have Roy, Matthew and Keri join the MHNE Board. Their backgrounds and expertise in the behavioral health, corporate, and autism communities will help us greatly in charting the future course of our organization.”
strained by caregiver duress, will be routinely assessed, monitored, and supported.

True rapprochement between the behavioral health and substance abuse worlds: Neuroscientific findings proving the connections between mood and anxiety disorders and substance use will lead insurers to insist that behavioral health and substance abuse services co-locate and integrate. This momentum will ensure that therapeutic and medication assisted treatment are provided based on each person’s needs and wishes, unrestrained by provider biases, and informed by science.

A healed rift between behavioral and physical health: In the future, all medical settings of every subspecialty will have behavioral health providers on their teams to provide services tailored to a consumer’s given condition (be it cancer or Crohn’s disease), psychological status (merely stressed or sunk in despair) and social stratum (resource-rich or low income). All independent behavioral health agencies will have established ties and easily accessed communication systems to surrounding medical facilities to share patient data, medication lists, and treatment plans for far better care coordination. Consumers and family members will no longer feel that one “healthcare hand” doesn’t know what the other hand is doing.

A command of complexity: Behavioral health agencies are already ahead of their physical health counterparts in identifying the highest-need consumers and creating wrap-around services to keep them out of emergency rooms, hospitals, and jails. They will continue to refine their approach to those at highest need by further extending into these and other sectors and community settings and networks. In the future, complex care management will be more advanced and effective, using predictive analytics, rather than hospital readmission rates and related metrics to identify consumers who require more intensive services across multiple settings. Outreach, engagement, and intervention will benefit from local liaisons and advisors whose community health workforce will be best able to engage high risk individuals and populations.

Expanded Ease of Access: Most outpatient services will include interprofessional, cross-trained and highly collaborative teams able to offer individualized care when and where needed and as informed by meaningful demonstration of success with similar conditions. Consumer feedback and data analytics will guide will guide ongoing attention to ensuring that teams are culturally and linguistically competent, and providers will have support to identify and address even their unconscious biases. Cross sector collaborations will support stratification and intervention to deploy these interprofessional teams, including medical and social experts, who will treat consumers holistically in their homes, communities and, when critical, within facilities. Telehealth and telemetrics will routinely and seamlessly reinforce care delivery at every stage of treatment and provide access in areas and settings facing provider shortages.

A firm grasp on value: Costs for this “go-anywhere/do-everything”, team-based care will be borne by shared savings, reductions in hospital utilization, and banded/blended funding from across the health and human service systems. Increasingly consolidated, multiservice providers will be organized into integrated networks to share resources and efficiencies. They will benefit from quality indices and population health strategies that help them pivot proactively to address emerging issues and target high-need/high-cost consumers with new or more intensive services. The result will be better overall care for all, especially the most vulnerable and populations that are currently devastated by health disparities.

During leadership: Leaders who thrive in the future will continue to be those who are bold, compassionate, and ready to take risks. They will direct organizations that attend to provider wellness and wellbeing with as much attention as to consumer wellness and wellbeing. Data-informed management systems will target provider support and training for providers based on measures of their performance outcomes, productivity, and satisfaction. Leaders will be supported by involved board members who share a commitment to progress and innovation.

Robust and transparent quality systems will guide and inform efficient and productive team-based care in a culture that...
A Performance-Driven Culture in a Children’s Mental Health Agency

By Andrew Malekoff
Executive Director, North Shore Child & Family Guidance Center

Developing a performance-driven culture in the children’s mental health system is a complex process that includes engaging, assessing, treatment planning, gathering data, measuring outcomes, and evaluating and continually improving care.

Although evidence-based practice (EBP) has become a norm, treatment-based evidence must also be considered given the multiple variables in play that do not adhere to the laboratory conditions within which EBPs were formulated.

For example, attention to crises and collateral contacts with family members and child-serving systems is essential to any credible children’s mental health service.

