

Priority Outcome 1: Prepare for Conversion of Medicaid Fee for Service to Medicaid Managed Care

Priority Rank: 1

Rationale: The changes in the environment related to the Affordable Care Act and New York State's Medicaid reform will result in the move to a managed care environment for behavioral health in 2014. The Erie County Department of Mental Health vision for the Erie County Adult System of Care (SOC) is that providers will be working together using person centered practices in support of recovery, where optimally effective services are available in a timely manner to the emerging populations and where Behavioral Health and Physical Health are integrated. In this system of care, providers are focused on working interdependently to reduce imminent risk for out of community placement or bend the trajectory of risk and to ease transitions by removing barriers to care. The new or evolving Medicaid services will be comprehensive, integrated and capitated. This will involve changes for individual consumers, family members, and service providers. There will be new reimbursement structures which may reduce or eliminate Medicaid add-ons. Clearly, this change is rapid and will occur with or without local design efforts. Erie County's local approach is intended to demonstrate value of the local service system prior to the next managed care Behavioral Health. Changes are occurring rapidly and there is an urgent need to manage healthcare reform at the local level. There is a short-term opportunity for Erie County, providers, consumers and stakeholders to take advantage of the reform opportunity offered by Health Homes and Medicaid Reform initiatives to demonstrate the value of locally driven systems of care and optimize the positive impact of changes on our local community. A primary goal is to bring together government entities and service organizations to quickly and proactively adapt to changing requirements.

OASAS Priority Focus Area: Service System Planning/Management

Sub-Focus Area: Collaborate with BHO/Health Home/Others on Care Management/Oversight.

OMH Priority Focus Area: Service System Planning/Management

Strategy 1.1: The Erie County Department of Mental Health will engage in dialogue with Providers, Health Homes and Managed Care Organizations regarding: * Use of data analytics * identification of shared expectations, procedures and policies to best serve individuals * Identification of critical metrics * Use of critical metrics to prepare our the system of care and * Improve behavioral health and physical health integration

Applicable State Agencies:

OASAS

OMH

Strategy 1.2: There is a need to reduce inpatient admissions as well as preventable hospitalizations. Erie County will use all available data sources to identify individuals and use the integrated SPOA to facilitate access to services for high risk individuals. Available data sources presently incorporated include Salient and PSYCKES. This data will be supplemented by and enhanced by other data as our analysis will be ongoing. Erie County will work collaboratively with providers to take advantage of DSRIP (Delivery System Reform Incentive Payment) opportunities. These collaborative efforts will focus on Behavioral Health projects within the DSRIP domains. Once identified, we will use evidenced based practices to promote engagement and appropriate quality services. Examples include the developing OMH service models targeted to individuals at their first psychotic break, and emerging peer fidelity practices.

Applicable State Agencies:

OASAS

OMH

Priority Outcome 2: Focus on risk mitigation and harm reduction

Priority Rank: Unranked

Rationale: In this rapidly changing environment, the model of traditional care coordination services will become more short term, episodic, and much of this resource will be tied to Health Homes. Erie County is committed to a "risk reduction" approach that incorporates the provision of services and supports to the right person, right time, right service, for the right outcome, for the right length of time. Since needs related to behavioral health, physical health, arrests, homelessness, and substance abuse are the critical risk factors to be addressed in attaining overall wellness, the adult system of care will focus reducing imminent risk and/or bending the trajectory of risk by removing barriers to care so that people can receive needed services and supports. Historically, rehabilitation & recovery have meant long-term support. Per the MRT recommendations, managed care entities should develop robust care coordination activities that include intensive data-driven strategies to identify (and serve) high need consumers e.g. those disengaged from care, those at high risk of suicide, and those with a history of violence. This will also require a robust Utilization Management to assure access to timely community based services. Providers will need to assist consumers to receive ongoing treatment & support through removal of barriers to community-based services both inside and outside of the healthcare system.

OASAS Priority Focus Area: Service Improvement/Enhancement

Sub-Focus Area: implement/Expand Best/Promising Practices.

OMH Priority Focus Area: Service Improvement/Enhancement

Strategy 2.1: Critical Time Intervention (CTI) is an empirically supported, time-limited case management model designed to enhance continuity of support for people with mental illness following discharge from hospitals, shelters, prisons and other institutions. This transitional period is one in which people often have difficulty re-establishing themselves in stable housing with

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access to needed supports. CTI works in two main ways: by providing emotional and practical support during the critical time of transition and by strengthening the individual's long-term ties to services, family, and friends. Ideally, post-discharge assistance is delivered by workers who have established relationships with clients during their institutional stay. The SPOA will assign non-health home eligible individuals to CTI providers in order to focus on imminent risk reduction and/or bending the trajectory of risk through removal of barriers to wellness that are encountered during transition from any level of care, and fully utilize generic community services for support rather than the healthcare system. In addition, in April of 2013 the Department has initiated a pilot initiative in Children's Outpatient Mental Health clinic. This pilot at two NYS OMH children's outpatient clinic utilizes the values and philosophy of CTI by pairing a CTI care manager with a clinical therapist. The goal of the initiative is to identify eligible youth with barriers to successful transition from clinic that would benefit from a CTI approach to develop and strengthen sustainable community resources to address those concerns.

