

February 2011

Guest Commissioner Column



Our job is to do incredible things for the children of New York State

by Kristin Riley, Deputy Commissioner and Director, OMH Division of Children and Family Services

We have invested wisely over the past decade in the social and emotional development of New York's young people and their families. Our horizon has been broadened to include early childhood mental health through the transition to adulthood. We know that we achieve the best results when we identify children who are struggling early, are effective at engaging people and use treatments that have been shown to work. As a system we have greater awareness of youth development and prevention, we are better at identifying and treating trauma and have seen dramatic increases in family-run and youth guided services. Real-life examples of [The Children's Plan's](#) commitment to strengthening the emotional well-being of children are easily found.

As we face what well may be the worst fiscal crisis in New York State history, all "*keepers of the social and emotional development of children,*" we will be called on to share our talent and creativity in the face of very difficult choices. The lessons on resiliency that we use often in our work with children and families apply to us in the field as well. Making choices and adapting to the challenges we face in the years to come does not mean that we will lose the gains that we have made. In fact we can use this opportunity to personify a message of hope and resilience for those we serve and for each other.

Many years ago a co-worker of mine presented me with a gift, a handmade ceramic plaque with **Our Job Is To Do Incredible Things!** emblazoned upon it. This plaque is an ever-present reminder of what the job is... in good times or bad and regardless of the issue at hand. Our job is to do incredible things for the children of New York State and their families.

In times like these what does "*Incredible*" look like?

Incredible is a child care worker taking the time to make a strong connection with a child with particularly aggressive behavior...letting that young person know that 'I am here for you and I really believe in you.'

Incredible is a clinician who follows through after a therapy session with a voicemail to a parent that said, 'keep up the good work, you are doing wonderfully with your daughter.'

Incredible is a program director taking the initiative to coordinate a youth voice speak out at their agency.

Incredible is an agency director who courageously redesigns their services with available resources, to best meet the needs of the young people in their community.

For all of you have done something today *Incredible* for a child and their family, I thank you! I would also ask that if you see some else doing something *Incredible*, thank them. We are all together in this effort to improve the social and emotional wellbeing of our children.

Medical Updates



Improved Access to Smoking Cessation Medication: One of Many Action Strategies to Help New Yorkers with Serious Mental Illness Stop Smoking

by Terry C. Armon, RN MS NPP, OMH Adult Services; and Gregory A. Miller MD, Medical Director, OMH Adult Services

This past fall, New York was honored to be selected one of five states to to conduct Leadership Academies for Wellness and Smoking Cessation sponsored by the Smoking Cessation Leadership Center (SCLC) and the Substance Abuse and Mental Health Services Administration (SAMHSA). This initiative was launched in November with an all day summit that produced an Action Plan for promoting efforts to increase successful smoking cessation efforts for people living with serious mental illness in the state of New York. Our goal for New York is that one out of ten people with serious mental illness will successfully quit smoking by 2015.

One of many strategies that is part of New York's Action Plan is to work with our partners to increase the extent of Medicaid Funding for medications used for smoking cessation, since evidence is emerging that people with SMI need to take these medications longer and in higher doses.

Currently, NYS Medicaid Smoking Cessation policy covers a maximum of two twelve week courses of NRT per year. However, some people who have serious mental illness need to take higher doses of medication, in combination, and for longer periods of time in order to successfully quit smoking. Long-term use of nicotine replacement therapy (NRT) has been shown to be safe and effective for people with SMI. To date, research has shown no serious side effects with longer term use of NRT.

OMH in partnership with DOH, submitted a proposal recommending

that coverage of NRT for smokers with SMI be eligible to receive continuous, uninterrupted prescription coverage of NRT (including nicotine patches, gum, lozenges and/or inhalers.) These changes would increase the success rate of quit attempts by people living with SMI. About 350,000 people with SMI in New York are smokers. If one out of 10 of them are helped to quit by 2015, that means 35,000 fewer people at risk of the ravages of severe and fatal illness caused by cigarette smoking!