There are costs associated with collateral contact, which can be especially costly in the children’s mental health system. The payer mix is also important to understand.

Measurement Criteria and Continuous Quality Improvement

It is best to select data that is likely to show change and success, using data that is measurable and actionable. For example, data that measures engagement and retention can lead to planning and action steps to improve practices that lead to children and their families staying in treatment.

Using a continuous quality improvement (CQI) model aiming at incremental change can help. This might include considering the following three questions: (1) how are we doing? (2) how do we know? and (3) can we do better?

A Plan – Do – Study – Act (PDSA) approach can then be used for implementing incremental change projects.

For example, at North Shore Child and Family Guidance Center we keep...
The staff also had a strong foundation in social determinants of health and their overall impact on behavioral health and health outcomes. The investment of Master’s Level staff, oftentimes at a higher salary, was nonetheless made to safeguard that the pilot was initiated with skilled staff with expertise in delivering personalized engagement and care planning. This seasoned staff was the gateway to JCCA’s broader specialized for children’s engaged families in a professional and person-centered way related to Community-Based Care Management services and HHSC’s program. The staff needed to be nimble, and despite the multiple stakeholders involved, an expectation was set that alliance would be in the best interest of the child and family served. The expectation was established that the intake/outreach coordinator would ensure a warm hand-off to CBC’s HHSC and JCCA’s Care Management program and communication of the disposition of the referral was shared with the referent.

Communication & Relationship Building: Community providers have historically coped with patient needs that have afforded stakeholders an opportunity to view each other as collaborators, yet it remains important to address “buy-in.” The longstanding “what’s in it for me?” mentality would need to modify their traditional referral processes. Both entities rallied their workforces, guided by the goal of creating access, engagement and enrollment to HHSC services, with a shared understanding that this focus would improve the health and behavioral health outcomes of all enrolled children. Promoting an efficient enrollment process was paramount to the success of the pilot. A few tenets have guided this collaborative endeavor, including a unique focus on the intersection between the provider (MMC), the Lead Health Home (CBC) and the Care Management Agency (JCCA), while at the same time not losing sight of the child and family served. Here are some best practices and lessons learned from our pilot:

**System from page 8 reminder phone calls, to car services to help us get across town, these simple services help us follow through with care and stay motivated.**

"Back in the day when I first came here, I wasn’t going to any appointments or groups. I didn’t care. I just got my apartment and I was happy that I wasn’t on the streets. But everything changed and it’s gotten much better...I don’t want to miss anything because I want to progress."

The reassurance of knowing that services are available: Thinking back to the way services have changed, we also realized that, in some ways, transformations in care have paralleled changes in how society speaks about mental health. Initiatives like New York City First Lady Chirlane McCray’s ThriveNYC, acknowledging mental health, educating the public that mental illness is nothing to be ashamed of, and promoting available services are not only helpful in breaking stigma, but also help us feel empowered along our path: and to keep going...And I haven’t utilized or needed a Care Coordinator, I practice something called mindfulness, which, to be honest with you, has been one of the major factors in allowing me to stay on the true path. I’ve had no drugs, no crime...But if I ever reach the point where I believe I need a Care Coordinator, I know who to call. I know about these services and am aware that they are available. If I ever need it, I’ll take advantage of them.

While our experiences have been mostly positive, we still see challenges in the current system of care. Some of us expressed confusion about all the services available to us, not knowing everything available to us, not knowing everything at

In order to minimize the length of time from referral to outreach/enrollment activities, MMC provided access and trained JCCA staff on their electronic health record (EHR) systems. This enabled the intake/outreach coordinator to quickly access referrals, connect with the families immediately at the clinic or in the community, and begin the engagement and enrollment process promptly. This workflow enhancement not only reinforced the ability to identify methods of obtaining necessary supporting documentation used to determine HHSC eligibility and appropriateness criteria for Care Management services.

