

Local Governmental Unit and Stakeholder Input for Behavioral Health Care Redesign

A major goal of this year's Plan was to seek broad input from local governmental units (LGUs) and stakeholders for consideration in the redesign of Medicaid health care and for maintenance of other critical features of the public mental health system (e.g., unique needs of children and families, of people who do not have health insurance). From March–September, the Office of Planning gathered this input from a number of perspectives:

- Annual LGU mental hygiene plans
- Policy analysis of LGU responses to a set of questions addressing Medicaid redesign, spending and government Efficiency (SAGE), and mandate relief
- Recommendations to Commissioners Hogan and González-Sánchez from the Conference of Local Mental Hygiene Directors (CLMHD)
- Recommendations from the New York City (NYC) Department of Health and Mental Hygiene's (DOHMH) Bureau of Mental Health
- Meetings with individuals and family representatives who are engaged or were previously engaged in receiving services, including notes taken by OMH at the DOHMH's annual hearing held by the Bureau of Mental Health
- Meetings with mental health advocacy groups
- Yearly public hearing and dialogue with the Commissioner and comments and hearing testimony submitted

This chapter offers summaries of data and information gathered. (Detailed reports make up Appendices 2–9). As with previous Statewide Plans, the information was mapped, where possible, to the OMH Strategic Framework domains as follows:

1. People First

Respect individuality by demonstrating hope and positive expectations, a belief in recovery, and regard for diversity.

2. Person-Centered Decision Making

Provide supports and treatment based on self-defined needs, while enhancing personal strengths.

3. Basic Needs Are Met

Enable and encourage people to meet basic needs; be engaged in work, education, or activity; and live in safe, affordable housing.

4. Relationships

Strengthen connections to others, families, and the community, and help to overcome stigma and discrimination.

5. Living a Healthy Life

Aid people to support and manage their own well-being, meet life's challenges successfully, and maintain physical health.

6. Mental Health Treatment and Supports

Foster access to treatment and supports that enable people to lead satisfying lives in their communities.

7. Self-Help, Peer Support, Empowerment

Promote recovery and a greater quality of life through access to self-help, peer support and empowerment services.

8. Mental Health System of Care, Workforce and Accountability

Reinforce competencies for delivering recovery-oriented services, and ensuring participation in governance and involvement in managing quality and performance.

Annual Plan Priorities of LGUs

This year, 60 of 62 (96.8 percent) counties submitted and certified their priorities in time for analysis in the online County Planning System (CPS). The majority of the 120 priorities (64, 53.3 percent) relate to mental health. Co-occurring mental health and substance abuse priorities account for 20 percent, while co-occurring mental health and developmental priorities total 13.3 percent. In all there were also 13.3 percent of priorities that crossed all three disability areas. The distribution is similar to previous years, where cross-systems, comprehensive, integrated person-centered services and supports are designated by counties as essential to effective service provision.

Across the State, priorities fall largely into Domain 6, Mental Health Treatment and Supports, with (56, 46.6 percent), rising 3.3 percent since last year. Also rising slightly from a year ago is the number of priorities focused on Basic Needs (Domain 3), largely the need for housing with supports to promote successful community living. Compared to 19.8 percent last year, Basic Needs priorities are at 22.5 percent. Priorities related to the System of Care, Workforce and Accountability (Domain 8) ranked third at 14.2% and reflect ongoing concern with fiscal viability of community programs and other effects of regulatory reform.

Overall, the data appear to indicate the crucial role counties play in overseeing, operating, managing and evaluating resources and resource needs in a time of serious fiscal constraint. Counties are striving to ensure quality mental health treatment and supports with no new monies, while at the same time responding to a changing service system, including

implementation of clinic restructuring and reforms being introduced in preparation for Medicaid managed care. While top-two priorities largely fall into the three domains described here, counties are clearly committed the goals described in the other domains (e.g., person-first, recovery-oriented services and supports, peer support), thereby enabling adults, children and families to live productively in their communities. Features that describe the nature of top priorities by OMH region are included in Appendix 2.