The expert panel behind the Clinical Practice Guideline for Treating Tobacco Use and Dependence indicated that pharmacotherapy, if not medically contra-indicated, is a first-line treatment for all smokers trying to quit. Recent studies indicate that for people with SMI, the rate of relapse to smoking may be lower with longer duration, more intensive pharmacologic treatment.

Our efforts to increase access to medication for tobacco cessation form an important strategy. Yet, there are equally important strategic directions that we are pursuing such as the disseminating specialty training, engaging recipients and advocates for people with SMI to work with us and promote our efforts, and driving policies and regulation that encourage wellness and tobacco dependence treatment in all mental health treatment settings. We know that it is possible for people to stop smoking, even when they live with serious mental illness. Our goal is to give all of our recipients all the opportunity and help they need to quit smoking.

Improving Employment Outcomes



Progress Continues Toward Improving Employment Outcomes for NYers with Disabilities

by Michael Seereiter, Medicaid Infrastructure Grant Administrator

As first reported in the [August, 2010 edition of OMH News](#), under OMH's leadership, New York's Federal Medicaid Infrastructure Grant (MIG) funded [New York Makes Work Pay](#) [☑] (NYMWP) program is focused on promoting economic growth inclusive of individuals with disabilities through several initiatives. Moving into 2011, chief among those efforts is the development of a comprehensive job matching/employment support coordination and data system to be used by all providers of employment supports and assistance. It is anticipated that this system will fundamentally improve the opportunity for people with disabilities to successfully find employment opportunities. Regardless of where people with disabilities seek employment opportunities or supports, they will have access to the same resources available to all individuals through use of the NYS Department of Labor's (DOL) *One-Stop Operating System*

(OSOS). Providers of employment services and supports from OMH, the Office for People With Developmental Disabilities, the Office of Alcoholism and Substance Abuse Services, Adult Career and Continuing Education Services (formerly VESID) at the NYS Education Department, the Commission on the Blind and Visually Handicapped, and the Office for the Aging will all utilize the OSOS system and have access to job opportunities posted in DOL's *NYS Job Bank*.

Using the OSOS system, providers of services to people with disabilities will enter information about job seekers they are supporting. The OSOS system will then use its Skills Matching & Referral Technology (SMART), which has the capacity to identify individual job seeker's skills based upon that individual's unique experiences. SMART then matches those identified skills with the skills and talent sought by businesses/employers for individual jobs posted in the *NYS Job Bank*. Job seekers are then provided with an individualized report containing all the jobs posted by businesses/employers in the *NYS Job Bank* that match those skills. On a scale of 5-stars to 1-star, jobs are rank ordered based not only on how closely they match a job seeker's skills, but also based on the preferences the job seeker identifies in the OSOS system (e.g. part-time vs. full-time; the 1st, 2nd, or 3rd shift; proximity to accessible public transportation, etc.). In addition, OSOS offers an ongoing search function that provides notifications for any new jobs posted in the *NYS Job Bank* that match the job seeker's individual skills and preferences.

The OSOS system's SMART technology will prove extremely useful in identifying skills that job seekers with disabilities possess that may not have been identified based solely on their work experience. For example, SMART will help identify skills acquired through pre-vocational experience or via an individual's hobbies and other outside interests. By the time the OSOS system is made available to the disability employment serving agencies later this year, SMART will also have the capacity to assist with resume writing.

In collaboration with the NYS Commission on National & Community Service/New Yorkers Volunteer, DOL and OMH are also exploring how to incorporate volunteer opportunities into the ongoing development of the OSOS redesign regarding employment opportunities. Volunteer opportunities are a natural way in which people gain experience, establish or expand their personal social networks, and demonstrate their value to potential employers. In addition, for people with disabilities who may not have any work experience, or for those with long gaps in their employment history,

volunteering can provide the opportunity to explore potential areas of interest and gain/regain confidence in one's ability to participate in a meaningful way in one's own community. Using OSOS and SMART, it is anticipated that disability-related employment service providers will be able to match individuals with volunteer opportunities appropriate to their skills and preferences, and should help many people move closer toward paid employment. Looking ahead, it is hoped that SMART can also be used to identify gaps in an individual job seeker's skill base and point job seekers to volunteer or other opportunities that may help them acquire the skills necessary for a particular job and to move ahead in their chosen career.