Outcomes & Programmatic Enhancements: There was an understanding that roadblocks and obstacles would need to be addressed along the way. The goal was to start small and learn as we progressed. MMC provided space several days a week for JCCA staff to engage families privately. Space, always being a scarcity, proved to be both invaluable as it communicating a formal extension of the services rendered at the Newkirk Family Health Center and, on occasion, a challenge as well. Long-term goals at both MMC and JCCA were recognized, with some system transformation must include all stakeholders ultimately be successful. The longer-term impact of these transformations remains to be seen. The Co-Location Care Management Model has yielded early modest successes and CBC, JCCA, and MMC continue to coalesce our programs around the goals to provide the quadruple aim: better care, improved health outcomes, lower healthcare costs, and improved experiences by individuals meaningfully engaged in their health outcomes. We remain committed to designating opportunities such as this one toward the ongoing improvement of children and young adults’ system of care, while simultaneously adapting to the larger healthcare system transformation.

About the authors: Amanda Semidey, LCSW, is Vice President of Care Coordination at Community Behavioral Care Association (JCCA). For more information regarding the Co-Location Care Management Model, contact Amanda Semidey at Asemidey@cbcare.org or visit our website at http://www.cbcare.org.

Co-Location Care Management Model has allowed CBC, JCCA, and MMC to strengthen the service delivery system, while working toward the ultimate goal of integrating care for children and their families. While these findings demonstrate early successful collaborations, CBC, JCCA, and MMC continue to focus on building a strong alliance, with the identified undertaking of community access to Care Management services aimed at prevention and improved outcomes. Starting in July 2018, the Co-Location Care Management Model was expanded to include referrals from MMC’s Pediatric Emergency Department and Pediatric Inpatient units. Their numbers thus far may be modest, with only 20 referrals from the hospital directly; nevertheless this reinforces the commitment to creating pathways to healthcare and Community-Based Care Management services.

CBC, along with our partners JCCA and MMC, aim to be at the forefront of changes in the overall health care delivery system in order to ensure all individuals receive needed services in their community in the most expeditious and appropriate manner. Our mission has allowed the stakeholders to focus on both short and long-term goals, while recognizing that a system transformation must include all stakeholders ultimately be successful. The longer-term impact of these transformations remains to be seen. The Co-Location Care Management Model has yielded early modest successes and CBC, JCCA, and MMC continue to coalesce our programs around the goals to provide the quadruple aim: better care, improved health outcomes, lower healthcare costs, and improved experiences by individuals meaningfully engaged in their health outcomes.

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Promise and Peril from page 10

PTSD, despite the FDA’s approval of the drug for this condition. Other examples include a negative trial of trauma-focused psychotherapy for PTSD, a negative trial of FDA-approved naltrexone for alcoholism, and a negative trial of depot risperdone (vs. oral) for schizophrenia - all in solely VA populations. Why is the veteran population so often at odds with the general population? One proposed reason lies in who these people are and the training they received. All of these study participants go through a minimum basic training i.e. boot camp where the purveying ethos is no man left behind; these are people willing to take a bullet for one another. Devotion to the cause, “esprit de corps”, is impressed heavily upon veteran soldiers and lasts a lifetime. Though a veteran themselves may not be experiencing benefit of a particular treatment or therapy, they may be inclined to see that one of their combat brethren has the opportunity for wellness, and over-report improvement to make a particular therapy or medication available to all, not appreciating the impact this has on statistical analysis.

There are numerous proposed reasons studies of the VA population often do not coincide with studies of other populations. Medication compliance, selection bias, and secondary-gain issues among them. The VA however, thankfully, is familiar with the shortcomings of studies performed in their facilities, and practitioners in this community continue to prescribe Prazosin for PTSD-associated nightmares, depot risperdone for Schizophrenia, and naltrexone for alcoholism. Recommendations in VA practice guidelines state that sertraline be used as first-line pharmacotherapy for PTSD, with trauma-focused psychotherapy promoted as first-line evidence-based psychotherapy. Finally, with the data from this recent TMS study in front of them, the VA purchased 40 TMS devices for use in its facilities around the country.

