

Executive Summary

The changes in the environment related to New York State's movement towards managed care environments are prompting action by Erie County to adapt its Systems of Services (SOS). The vision for the Erie County System of Services is that providers will be working together in an organized system of care, where optimally effective services are available in a timely manner to the emerging populations. In this system of services, providers are focused on working interdependently with individuals, families and natural supports to reduce imminent risk or bend the trajectory of risk and to ease transitions to care and support by removing barriers to care that will keep people in the community rather than focusing on keeping people out of the institutional care. Services will be provided using a person centered approach to care that provides access to the right service at the right time for the right length of time for the right outcome. Throughout the reform initiative if there is an opportunity to do a short-term pilot that is data informed Erie County will employ this approach to further healthcare reform efforts.

The impetus behind healthcare reform in Erie County includes a belief that changes are occurring rapidly and that 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 Regional Behavioral Health Organization and Health Home initiatives. Erie County intends to demonstrate the value of locally driven systems of care that align with New York State's healthcare reform initiatives in the next 6-8 months, before the next round of Requests For Proposals are released for managed behavioral health care. To address this locally Erie County will focus local health reform efforts on:

Priority Populations: Priority participant lists will be developed to reflect those people who are at greatest risk of needing deep end services

Efficacy of Practice: The efficacy of clinical practice of the Erie County will be attained through changes in practice and fidelity to evidence based practices.

Access to services: The capacity of the system will be managed to improve access for the priority population to the right service at the right time for the right reason for the right length of stay

Metrics that Matter: Data informed practice and data informed structures will be the underpinning of this change initiative to identify high risk/high need populations, track clinical outcomes, and measure the overall performance of the system of services

Erie County is committed to a healthcare reform "risk reduction" approach. Historically, rehabilitation & recovery have meant long-term support. Now providers will assist consumers to receive ongoing treatment & support through removal of barriers to community-based services both inside and outside of the healthcare system.

Under Healthcare Reform the expectation of the services available and provided to individuals will change for consumers, providers, and regulators. In Erie County changes needed for providers, consumers and county staff include the following:

Consumers - What expectations do clients have of the service they receive? Under reform consumers will have the information needed to make informed choices to move toward greater self-management, and will be prepared for discharge and transition.

Providers - What expectations do providers have of the services they will deliver? Provider focus on inpatient diversion and long-term support will need to shift to their practice to assist consumers by removing barriers to services that will support them in their recovery. Providers will need to assist consumers on linkages and transitions to services and community supports. Recognizing that services need to be individualized, stability and treatment are essential to recovery with the right blending of supports both natural and formal so that people get the right level of support when needed.

How will Erie County measure Systems Change?

- Measures of engagement & timely access

- Measures of fidelity to practice i.e. identify how the interventions are done and measure the interventions
- Measures of outcomes
- Measures of community impact e.g. emergency room presentations, inpatient cost, homelessness and arrests

Erie County recognizes that the scope of this reform initiative will have significant impact on consumers, providers, and county operations as the transformation occurs in the context of uncertainty, rapid change and state managed care initiatives. The impact will prompt changes in clinical and business practices, the experience that consumers have with providers, and the shape of services delivered to consumers.

- Providers may choose to adapt to the Erie County Healthcare Reform incrementally or with a more robust system change approach. Providers who can achieve a valued outcome within a normative timeframe, will likely move ahead of their competition and gain market share. Consumers will experience an approach in which the provider will focus on short-term interventions & supports that are person centered and recovery oriented. As a result consumers may experience a sense of loss of services and/or long-term relationships due to their prior involvement with and dependency on the formal provider network and long-term support models.
- Providers will need to work with consumers to manage their expectations relative to lengths of stay and relationship with the provider system, so that the consumer is given hope for recovery through improved self-management skills.
- Erie County will work with providers and consumers to promote self-sufficiency through role modeling of peers, support during critical transitions, and with on-site services relative to work and independent housing, and through transitions.

Critical Time Intervention (CTI) will be a critical tool to support this approach. 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. CTI works in two main ways: by providing emotional and practical support during transitions 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.

Erie County made significant strides in changing the Erie County Children's System of Care by employing training, communication, inclusive planning and culture change in service delivery that included consumers, families and providers. The transformation of the children's system has been significant, resulting in improved community service options, decreased use of residential treatment, measurable clinical outcomes and consumer satisfaction. These efforts and outcomes have been recognized by CMS and the New York State Office of Mental Health. Therefore Erie County is committed to using similar approaches in communication and culture change in service delivery in this Healthcare Reform initiative, and will include peer training of providers and the development of a learning community.

Our immediate first priority is to prepare for the conversion of Medicaid fee for service to Medicaid Managed Care. The new or evolving Medicaid services should be comprehensive, integrated and capitated. This will involve changes for individual consumers, family members, service providers of behavioral and primary health care. New reimbursement structures may reduce or eliminate Medicaid add-ons.