Metric 2.1:

- 1) CTI Fidelity measures and reporting will be in place
- 2) Train the trainer model for CTI will be implemented
- 3) All Adult SPOA non-health home care coordination slots will use CTI
- 4) Length of stay consistent with CTI 6 month model
- 5) For Children's clinic CTI pilot:
 - a) Length of Stay post enrolled in CTI to be consistent with model of 3 months in clinic and 3 additional months in CTI;
- 6) Implement data analysis review to determine extent of impact of pilots on community tenure and service utilization post service delivery.

Applicable State Agencies:

OASAS
OMH

Priority Outcome 3: Expand access to housing, including that which is non-licensed.

Priority Rank: 3

Rationale: Behavioral Health Reform demands timely access to the right services for the right person, at the right time, for the right length of time, for the right outcome. Presently, the ability to quickly access housing in Erie County is limited at best. This prevents individual consumers who are most at risk from being able to access the stabilizing influence of adequate housing in a timely manner. This is borne out by the fact prior to the reform being implemented the waiting list for supported housing services in Erie County is consistently in excess of 100. Transition to more independent housing is limited and generally occurs after many months and years in the program. This is illustrated by the NYS OMH Residential Programs Indicators Report. The report shows that of those in residence at the end of the report period for the 2011 Calendar Year, the Median Length of Stay was 1155 days, or 3.164 years. Moreover, NYS OASAS Service Need Profile for Erie County shows that only an estimated 35% of the need being met. In order to be responsive to the new paradigm and facilitate timely access, successful transition from supported and supportive housing to independent housing must occur in much swifter time frame than has historically occurred.

OASAS Priority Focus Area: Service Improvement/Enhancement

Sub-Focus Area: Implement/Expand Best/Promising Practices.

OMH Priority Focus Area: Service Capacity Expansion/Add New Service

Strategy 3.1: Increase access to housing for High risk seriously mentally ill individuals. Through a Request for Proposal, the Erie County Dept. of Mental Health has implemented a pilot initiative that seeks to have a normative length of stay in supported and/or supportive housing of six (6) month while transitioning to successful independent housing with sustainable community tenure. The service agency is required to utilize and integrate the best practice of Critical Time Intervention (CTI). CTI has promising literature on achieving transition for those in need of housing within the targeted normative LOS. In close collaboration with the provider and County, the initiative will be rigorously monitored thru the use of data analysis, Quality improvement and Utilization Management practices. This initiative was implemented in August of 2012 and is now seeing its first consumer transition to sustainable community housing. Initial evaluation a site review is suggesting promising preliminary outcomes at this admittedly early juncture. We are now in the early stages of reviewing Medicaid data to determine the impact on community tenure and service utilization. Add 30 Supported Housing beds through NYS OMH funding. Referrals will be made through the integrated SPOA to assure eligibility and timely access for the target population. Add 25 additional beds through NYS OMH MRT. Referrals will be made through the integrated SPOA to assure eligibility and timely access.

Metric 3.1:

- 1a) The pilot initiative will be implemented and the normative LOS will be six (6) months.
- 1b) The practice of CTI will be broadened to the agency's supported and/or supportive housing capacity where the Median normative LOS in supported/supportive housing for new consumers will also decrease from pre pilot initiative Median LOS.
- 1c) NYS OMH supported housing will be at full capacity of 30. As of March 2014 at capacity
- 1d) NYS MRT housing will be at full capacity of 25. As of March 2014 23 of 25 beds were filled.

Applicable State Agencies:

OASAS
OMH

Priority Outcome 4: Better Integrate Behavioral and Physical Health

Priority Rank: *Unranked*

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Rationale: According to the New York State Medicaid Redesign Team (MRT) Behavioral Health Reform Work Group: *People with serious mental illness die 15-25 year earlier on average than average; and, *The majority of preventable admissions paid for by fee-for-service Medicaid to Article 28 inpatient beds are for people with behavioral health conditions, yet the majority of expenditures for these people are for chronic physical health conditions. The MRT has identified the fragmentation of behavioral health care, and lack of integration/coordination with physical health care as contributing to poor outcomes.

OASAS Priority Focus Area: Service Coordination/Integration

Sub-Focus Area: Integrate Care with Other Service Systems.