Indeed, these are exactly the type of findings in the field of TMS. This summer I had the pleasure of working with neuroscientists in the brain stimulation labs at the Medical University of South Carolina, where TMS is used to measure consciousness, EEG-guided TMS, TMS for pain, cocaine addiction, and acute suicidality, are not far-off theoretical concepts, rather their future applications are being tested right now, and that model is being applied broadly in many neuropsychiatric conditions.

Dr. Shapiro is currently a fourth-year postdoc in Westchester Medical Center in Valhalla New York. adam.shapiro@hotmail.com.

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Autism Services from page 22

Project SEARCH – Autism Enhancement, a training package offered to institutions wishing to prepare adults with autism for successful employment, evolved from NEXT for AUTISM’s collaboration with Project SEARCH at the Cincinnati Children’s Hospital Medical Center, an internationally recognized employment training service for people with significant disabilities. We first approached Project SEARCH to develop a comprehensive program enhancement, with clear sequences and goals that target the strengths and challenges of learners with autism. We then invited the TEACCH Autism Program at the University of North Carolina to work with us on the current autism enhancement package.

This three-way partnership resulted first in a high-school transition program that operated out of the Center for Autism and the Developing Brain at NewYork-Presbyterian Hospital in further partnership with the Southern Westchester Board of Education Services. From lessons learned and successes in this earlier internship program, the partners went on to develop the current Project SEARCH – Autism Enhancement package, which provides the framework for job and life skills training to adults. To date the package has been implemented nationally at sites including Drexel University, the University of California at Irvine, the University of Washington, Seattle, and again by NEXT for AUTISM at NewYork-Presbyterian Hospital in partnership with The Arc Westchester.

ADVICE emerged from the growing demand among companies to diversify their workforces and NEXT for AUTISM’s recognition that there were not enough specialists to help develop the capacity of corporations to integrate people with autism. NEXT for AUTISM has always been a firm believer that a broad range of people with autism can be excellent employees provided they have the appropriate supports. Together with Autism Speaks and led by a nationally renowned expert, James Emnett, we created ADVICE to train a cadre of consultants who will fan out to companies and provide management training on such areas as supporting people with autism at work, creating workplace structures to ensure successful outcomes, and employee sourcing. Corporations such as Cintas, Staples, and Quest Diagnostics have joined this partnership, resulting in hundreds of managers trained and an equal number of autism hired.

Please visit www.nextforautism.org for more information.

Employment Training for Adults with Autism

Project SEARCH – Autism Enhancement, a training package offered to institutions wishing to prepare adults with autism for successful employment, evolved from NEXT for AUTISM’s collaboration with Project SEARCH at the Cincinnati Children’s Hospital Medical Center, an internationally recognized employment training service for people with significant disabilities. We first approached Project SEARCH to develop a comprehensive program enhancement, with clear sequences and goals that target the strengths and challenges of learners with autism. We then invited the TEACCH Autism Program at the University of North Carolina to work with us on the current autism enhancement package.

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Promise and Peril from page 10

The past Chairperson of the Criminal Justice Committee of the Alcohol and Substance Abuse Provider (ASAP) Association of New York State (ASAP) joined New York Therapeutic Communities, Inc. (NYTC) in 1998 as the Regional Director, primarily responsible for oversight of the Stay’n Out in prison TC programs and was named Vice President of Clinical Services in 2005 and Executive Vice President in 2008. During this time, he has been instrumental in the agencies growth into outpatient treatment, management of the Executive Community health organization, oversight of the NYTC education and training programs and most recently in establishing an enhanced outreach and engagement program for opioid users in Brooklyn.

In accepting the position, Mr., Varma stated “I look forward to continuing the NYTC philosophy of delivering high quality, effective, client-centered care and to building on the over 40 years of success of this organisation in providing drug and alcohol services which previously may have been unavailable to all, not appreciating the impact this has on statistical analysis.