The timeframe for roll-out of NYS' comprehensive employment services job matching/employment support coordination and data system remains generally on track, with adoption of the system slated to begin in June, 2011.

Meeting Needs of Older Adults

Medical Care and Psychosocial Needs of Older Adults

by James Spencer, MD, Project Specialist, NYS-OMH Bureau of Program and Policy Development; and Julie Frodella, Project Director and Mental Health Practitioner, South Oaks Hospital

More than half of the older adults who receive behavioral health care receive it from their primary care physician. There has been much recent interest in the *medical* or *health home* model that provides comprehensive care, and in which a primary care physician (PCP) leads a team, which may include nurse practitioners or physician assistants. The team is responsible for providing all the patient's health care and, when necessary, arranges for appropriate care with other physicians. This model integrates behavioral health and primary care.

The New York State Office of Mental Health is currently supporting a group of Geriatric Demonstration Projects that have shown the value of behavioral and primary health care integration for the elderly. Primary care physicians have found that added assessment and treatment services provided by a mental health professional (MHP) are not only helpful in addressing varied behavioral health problems, but also may improve physical health and care delivery (e.g., better adherence to treatment plans, reduced frequency of unnecessary phone calls and office visits to MD). The MHP in a primary care practice or *health home* provides a practice component for identifying behavior related issues and dealing with them.

Important behavioral conditions that have been identified and

addressed in the primary care setting by these projects are symptoms of depression and anxiety, some of the psychiatric disorders described in DSM IV, and behavior related issues like smoking and obesity. These are all problems by themselves, but they can also have a significant impact on an individual's physical and mental health.

In addition to these symptoms, disorders and behavioral problems, certain types of psychosocial needs or stresses are often found; problems related to domestic conflict, care taking responsibilities, housing, financial management, home health support, safety, nutrition, social isolation, health insurance, and medication management appear with great frequency. They are elements in a complex set of needs of older adults who are "aging in place". These difficulties are particularly prevalent for the elderly who live alone without family or other support, and feel that they have nowhere to turn for help.

Primary care practitioners often struggle with these patient needs, because they can complicate medical care and patient follow through, including proper adherence to care recommendations and because they often cause stress with consequent anxiety and depression. These needs can lead to serious deterioration of a patient's physical condition, unnecessary office visits, or time-consuming phone calls to the doctor. Sometimes emergency room visits, hospitalizations and other forms of intensive, intrusive and costly medical intervention can occur because of the psychosocial difficulty and the stress they cause.

Such problems may be well known to the patient's doctor, but he/she may have neither training nor time to deal with them. When effective professional intervention does occur it often takes the form of what is called *case management*, because they are mainly psychosocial problems for which the patient needs help from family or social service agencies, or other sources that lie outside the usual range of medical services.

However, patients often do not know that help is available or how to obtain it. Or they may resist help for a variety of reasons. There is a need for intermediate flexible intervention by a physician or physician's representative. When successful, this may be followed by more sustained support from an agency or other non-medical source, but the initial intervention (which may involve expertise in overcoming resistance and forming a supportive relationship, identifying problems and potential types of aid, knowledge of available services, and immediate practical help) must come from the people responsible for

the patient's medical or mental health care.

Psychosocial problems often:

- Come to the attention of the patients' doctor or someone in his/her office, through observation, patient request or family concern expressed to the doctor.
- Are not "medical" problems, but do significantly affect patient health and medical care.
- Had not been resolved because the patients lacked information or lacked the cognitive or financial capacity to resolve them, or because they resisted the decisions or actions needed.

The interventions made by the MHP:

- Do not fit the usual categories of medical care, but benefit from the patients' recognition that their physician is involved and supports the intervention
- Are flexible and aim to do whatever necessary to support better health and better care
- Are sometimes resisted by the patient at first, but can be overcome with psychological expertise.
- Cannot initially be referred for conventional services because of patient resistance.