OMH Priority Focus Area: Service Coordination/Integration

Strategy 4.1: The ECDMH will work cooperatively with stakeholders to accomplish the following: * Work with the Erie County Health Department to increase behavioral health services co-located or embedded in primary care facilities * identify opportunities to improve the capacity of care managers and providers to address physical health needs * Work with Managed Care Organizations to improve access to behavioral health services for individuals with serious behavioral health disorders served in the physical health system * Explore additional opportunities to improve physical/behavioral health coordination * Explore data sources to track progress on physical health of individuals with behavioral health disorders

Applicable State Agencies:

OASAS

OMH

Priority Outcome 5: Better link high risk children & youth to treatment services in the community

Priority Rank: 2

Rationale: According to the New York State Medicaid Redesign Team (MRT) Behavioral Health Reform Work Group, lack of coordination extends well beyond physical health care into the education, child welfare and juvenile justice systems for those under the age of twenty-one. The MRT also identified access to early identification and intervention with children as a core standard. Included in this standard is access to first-level intervention and consultation within seven days. Currently, in Erie County, there is a lack of access to Mental Health Clinic, and related to this lack of access, the median length of stay is approximately one visit.

OASAS Priority Focus Area: Service Improvement/Enhancement

Sub-Focus Area: Implement/Expand Best/Promising Practices.

OMH Priority Focus Area: Service Improvement/Enhancement

Strategy 5.1: To better address issues around engagement of families with children presenting with behavioral difficulties, and perceived lack of access to Mental Health Clinic, Erie County will redeploy some of the current intensive Case Managers to focus on improving access for children with serious emotional disturbance by using Critical Time Intervention tenets to facilitate transition to licensed clinic programs. As of March 2014 this pilot initiative has been implemented and the steps outlined below accomplished. The first steps in this process have been completed: *Working with CTI experts in identifying critical practice elements for this CTI modification *Developing practice fidelity standards and reporting *Training ICMs in the CTI model *Defining the target population profile for this initiative *Identifying provider partners, both Targeted Case Management and Clinic *The initial Plan for data analysis is being developed.

Metric 5.1:

- 1) Reach expected capacity within 7 months of April 2013 implementation (fidelity dictates ramping up capacity in phases)
- 2) First grouping of children/youth/families have transition from the clinic with 75% success rate.
- 3) Expected Length of Stay once enrolled with CTI care management support is normatively
- 4) Complete initial data analysis review to determine impact on community tenure and service utilization

Applicable State Agencies:

OASAS

OMH

Strategy 5.2: Youth presenting in the Juvenile Justice, behavioral health and social services system are often at high risk for additional system presentation and/or out of home placement. Identifying at risk behaviors and addressing those in a timely and targeted fashion is critical to reducing this risk. The Department through the Children's system of care service delivery system, in collaboration with its county partner and service providers has implemented a new practice paradigm where such risks are identified at referral. Providers then are expected to have the first face to face visit within 3 days of receiving the referral and have a vendor service/or in lieu of vendor service availability, provide the service targeting the high risk behavior within 7 days after that initial first face to face visit.

Metric 5.2:

- 1) At least 85% of all new referrals will be seen w/n 3 days for the referral being received.

Applicable State Agencies:

OASAS

OMH

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Priority Outcome 6: Assist in expanding non-certified, integrated housing capacity/placement opportunities for individuals with Developmental Disabilities or who are Dually Diagnosed (DD and Psychiatric).

Priority Rank: 5

Rationale: The changes in the OPWDD system related to coming into compliance with the ADA and Olmstead Act is resulting in an increased focus in developing strategies to assist people to live in the least restrictive and most community integrated residential environment as possible. The Erie County Department of Mental Health supports the practice of person centered planning to support individuals in selecting environments of their choice of where to live. Planning should include assisting individuals to identify resources/supports based on specific needs as opposed to historical practices of all inclusive environments regardless of need.

OPWDD Priority Focus Area: Housing

Sub-Focus Areas: Family Care/Shared Living; Rental Subsidies; Respite; Nursing Home Transition and Diversion; Institutional Transition.