Seep Varma is a NYS Licensed Clinical Social Worker, and CASAC, and has been with NYTC for 20 years. He holds a MS degree from Columbia University School of Social Work, and a certificate in Non-profit management from the Har- vard Business School. He currently serves as the Chair of the Coalition for Community Services, is the Secretary of the Board for the Association of Alcoholism and Substance Abuse Providers (ASAP), and serves on the Board of the Treatment Communities of America (TCA).

Mr. Varma began his career at Hospitality House in Albany, New York. He has also worked as a Psychiatric Social Worker at Bellevue-New York University Medical Center and as Senior Case Manager for Treatment Alternatives to Street Crime (TASC). He has assisted in the development of a Psychiatric Social Work and Psychiatric community training curriculum for the University of Missouri, served as consultant for the National Development and Research Institutes (NDRI), and served as Teamwork and Culture Change

Small teams of staff members developing time-limited changes projects work best. Having some institutional knowledge of group work planning and development is essential to developing successful teams that are problem-focused and do not collapse prematurely or endlessly floundering. There are fundamentals to building a successful team that cannot be taken for granted. Most critical is proper planning, which includes clearly defining the needs to be addressed; formulating a clear purpose; affirming logistics that are acceptable to all team members and sanctioned by administration; and defining roles.

Time-limited cycles of up to four weeks in duration are best, as not to schedule meetings that have no end in sight. The key is then to follow-up texts and discovered that texts have the greatest impact in improving rates of attendance.

Hearts and Minds

A performance-driven culture is about what you do well, how you will measure its value and success, and how you contract for value-based rates.

For many organizations this may represent a culture shift. Agency leadership is required to keep the momentum moving forward, continuing to educate staff members and bringing them on board with their full hearts and minds.

Mr. Malekoff may be reached at North Shore Child & Family Guidance Center, at amalekoff@northshorechildguidance.org.
Merge from page 18

a lot to learn from CBHS, and hopefully they will learn from us…we want to better serve these populations and can do so through this merger.”

Photo Details: Back Row (L): Mark Savvary (Hudson Valley Mental Health), Seth Diamond (Westchester Jewish Community Services), Elizabeth Kadatz (Rehabilitation Support Services, Inc.), Amy Gelles (The Guidance Center), Ashley Brody (Search for Change), Katarina Hoosas (Access Support for Living), Andrew O’Grady (Mental Health Association of Dutchess), Jeff Spitz (Restorative Management); Middle Row (L): Saqib Altaf (Hudson Valley Community Services), Susan Sayers (Coordinated Behavioral Health Services), Andrea Strauss (Hudson Valley Community Services), Charlotte Ostman (Mental Health Association of Westchester), Amy Anderson-Winchell (Access Support for Living), Kathy Pandekakes (Human Development Services of Westchester), Nadia Allen (Mental Health Association in Orange County, Inc.), Pat Lemp (Westchester Jewish Community Services), Stephanie Vargas (Mental Health Association of Rockland), Lydia Edelhaus (Mental Health Association of Dutchess); Sitting (L): Diane Russo (CoverCare Center), Susan Miller (Rehabilitation Support Services, Inc.), Eric D’Entrone (Arms Acres/ Liberty Management), Adrienne Marcus (Lexington Center for Recovery), Alison Carroll (CoverCare Center), Charles Quinn (RECAP: Regional Economic Community Action Program); Missing: Sonia Wagner (Mental Health Association of Rockland), Stacey Roberts (Mental Health Association of Westchester), Kelly Darrow (Human Development Services of Westchester), Polly Keggian, Aron Reiner (Bikur Cholim);

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talked about needing a place like the Hub. The only thing we were missing was ICL.” I took what she said as both a great honor and a profound responsibility. The Advisory Council, which Cruz is an active member of, continues to help us understand the structural and cultural barriers to health and well-being as well as service gaps and program needs.