In a *Health Home* or integrated primary care practice, an MHP can:

- Screen and assess for symptoms such as depression, anxiety, and specific psychiatric disorders, and then provide
 - Short-term counseling or therapy, sometimes with medication from the PCP
 - Referral to more extended care when necessary
- Screen and assess for other behavioral issues such as dietary habits, smoking, and alcohol use that affect health and medical care, and then provide
 - Short-term counseling and other brief interventions aimed at behavior change or preparation for referral
 - Referral to longer term intervention aimed at behavior change
- Screen and assess for psychosocial problems that affect health and care, and then provide
 - Short term *brief case management*
 - Referral to more extended case management care and assistance

This is an edited version of a [longer article](#)  first published in the Spring 2011 *Mental Health News*.

IT Update

OMH Email Address Changes Underway

from the omh.ny.gov Project Team

In compliance with New York State CIO/OFT policy, all State Agencies are required to convert their internet/web domains from "agency".state.ny.us to "agency".ny.gov by January 1, 2012. This policy affects Internet web addresses as well as email addresses, where OMH addressing will change from @omh.state.ny.us to @omh.ny.gov.

Additionally, OMH email addresses will be modified to reflect standard internet naming conventions which are defined as firstname.lastname@. To ensure compliance with the above directive, CIT is implementing the domain name change in tandem with the internet naming convention change. Both changes are planned to take effect in February 2011.

What Should You Know?

- Receiving Email at OMH
OMH will continue to receive email using either the @omh.state.ny.us or @omh.ny.gov until January 1st, 2012 when only @omh.ny.gov will be accepted.
- Sending Email from OMH
 - *Current Address* – OMH sends email only as USERNAME@omh.state.ny.us
 - *New Address* – Beginning in February, all email leaving OMH will be using the new email domain name @omh.ny.gov. Recipients of OMH email will then see USERNAME@omh.ny.gov.
- User Name Change
In conjunction with the domain name change, CIT will be adding the Internet email addressing standard of firstname.lastname@. OMH will continue to accept email from correspondents outside OMH addressed to an employee's OMH-issued UserID, former Email nickname, as well as the employee's new firstname.lastname@ email address.

What Should OMH Employees Do?

In case someone that you regularly communicate with has an email filter, you should let them know your new email address so that they can allow your new address. If you are on an email list or member of a list service, change that address to use your new address. Otherwise, there is nothing that you need to do but give out your new email address for future mailings.

From the Field



[Enlarge](#)

Western Field Office Budget Team: Preparing for the Future

by Chris Marcello, Supervising Budgeting Analyst; and Lori Buchanan, Associate Budgeting Analyst

The Western Field Office budget team is working closely with counties and providers in the 19-county Western region preparing them for OMH's many new initiatives. Some of the initiatives we are closely involved with are PROS expansion, implementation of an updated contract Program Work Plan and the launch of a new fiscal reporting system, the County Allocation Tracker. We are working closely with Western Field Office program staff and our budget and program colleagues in Albany to ensure a smooth transition through these many changes.

Part of our role as budgeting analysts in the region is reviewing the fiscal implications of new community mental health programs. One significant change to the regional program landscape is the addition of several new PROS programs. As the PROS program model offers an innovative way to provide rehabilitative services, the PROS finance model also presents new opportunities for providers. We meet frequently with counties and providers to review the dynamics of the PROS fiscal model. On February 1, the Western Region's 18th PROS program opened its doors and we continue to work with other providers to discuss PROS.

As Field Office budgeting analysts we also manage the provider and county budget review process. For providers with direct contracts with OMH, the budget team reviews contract documentation with a focus not just on dollars but program deliverables. This renewed focus on outcomes has been formalized through a standardized Program Work Plan, or Appendix D, developed by Community Budget and Financial Management (CBFM) with input from program and Field Office staff. The updated Work Plan requires agencies to detail contract deliverables and other vital programmatic information as part of the contract submission. This enhanced Work Plan has significantly improved the quality of contract submissions and strengthened dialogue between the Field Office and the provider community.