Our second priority is to assure that individuals who are at risk of deeper-end service penetration that are not enrolled in a managed system. Our local responsibility is to assure access to timely, adequate, affordable, appropriate, and quality outcome driven services. This sub-population includes uninsured, under-insured, and at least initially, dual eligible individuals.

Our third priority is to reduce the number of potentially preventable admissions to hospitals for individuals diagnosed with behavioral health disorders.

2013 Priority Outcomes

Priority Outcome 1

Prepare for Conversion of Medicaid Fee for Service to Medicaid Managed Care

The Behavioral Health System is in a period of rapid change

- In October, Managed Care Plans took over the Medicaid pharmacy benefit which had previously been carved out of the plans
- In January, Regional Behavioral Health Organizations began monitoring behavioral health inpatient admissions and discharges for individuals with Medicaid coverage
- The New York State Department of Health recently designated three Health Homes Networks in Erie County for the purposes of decreasing cost and improving coordination of care for Medicaid enrollees with chronic conditions
- Much of this effort is initially targeted at reducing emergency room visits, hospitalizations, and re-hospitalization.

According to the Medicaid Redesign Team (MRT) Behavioral Health Reform Work Group Final Recommendations, "for Phase II of BHOs, OMH, OASAS and, DOH will implement one or more risk bearing care management options." Also per the MRT final report, full-benefit Special Needs Plans or Integrated Delivery Systems (IDS)s should be implemented in New York City by April 1, 2013; we anticipate that a risk bearing care management will be implemented in the Western region by the end of 2013 at the latest.

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

Agencies: OASAS; OMH; OPWDD;

This outcome has been selected as a top priority.

Strategy 1.1

The Erie County Department of Mental Health will engage in dialogue with the Regional Behavioral Health Organization and Managed Care Organization regarding:

- Use of Data Analytics: Erie County will work on the development of a risk-based, predictive model to explain trajectory of deep-end system penetration. Primary focus is to make the results translatable to professionals so the results can impact administrative, supervisory and direct practices. This model will be incorporated into the daily decision making processes of professionals in the adult system of care.
- Business Practices: Erie County will work on the development of performance measures that are meaningful, and are used to support critical metrics and activities
- Quality Improvement and Accountability: Erie County will work to develop and identify critical metrics, outcomes and system needs based on evidence based practices, utilization management data and other critical data to drive decision-making and contract performance standards

- SPOA: Erie County will launch a paradigm shift for the placement, service methodology and outcomes associated with housing and care coordination will be used such that the assignment of individual consumers to appropriate housing will utilize a risk based algorithm and interventions will support individual transition to fuller community participation and decreased dependence on behavioral health housing and care coordination.
- Utilization Management: Erie County and Erie County Providers will drive clinical and service decisions based on the 5 Rights of UM (right person, right service, right time, right length of time, achieving right outcome).

Metric:

Metrics to monitor progress:

- * Meetings with RBHO and Managed Care Organizations
- * Set joint data monitoring processes in place
- * Initiate a quality improvement process with the RBHO and at least one Managed Care Organization

Agencies: OASAS; OMH; OPWDD;

Priority Outcome 2

Focus on risk mitigation and harm reduction

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.

Agencies: OASAS; OMH;

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 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.

Metric:

- 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
- 3) Length of stay consistent with CTI 6 month model

Agencies: OASAS; OMH;

Priority Outcome 3

Assure Access to Services for Individuals at Risk of Deeper-End Service Penetration

According to the Center for Health Care Strategies in "Predictive Modeling: A Guide for State Medicaid Purchasers", "Medicaid purchasers are becoming increasingly interested in the potential value of predictive modeling to identify high-risk patients who are likely to benefit from care management interventions... in order to target public resources more effectively".

Predictive models can be described using three key features:

- 1) The outcome being predicted such as high cost inpatient, ER use, homelessness
- 2) Predictor variables used to predict the outcome and can include demographic information, prior utilization data, prescription claims, functional status etc.
- 3) Predictive models can be described by how predictor variable are combined to create the predicted outcome.

Given the focus on Managed Care, our concern is that high need individuals who are not enrolled in a managed system will have barriers to timely, adequate, affordable, appropriate and quality outcome driven services. These individuals include uninsured, under-insured, and at least initially, individuals with both Medicare and Medicaid.

Agencies: OASAS; OMH; OPWDD;

This outcome has been selected as a top priority.

Strategy 3.1

Erie County will work on the development of a risk-based, predictive model to explain trajectory of deep-end system penetration. Primary focus is to make the results translatable to professionals so the results can impact administrative, supervisory and direct practices. This model will be incorporated into the daily decision making processes of professionals in the adult system of care. 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 will include PYCKES, Medicaid Adjudicated Claims and Salient. These data sources will be supplemented by other local data. 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.