The Council is helping ICL establish formal linkages with community-based organizations to allow the Hub to make available additional support related to conditions that can cause or exacerbate health concerns, like legal services, domestic violence support, or advising on entitlements and housing.

Central to our community engagement plan is collaborating with clergy. We’re working with faith-based communities and local ministers and religious leaders to address how we can help support church members and how clergy can help us better understand, to the importance of role religion plays in the life of the community.

Recipe from page 21

Of course, in order for this recipe to flourish, we must recognize hurt and healing comes in many forms and each individual has a unique set of circumstances to consider. We must also keep combatting stigma, removing barriers to treatment, improving access to care, developing new treatment modalities and allowing individuals the appropriate amount of time to get well.

Still, I’m happy to say Rosecrance has helped thousands of clients get this recovery recipe right! And, we will always bring more people into the conversation of recovery so that, together, we can celebrate and incite change.

So, whether you work in the addiction or mental health field, you are in recovery yourself, know someone in recovery or have a family member who happens to be reading this, I urge you to get involved. Get educated. Share your stories and, most importantly, be a voice for recovery through the month.

Dr. Thomas Wright is the Senior Vice President of Medical Affairs and Chief Medical Officer at Rosecrance, a non-profit organization and national leader in substance use and mental health treatment services.

Collaborations from page 18

behavioral and medical conditions and uses wrap-around enhancement funds to address immediate, easily resolved social needs, such as food and clothing, to secure trust and engagement in care. The HEALTHI multidisciplinary teams’ outreach efforts are in person at the individual’s address, known hangouts, and/or through known social networks. If an individual is hospitalized at the time of referral, the HEALTHI team engages with them, as well as the inpatient staff, at the hospital and plays an active role in the discharge and aftercare planning process as both their advocate and a community services expert. This is a time-limited 6-month intervention that begins with assertive outreach and engagement, continues with intensive care management and ends with transition to community-based services to maintain recovery. The teams have small caseloads to enable the level of intensity needed to connect and manage the care needs of this population.

The HEALTHI team provides 24/7 on call coverage, ensuring individuals have access to community services and care at all times. The team also utilizes CBC’s network of community-based services to expedite access to crisis care such as respite beds and weekend clinic services. Since April 2018 the HEALTHI team has enrolled 48 individuals, with 92% engagement and connection to primary care; 90% of those discharged from a hospital had an outpatient visit within 30 days, and 100% of people with schizophrenia prescribed an antipsychotic medication were adherent with their prescribed medication regimes. Though outcome data for the DSRIIP year is preliminary, the team has closed over half of the identified “Gaps in Care,” which promote better health and community tenure.

Additionally, CBC is working closely with the Mount Sinai PPS on another hot-spotting intervention program, Community Outreach for Recovery and Engagement (CORE). This partnership with The Bridge was launched in mid-July to provide outreach and engagement for high-utilizers of Emergency Department (ED) and inpatient services identified by the MS PSS partner agencies. CORE consists of a multi-disciplinary team with a primary goal to outreach, enroll and provide care coordination to 50 high utilizers over the year. In the first 2 months of the program, the staff has reached out 33 individuals with over 50% successful enrollments in CORE. The team continues to work on engaging individuals in outpa
tient behavioral health treatment, facilitating appointments for primary care to manage chronic health conditions, and tackling many of the social determinates of health, like housing stability and food security. During this 6-month intervention, the mission of CORE is to provide intensive support in order to stabilize and transition individuals to ongoing community-based services.