Policy Analysis of LGU Responses to Questions on Medicaid Redesign, Spending and Government Efficiency (SAGE) and Integrated Mental Hygiene

Last year this year also, the interagency Mental Hygiene Planning Committee asked LGUs to respond to policy concerns in relation to changes under way at the local level. The Policy and Planning Activities Report section of this year's mental hygiene planning cycle, therefore, provided localities with the opportunity to weigh in on substantive policy and planning issues affecting the mental hygiene disability areas at the State and local levels. In all, 36 counties responded fully or partially to questions 2 (Medicaid redesign), 3 (mandate relief) and 4 (integration of mental hygiene services) on the Planning Activities Report. Responses were considered by region within the same geographic framework being used for the creation of the regional behavioral health organizations (BHOs).

Counties answered any or all parts of the three survey questions. Eighty percent of all responses came from counties in the Central and Western New York regions. Question 4 drew the highest number of responses, reflecting in part the emphasis on integrated planning across the three mental hygiene agencies and impending changes under Medicaid redesign. Of note, NYC, which comprises the five boroughs (counties) of the NYC Region, did not respond to the any of the survey questions.

As indicated in Appendix 3, most of the concerns related to the planning, financing, delivery and evaluation of mental hygiene services centered primarily on mental health/chemical dependencies (defined under Medicaid redesign as "behavioral health") and physical health. Counties uniformly pointed out ways they wished to see tighter integration between the mental health and substance abuse systems of care and provided numerous recommendations for reducing regulatory and statutory barriers to effective care. Counties also highlighted areas where improved coordination and integration of care could occur between mental health and developmental disabilities.

Broadly, counties across the state offered recommendations on the movement toward Medicaid managed care and ultimately toward the provision of the most effective services, while reducing costs and making the best investment of Medicaid funding. These priorities include:

- Implementing the integration of chemical dependence and mental health services and ultimately integrating behavioral health services with physical health services and related supports for successful community living

- Incorporating case management services and care management for people with complex conditions, while strengthening community linkages along the recovery continuum of care to reduce unnecessary inpatient care and detoxification admissions, as well as readmissions, among Medicaid beneficiaries who are identified as “high use/high cost”
- Providing integrated physical and behavioral health care based on the values of person-centered, recovery-oriented care, and utilizing models of co-located care that help to reduce stigma and improve the outcomes of care
- Engaging with the State agencies to identify areas for regulatory and statutory relief, enabling better alignment between the goals of Medicaid redesign and the on-the-ground operations (e.g., billing models that incentivize integrated care rather than contribute to siloed care) as well as fostering implementation of integrated services and care management with the least administrative and clinical burden
- Implementing electronic medical records and having access to robust Medicaid data to better manage the care of Medicaid beneficiaries with the most serious and complex conditions, monitoring outcomes of care, identifying people who may need treatment but have been lost to care so providers may reach out and engage them in care, and examining indicators of overall system of care performance
- Having the ability to access flexible funding to provide critical support services (e.g., peer, housing, employment) not funded under Medicaid but proven by science to be essential to successful community life for individuals with serious behavioral conditions

Appendix 3, which offers a qualitative review of regional concerns, sheds light on variation across regions as well as differing geographic features of counties (e.g., rural vs. urban).

Recommendations to Commissioners Hogan and González-Sánchez from the CLMHD

In May 2011, CLMHD advanced a set of recommendations for modifying the roles of stakeholders, including providers, consumers, and the LGU. It noted the current LGU’s responsibility for managing the local system for all consumers—not just those enrolled in Medicaid—and the need to institute new and enhanced core functions and responsibilities in a regional behavioral healthcare organization (RBHO) and managed care environment.

CLMHD outlined a framework for the core functions and responsibilities of the LGU in advising and monitoring the impact of care management arrangements for the system and consumers with mental illness and substance abuse disorders and families during Phase I.