Metric:

- 1) Identify risk factors for trajectory
- 2) Develop profiles to make results translatable to professionals so that the results can direct practices

Agencies: OASAS; OMH; OPWDD;

Priority Outcome 4

Expand access to housing, including that which is non-licensed.

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 that 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.

Agencies: OASAS; OMH;

Strategy 4.1

Through a Request for Proposal, the Erie County Dept. of Mental Health will implement 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 will be 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

Metric:

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) As a result of the pilot initiative and expansion of the practice, the current wait list which presently is consistently in excess of 100 will substantially decrease.

Agencies: OASAS; OMH;

Strategy 4.2

Expand the capacity of OASAS Community Residential Capacity provided by Cazenovia Recovery Services by two beds. Due to this planned expansion and, issues associated with the physical plant condition of the New Beginnings program for which it is targeted, this will also involve the necessity of relocating this program.

Metric:

Current program will be relocated and will be expanded by 2 beds.

Agency: OASAS;

Priority Outcome 5

Decrease Preventable Hospitalizations through Integrating Behavioral and Physical Health

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.

While implementation of Health Homes began prior to the final MRT report, the New York State Department of Health model for Health Homes expands on the traditional medical home model to build linkages to "community based services and supports, and to enhance coordination of medical and behavioral health care with the main focus on the needs of persons with multiple chronic illnesses". The New York State Office has supported the change in

focus of case management to better help individuals manage chronic health conditions. Furthermore, Health Homes are responsible to decrease both physical health and behavioral health emergency room and inpatient use.

Agencies: OASAS; OMH;

This outcome has been selected as a top priority.

Strategy 5.1

Three health homes were designated in Erie County. The Erie County Department of Mental Health will work with the Health Homes, Targeted Case Management Providers and other stakeholders regarding: *Development of new contract provisions for targeted case management programs that specify procedures that will be used to reallocate slots and the usage of service dollars *Development of agreements with Health Homes regarding their responsibility to coordinate care and prevent unnecessary physical and behavioral health hospitalizations that includes reporting on the State Plan Amendment quality measures *Establishment of cooperative relationships with Health Homes to address joint concerns, and risk management for consumers *Establishment of a community solution for electronic health records, with the Community Foundation of Western and Central New York

Metric:

*Decrease preventable hospitalizations for individuals with Behavioral Health disorder by 15% by 1/1/2012

*Contract changes with targeted case management programs in place

*Agreements with Health Homes in place

*Ongoing monitoring against critical metrics has begun

Agencies: OASAS; OMH;

Priority Outcome 6

Better link high risk children & youth to treatment services in the community

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.

Agencies: OASAS; OMH;

Strategy 6.1

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. The first steps in this process will be as follows: *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

Metric:

- *Steps detailed in the strategy have been accomplished
- *Target number of children/youth to be served has been established
- *First clinic appointment is within a maximum of 7 days of referral
- *First grouping of children/youth have graduated from the program with 80% success rate of transition into mental health clinic

Agencies: OASAS; OMH;

Priority Outcome 7

Assist in expanding housing capacity/placements in integrated opportunities for individuals with Developmental Disabilities/Psychiatric Disabilities outside of the certified residences.

Agency: OPWDD;

Strategy 7.1

The Erie County Department of Mental Health will provide support and technical assistance as identified by the WNYDDSO (OPWDD) including but not limited to the following: •Participate in the development of a committee to research alternative housing services/models •EC SPOA staff will participate in housing related care coordination meetings for dually diagnosed individuals who at risk of homelessness or homeless; Identification and Linkage to services •Participate in developing comprehensive care plans that are cost effective and inclusive of identified needs

Metric:

- When requested by the WNYDDSO (OPWDD) participate/consult in the development of person centered capitation models via the pilot case studies.
- Review data from the ECDMH MIS to evaluate the number of MH/DD housing placements. Data reports will be a standing agenda item on the OPWDD subcommittee agenda.

Agency: OPWDD

Priority Outcome 8

Participate in the development of a continuum of employment options designed to move individuals toward competitive and community activities that are meaningful and productive.

OPWDD's focus is to develop a full continuum of employment options designed to move individuals toward competitive employment and community activities that are meaningful and productive. The silos of 'pre-vocational services', supported employment services,' and 'day habilitation' can be integrated as a fluid entity designed to make employment a goal for everyone. (Explanation per the 2012 Interim Report: NYS Office for People with Developmental Disabilities: 2011 - 2015 Statewide Comprehensive Plan)

Agency: OPWDD

Strategy 8.1

The Erie County Department of Mental Health will participate in the development of cross county learning communities, Redistribution of resources when and where appropriate, Promote the participation in New York Employment Services System (NYESS)

Metric:

Possibly modify OPWDD employment related county contracts per stages of development

Set joint meetings to develop outcome measures and quality improvement planning based on data reports from OPWDD contract agencies and New York Employment Services System (NYESS)

Agency: OPWDD