In 2014, CBC embarked on the implementation of an innovative care transition program called Pathway Home, which has, through a multidisciplinary team approach and the use of Critical Time Intervention (CTI) techniques, significantly improved community outcomes after long-term psychiatric inpatient hospital stays. Initially, a one year grant funded program, the astonishing outcomes and improvement in health outcomes led to a partnership with the New York State Office of Mental Health (OMH) and the expansion of the program to serve additional populations. Pathway Home is a high-touch, intensive, care coordination program that promotes pre-discharge engagement, immediate needs assessments, peer role modeling and connection and engagement with community providers. During this 9-month intervention, individuals are supported by a team, with a focus on increasing community tenure and avoiding readmission to the hospital and partnering with community services for the Underserved (SUS), Catholic Charities Neighborhood Services (CCNS) and Institute for Community Living (ICL) in the care delivery and the teams use the extensive services of the wider CBC provider network to ensure successful community outcomes. Currently serving over 500 people annually, Pathway Home outcomes include over 90% aftercare follow-up to behavioral health appointments, 94% with no hospital readmissions and a 77% enrollment in Health Home care management services.

CBC’s network of community-based providers understand their communities and have been historically addressing gaps in care and will continue to realize more meaningful outcomes for individuals most in need. In an era of significant and serious healthcare system transformation occurring at the Federal, State and local level, community-based partnerships like these will continue to be the future of healthcare reform. By understanding communities, addressing gaps, and working together, CBC network providers will continue to improve on population health outcomes, reduce healthcare costs and increase consumer satisfaction.

Since the start, the Hub project has been defined by dedication and collaboration. It’s a true team effort -- from the funders and board and my role with the Advisory Council, which brought together the architects and designers who took up the challenge of creating the center that fulfilled our vision. And our committed and talented staff did the heavy lifting to get us to the finish line and continue to do the work of healing and supporting all those who come to us for help.

We are optimistic that the Hub will bring the people of East New York the improved access to care they deserve and better serve a community that has been highly underserved for generations. And it may well be a model that could be replicated around the city, the state and even the country.

Whatever “door” people enter at the Hub, we believe they will find the finest care and the process experience a sense of improved possibilities for their future and the future of the community.

Come visit the East New York Health Hub and see for yourself how health and behavioral health care can live together – and help people flourish – under one roof.

Looking Ahead
ACES from page 6

does not end with understanding our clients’ experiences. While “trauma-informed practice” is an increasingly well-known service approach, we must also focus on the inevitable impacts of vicarious trauma on our sector. Yet mere recognition of our own trauma experiences is not enough – we also need to reflect on how our experiences influence our interactions with clients. How do we ensure that direct service, administrative staff, and others working within our sector are managing their own trauma responses and are using strategies that minimize the re-traumatization of others during interactions? How do we ensure that individual employees, their families, and their communities have access to the same basic rights and healing opportunities that they work to provide for those designated as behavioral health consumers?

The answers to these questions are not simple, and not found in the mastery of a single technique or practice. And the responsibility for answering these questions cannot solely rest in the hands of individual practitioners. The ability to transform our system of care starts with shaping the culture of our organizations to support practitioners. True transformation requires awareness of the systems of oppression underlying intergenerational and environmental trauma, reflection on the power dynamics between staff and clients that may be unconsciously perpetuated as a result of trauma, and organizational structures that transparently address these dynamics by providing the training, skills, and safe space for staff to reflect. Examples – at an organizational level that evidence the attention to these areas may include: an emphasis on regularly-scheduled reflective supervision; explicit skills training focused implicit bias, internalized oppression, vicarious trauma, and institutionalized racism; authentic feedback expected and modeled at all levels of the organization; and transparent leadership that intentionally addresses staff’s mental and emotional well-being.

On an organizational level, the recognition and response to trauma must be woven into the fabric of the culture in order to support staff reflection, healthy responses, and resilience. This approach must exist throughout the organization, as transformation on this level requires a willingness to challenge the existing paradigms and shift practices to ensure that the principles of trauma-informed care exist throughout the organization’s infrastructure. These guiding principles include: 1) safety, 2) trustworthiness and transparency, 3) peer support and mutual self-help, 4) collaboration and mutual aid, 5) empowerment, voice and choice, and 6) cultural, historical and gender considerations. These guiding principles must be integrated into hiring practices, supervision structures, design of physical space, and leadership practices, making them the lifeblood of the organization. Recently, we were involved in an initiative that sought to exemplify programs and practices that can help advance organizations’ ability to meaningfully address trauma. During the fall and winter of 2017 and 2018, The Nonprofit Coordinating Committee of New York (NPCC), in partnership with Vibrant Emotional Health, and with generous support from The New York Community Trust, provided a series of workshops called Addressing Trauma: Self-Care Strategies for You and the Communities You Serve. Based on attendance numbers and feedback from direct service and management staff, the demand for such forums is great.