The role of the LGU is pivotal in determining the impact of statewide policy decisions and managed care operations on local systems of care. The core functions and responsibilities of the LGU in a BHO/managed care environment are anchored in Article 41 of Mental Hygiene

Law, which vests in the LGU the responsibility to develop plans to meet the needs of people diagnosed with mental illness and alcohol or substance use/abuse conditions. The statutory role of the LGU makes it an important change agent in the role of moving each county toward Medicaid managed care arrangements (e.g., planning for the needs of all residents, not just those receiving Medicaid services, ensuring a continuum of care to meet residents' needs, facilitating court-ordered services, and financing services).

Given its role in statute, CLMHD offered a series of recommendations to ensure full participation by LGUs in developing, monitoring, and governing BHOs. Specifically, for Phase 1 of BHO implementation, CLMHD calls for LGUs to be:

- Participating in defining key elements of redesign, including advice on benefit plan, development of networks that ensure a comprehensive, responsive, recovery-oriented behavioral health care for members
- Monitoring quality for impacts of change on the entire local system of care (e.g., non-Medicaid recipients) and on member services (e.g., monitoring access to care, provider choice, member satisfaction)

More details associated with the CLMHD recommendations, including suggestions for steering committee oversight, are available in Appendix 4.

Recommendations from the New York City Department of Health and Mental Hygiene's Bureau of Mental Health Services

In August, the Bureau of Mental Health Services provided a written response to questions posed by OMH for stakeholders and LGUs to consider in preparation for its yearly public hearing (see Appendix 5).

It offered suggestions for the Phase 1 of BHO implementation and urged that this period be used to obtain an accurate picture of the regional inpatient behavioral health services utilization and the quality of care coordination taking place for people with behavioral disorders. It noted that BHOs will be well positioned to inform the State and LGUs about service gaps and unmet needs that are contributing to readmissions and multiple emergency health services utilizations. Through information sharing and data exchange, BHOs will also have the ability to keep everyone abreast of opportunities for improvement and lessons learned.

The Bureau urged that the Behavioral Health Subcommittee of the MRT prioritize essential recovery-oriented elements, including health information technology (HIT) to serve as a “lynchpin of integrated care delivery”; the integration of peer supports into health care delivery, with a set ratio of peers to consumers to ensure access; integration of care for dual disorders; and establishment of quality health home operational standards and guidelines.

Truly integrated care will evolve from attention to positive outcomes achieved through basic screening/prevention and well-coordinated referrals, improved collaboration among primary and specialty providers, effective care management that enables people to link to

providers best able to meet their overall health needs, improve communication among care providers, and staff cross-trained at all levels of primary and specialty care, particularly for mental health screening and chronic disease indicators.

Care management networks should provide consumers with behavioral health conditions seamless access to physical health services and/or rehabilitative services (e.g., education, employment, housing, social service benefits) or well-connected access to such services. HIT, it adds, should be an essential component of integrated care, with built-in care planning functions that foster holistic health care.

All of these components should be supported by guidelines for the implementation of recovery and resiliency practices at the systems level such as the inclusion of peer-run agencies in services provision and support for community integration, for example, through social, employment and educational opportunities. Additionally such guidelines should include the promotions of prevention and wellness strategies such as advance directives, alternative approaches (e.g., peer respite to avoid hospitalization) that show promise in helping people manage their conditions.

At the program level, the Bureau urges the development of recovery-oriented performance indicators to monitor individual and program outcomes, and recovery-oriented program evaluation. It calls for holding programs accountable for producing positive outcomes. Importantly, it notes, programs must provide services in culturally and linguistically competent ways from promoting wellness, to addressing trauma, economic-self-sufficiency and self-agency.