We have also been working with our 19 county mental health departments with the implementation of the County Allocation Tracker, or CAT. The CAT is a "real-time", web-based budget reporting system. This new system enables counties to allocate OMH State aid and other mental health revenue across all OMH-funded providers in a county on one consolidated report. This new system, effective January 2011, should improve transparency and efficiency as counties can make appropriate changes to the CAT anytime

during the year based on funding or program changes.

To further assist county mental health departments, the budget team provides technical assistance forums including quarterly “Fiscal Officer Meetings”. Fiscal Officer Meetings, held at different regional locations, give county staff an opportunity to discuss relevant issues with their colleagues and Field Office staff. These meetings often include guest speakers from OMH Central Office. Recent speakers have addressed a range of timely topics:

- Peg LaWare, Director, CBFM/Administrative Services, *CAT and Federal Salary Sharing*;
- Bob Blaauw, Director, Community Fiscal Services, *COPS and CSP: Reporting and Reconciliation*;
- Gwen Diamond, Project Analyst, Financial Planning, *Clinic Restructuring*.

The Field Office is very grateful for the assistance our Albany colleagues provide at these and similar regional meetings.

Promoting Cultural Competence

Cultural Influences on Mental Health Care for Filipino Americans

Materials for this article contributed by Gladys Reyes, Research Intern and Terry Dugan, Research Technician MA

The Nathan Kline Institute’s Center of Excellence in Culturally Competent Mental Health maintains research-based profiles on its [website](#) of features of cultural groups that can impact their access to, receipt of and outcomes of services. This is an abstract of a profile of Filipino Americans based on research studies, Bureau of Census data, and epidemiological surveys; for more information please visit our [website](#).

Filipino Americans constitute the second-fastest-growing Asian American group in the United States after Chinese Americans. In New York, they comprise about 12 percent of the Asian and Pacific Islander population in the state and are estimated to number 78,100. According to the U.S. Census Bureau (2008), they have a significantly lower poverty rate than that of the general American population. More than thirty seven percent of Filipino Americans have a bachelor's degree and another 30 percent have some college or associate's degree.

The prevalence of depression among Filipino patients in primary care settings is estimated to be higher than 14 percent and higher than that of other Asian groups. Filipino Americans are also reported to have a higher incidence of schizophrenia than other Asian ethnic

groups. Delays in help seeking may explain why they are diagnosed with schizophrenia at a later age, about 43 years for male patients and 36 years for female patients. In addition, a study also found that there was an unusually high mortality ratio of 2 out of 7 for Filipina American women with schizophrenia. Many Filipino Americans view psychiatric hospitalizations as ominous and very likely permanent because psychiatric hospitalization in the Philippines has always been reserved for very severe and often irreversible chronic cases or for violent patients.

They have lower reported rates of use of any type of mental health services and often seek help from their friends, relatives, priests, ministers, herbalists, spiritualists, or fortune-tellers or *albularyos* (faith healers) instead of going to physicians. Barriers that explain why Filipino Americans seek mental health services at a much lower rate than the already low rates of other Asian American groups include dealing with family hierarchy and reputation, stigma associated with the presence of “bad blood” in the family, fatalistic attitude and dogmatic religious beliefs, lack of belief in one’s capacity to change, communication barriers, externalization of complaints, and lack of culturally competent services.

The type of care provided to Filipino Americans and the attitudes of provider should be tempered by the following reported findings: Many Filipino immigrants may have little understanding of keeping psychiatric appointments or even making appointments because in the Philippines patients can drop in to the family doctor’s office and are seen on a first-come, first-serve basis. This becomes a common reason for dropping out of treatment or for being labeled “unmotivated” by their clinicians. The concept of prolonged care is new to Filipinos who are used to seeing doctors only for symptomatic relief of acute problems. A recent study found that higher acculturation resulted in negative attitudes towards seeking professional mental health interventions. When Filipino Americans finally seek treatment, their strong familial relationships provide a positive context for care. Filipino American families, however, need psychoeducation to address the stigma of mental illness and treatment in their culture.

OMH News is published monthly for people served by, working, involved or interested in New York State’s mental health programs. [Contact the editor.](#)

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