To help nonprofit organizations weave the trauma-informed concepts from the training series into the daily fabric of organization life, Vibrant Emotional Health created a corresponding toolkit called Staying in Balance: Healthy Solutions for Managing Workplace Stress. This toolkit can be a helpful place for organizations to start to identify and address issues related to stress, self-care, and organizational practices; it is easily accessed on the NPCC website: www.npccny.org.

Organizations are learning to dismantle the roots of structural racism, violence, and stigma, but it can almost feel like a game of whack-a-mole: new payment structures vs. trauma-informed evidence based practices vs. diversity equity and inclusion initiatives. Without adherence to a guiding principle of equitable access to behavioral health for all—inclusive of living wage and job satisfaction for the workforce—organizational life will continue to mirror the lack of control and safety that come with trauma exposure. As champions of behavioral health, we need to ask ourselves, can we in good conscience continue along a status quo path? As service providers, we are committed to shifting the paradigm of care and transforming from within. As a system, we value reflective practice in our clinical work and take this value and apply it to our organizational culture. We recognize what needs to be done and are increasingly taking steps, albeit sometimes slowly, to integrate trauma-informed practices throughout everything we do. This work is daunting. It is challenging. It isn’t easy—but nothing truly transformational ever is. We know that people heal from trauma within the context of relationships. So, too, we should realize that our individual organizations cannot reshape the system alone. We must collectively create the trauma-informed transformation that we want to see. We are all in this together.

About the authors. Lisa Farst, LMSW, MPH, is Assistant Vice President, Center for Policy, Advocacy and Education, Vibrant Emotional Health; Cristina Harris, MSW, is Program and Training Manager, Center for Policy, Advocacy and Education, Vibrant Emotional Health; and Elizabeth Speck, PhD, Principal, MindOpen Learning Strategies, LLC.

References
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promotes ongoing improvements to respond to continually evolving health, behavioral health, and human service needs within each neighborhood and for the full array of diverse populations served.

These prognostications are informed by national trends, the goals set by and for emerging networks, and new financing structures that will drive continual innovation. We can see the potential highlighted within emerging CBO consortia (such as Communities Together for Health Equity), among provider networks (such as Behavioral Health Care Collaboratives like Coordinated Behavioral Care), and in models, such as Certified Community Behavioral Health Care Centers. Transformation efforts and new financing structures, and upcoming opportunities, are setting the stage for continual evolution.

The way we get there is through a deep dedication to quality. Quality defined both by the client standing in front of us and sound science. An embracing of analytics that arms us with information that drives a culture of continuous quality improvement. We also enable this future with the partnership and collaboration of our payers willing to incent innovation and empowering providers to solve problems creatively leveraging the strengths of the individual and culturally dynamic community resources. Using leading edge technology to communicate with clients using the media that work for them whether text, social or other.

The question recurs whether value-based and alternative payment arrangements can truly incent quality care and innovation. How do we avoid teaching to the test and how do we preserve effective but undercapitalized community-based care that has been keeping people safely in the community and out of hospitals and institutions for decades? Through provider led networks that embrace a spirit of integration, coordination and mutual accountability. If and only if financing rewards not just the critical outcomes of reductions in hospitalizations but also recovery-focused outcomes. And if payers are willing to invest in the transition from here to there — empowering providers to take risks and to engage increasingly sophisticated tools, data and technology to do so with eyes open and full information.
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