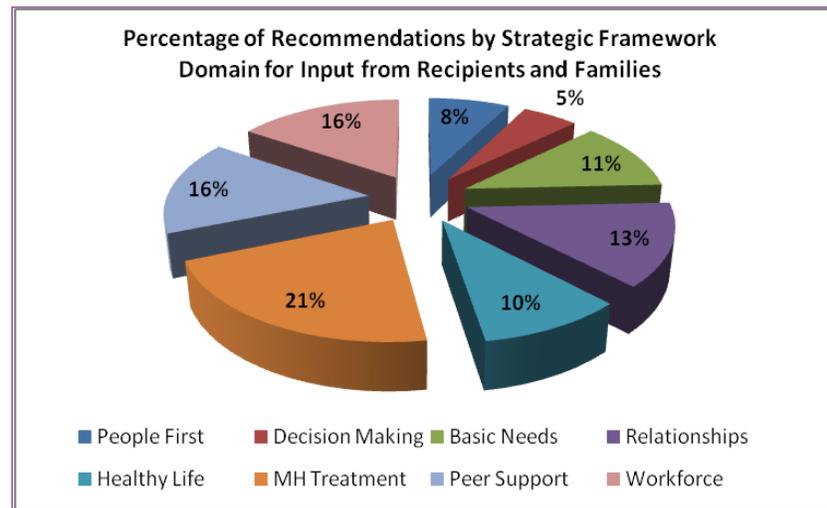
To ensure a well-prepared work force for care management, the Bureau calls for certification of the peer specialist role in NYS, the creation of professional education guidelines to ensure recovery education, and include tenets of recovery, integrated care and evidence-based practices in such guidelines.

Recommendations from Recipients and Families Who Are or Were Previously Engaged in Mental Health Services and from Recipients Hospitalized in Forensic Psychiatric Centers

Recommendations from Recipients and Families Who Are or Were Previously Engaged in Mental Health Services

As illustrated in Figure 1, among the recommendations from recipients and families, the highest percentage occurred in the domain of mental health treatment and support, followed by the domains of peer support and workforce/ system/ accountability issues. Common themes in these three areas include:

Figure 1. Percentage of Recommendations by Framework Domain



Mental Health Treatment and Supports

Overall, there appears to be a sense that the health home option provides new opportunities for recreating community mental health treatment and support so that physical and behavioral health care are well integrated and reduce the stigma and discrimination associated with mental health care. Essentially recipients and families urge health home environments that are welcoming and staffed with individuals, including peers, who “love working with people who are dealing with serious mental health conditions.” Health homes need to “attract providers to their network who truly believe in and have a demonstrated commitment to recovery and wellness.” They should employ physician assistants and nurse practitioners as much as possible because “they take time to listen” and they assume with ease the role of coaching people to reach their wellness goals.

Part of a health home’s role is to be attractive and “hip” to people who are leaving inpatient care, thereby having a greater degree of success in engaging people in care and connecting to community supports when indicated. They should foster self-direction, enable people to determine approaches that enable them to be healthy, and never force treatment.

Health homes should “match the level of care to a person’s needs” and identify recovery-oriented, culturally competent approaches that promote rehabilitation following hospitalization (e.g., peer visiting, crisis diversion). Care should be comprehensive and tailored to clinical need (e.g., expertise in trauma-informed care, warm lines, community crisis response, management of metabolic disorders) and informed by close connections to the community (e.g., use peers to train first responders and law enforcement personnel in empathy and strategies for maintaining

calm). Health homes should aid in building collegiality among public and private network providers and community agencies, rely upon health information technology to strengthen communications between providers and strive for well-integrated care.

Health homes should work closely with inpatient providers to have robust discharge planning that avoid unnecessary readmissions by taking each person's needs into account (e.g., Has social security paperwork started? Have connections to peer services been made? Where will the person be living?) Moreover, health homes should support efforts to reverse a culture of dependency created by hospitalization by embracing peer services and fostering each person's confidence and strengths.

Health homes should also prioritize care for special populations (older adults, people being released from jails) by building on resources available across the State (e.g., mental health courts, geriatric demonstration projects, programs that help to modify living environments for older adults).