Strategy 6.1: The Erie County Department of Mental Health will provide support and technical assistance to the DDRO – Region 1 (OPWDD)m including but not limited to the following: • Discuss housing opportunities/individuals needs with the OPWDD Subcommittee as system reform occurs to include advocacy for reinvestment of State funding from Intermediate Care Facilities (ICF) to Home and Community Based Services (HCBS) Waiver compliant residences. • Participate in housing forums Coordinated by OPWDD, with local providers/representatives from

Housing establishments to educate and promote the utilization of accessible housing assistance opportunities outside of OPWDD, as well as, how to best utilize community resources to leverage with OPWDD resources. • Support the efforts of the OPWDD Subcommittee to partner with the Housing Independent Action Coalition (HiAC), Parent Network (local) and Parent to Parent (state) organizations to host housing forums to educate families and caregivers about community housing options currently available and system reform. A primary goal of the forums will be to change the general perception of independent housing for individuals with Developmental Disabilities. • As individual cases are identified, ECDMH SPOA staff will participate in housing related care management meetings for dually diagnosed individuals who are at risk of homelessness or homeless resulting in the identification and linkage to services • Provide letters of support per Certificates of Need as identified by the DDRO-Region 1 Metric: • When requested by the DDRO-Region 1(OPWDD) ECDMH will participate/consult in the development of person centered housing models, vacancy management planning, or developing a continuum of housing opportunities

Metric 6.1: • When requested by the DDSO-Region 1(OPWDD) ECDMH will participate/consult in the development of person centeredcapitation models via the pilot case studies.

Applicable State Agency:
OPWDD

Priority Outcome 7: Support community education regarding OPWDD systems change and disability education.

Priority Rank: *Unranked*

Rationale: Because of system reform, ECDMH supports the OPWDD subcommittee's goal to educate families and individuals to OPWDD and community based non OPWDD supportive services.

OPWDD Priority Focus Area: Putting People First

Sub-Focus Areas: Self-direction; Access to Services/Front Door; Managed Care Transition.

Strategy 7.1: Partner with Parent Network of WNY to request information on how to best educate families. • An objective of the subcommittee will be to initiate collaboration from the Developmental Disabilities Alliance of Western New York (DDAWNY), MSC subcommittee of DDAWNY, Self-Advocacy Association and Provider agencies supervisors who have a hand in community education or are in need of being educated • Facilitate Family Resource Forums for parents and families receiving/who are in need of services accompanied by their MSC when possible. The format of each forum will include a self-assessment, education and action plan related to services desired/needed. Presenters will include individuals receiving services, parents, and providers. • Utilize materials developed by OPWDD per the Transformation Agenda to include housing, employment, and self-directed services.

Metric 7.1: The outcome will be measured by the number of community forums held.

Applicable State Agency:
OPWDD

Priority Outcome 8: Support the development and coordination of integrated psychiatry services for individuals who are Dually Diagnosed with Developmental and Psychiatric Disabilities.

Priority Rank: *Unranked*

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Rationale: The Erie County Department of Mental Health (ECDMH) recognizes the importance of providing mental health services to this population. The County has funded specialized psychiatric services for people with a dual diagnosis through a local provider, but dwindling fiscal resources are causing a reduction in these services. However, there are many people within Erie County that are dually diagnosed a growing need to treat the identified individuals continues.

OPWDD Priority Focus Area: Health
Sub-Focus Area: Clinical Services.

Strategy 8.1: The Erie County Department of Mental Health will pursue a cross system solution with OPWDD and OMH. The primary agenda will include the following: • Describing the underlining issues across systems that are preventing the development of essential services to people who have dual diagnoses. • Monitor the implementation of START and utilization of services as it relates to behavioral health

Metric 8.1: ECDMH will request a meeting with OPWDD and OMH to begin discussions on solutions to breaking down the barriers and ncreasing access to services.

Applicable State Agency:
OPWDD

Priority Outcome 9: Expand Chemical Dependency (CD) system treatment capacity and accessibility.

Priority Rank: 4

Rationale: To alleviate specific gaps and insufficiencies in accessibility to CD services.

OASAS Priority Focus Area: Service Capacity Expansion

Sub-Focus Areas: Community Residential Treatment; Supportive Living Treatment; Other Recovery Support Services; Services for a Target Population (specify population):.

Strategy 9.1: Presently there is no 24/7 local single phone number for individuals or family members to call in the event of a chemical dependency crisis nor, is there any outreach/intervention capacity in this type of urgent crisis event. Establishing this capacity will improve access to treatment services during times of a CD crisis. - Define the details of desired local 24/7 crisis response service. - identify funding – Deveiop and implement plan for establishment of this service.

Applicable State Agency:
OASAS

Strategy 9.2: Expand Chemical Dependency (CD) residential capacity. This level of care continues to be identified locally as having insufficient capacity. - Determine details such as whether additional community residence or supportive living, how many beds, if there should be a specific special target population, etc. - identify funding and determine service provider.

Applicable State Agency:
OASAS

Strategy 9.3: Over the past half-dozen years there has be a significant decrease in total local CD outpatient capacity, particularly for the under- and un-insured. Establiish a small deficit funding pool for under- or un-insured Individuals in need of outpatient treatment, making CD outpatient services more accessible to under- or un-insured individuals. - Determine the details for how such a funding pool would work including capacity, eligible target population definition or priority and, payment mechanism. - Identify funding

Applicable State Agency:
OASAS