Primary care, behavioral care, and other specialty providers all require training to understand the roles and responsibilities, and promote mutual respect for the strengths and contributions that each member brings to the health home team. Professional and ancillary staff will likely require education about the role peers play in promoting health and well-being and help them to incorporate peers and their expertise into integrated health teams (e.g., treating peers as members of the team who bring peer expertise and knowledge, not as "patients."). Another area of education for health home teams will be in increasing sensitivity and knowledge about cultural groups in network communities, to ensure that beliefs and values are seen within the context of culture rather than misinterpreted as signs and symptoms of mental health challenges.

While children will not be enrolled into health homes during the transitional Phase 1, health homes serving children and families already enrolled should provide care based in the values of the Child and Adolescent Services System Program (CASSP) and the NYS Children's Plan and assure essential community and family support services for children and their families, including case management, school-based clinic services, mobile services, crisis management and outpatient treatment.

Self-help, Peer Support, and Empowerment

There was widespread support for incorporating authentic peer support and peer-run services into BHOs and health homes, where peers are not employees of, but rather providers of services via contracts with health homes. There is an expectation that health homes will have an adequate array of peer support services as part of the services mix. Recipients also voiced that peer support training should be standard and include certification and that peer services be a billable rehabilitation service under Medicaid.

Peer services are urged at every point in the care continuum, from early on when behavioral challenges are identified, to avert the need for emergency department services, to assist treatment planning, and to provide bridge services and ongoing community support following discharge from the hospital. Recipients and family members expressed widespread agreement that peer services are vital in emergency departments. They asked that individuals

seeking psychiatric emergency intervention be offered the opportunity to talk with a peer while awaiting professional psychiatric assessment, ensuring that people in crisis are not isolated and alone with their thoughts and feelings. There was strong support for making peer support a standard of emergency psychiatric care and for helping people to head off crises using peer respite, peer empowerment centers, and warm lines. In NYC, recipients requested a 24/7 peer warm line for empathic, cost-effective support. Mobile peer services should also be provided in the community, and include outreach, engagement, and responsiveness to individual need (e.g., for people isolated due to behavioral conditions).

Health homes should also rely upon peers to mentor people in care, helping them to find their strengths, manage symptoms, and gain stability in community living (e.g., support employment goals, connect to natural community supports, benefits counseling). Recipients underscored the value of contracting with peer providers, noting that their presence conveys the powerful message that recovery is possible and gives hope to people who would otherwise not have it.

Mental Health System of Care, Workforce and Accountability

Recommendations strongly endorsed the need to help recipients and families understand features of BHOs, health homes and educate them about the choices they may need to consider during Phase 1 of BHO and health home implementation. Recipients asked for clear direction and access to information about whether to enroll in a managed care plan or continue to receive Medicaid on a fee-for-service basis. As implementation occurs, people who receive or have received services and their families should be engaged in identifying recovery outcome measures and the use of valid and reliable measures of primary and behavioral health care as well as data to identify gaps in services and quality health care.

Provider education is another area with a number of recommendations from recipients and providers. A primary focus of provide education should be on changing the culture of care from one focused on what is wrong with an individual to one that seeks from individuals their personal stories that tell what happened to them. Sharpening the engagement skills of physicians will be crucial to achieving positive outcomes for people with behavioral challenges. Cross-training of primary and specialty care providers, increasing their knowledge and understanding of behavioral disorders and recovery approaches, will be key to the success of health homes, recipients also advise.

A number of dimensions of accountability and system of care issues were also addressed by recipients. Most important is the recommendation that people engaged in services and their families must be involved in policy and decision making and included in planning the design of BHO oversight and health home services and supports.

Incentives need to be created for health homes to work with individuals who have the most complex medical and behavioral health conditions and not turn them away from care. Incentives also need to be created to attract psychiatrists and psychiatric nurse practitioners into health homes in more rural and underserved areas of the five OMH regions. Incentives also need to be provided to recipients that promote self-directed health goals (e.g., flexible funding to cover the cost of gym membership, running shoes or a bicycle).

Health information technology needs to be employed, recipients say, to improve communication between primary and behavioral providers, to avoid errors (e.g., medication interactions, alerts to physicians that a medication waiver is needed), to reduce the burdensome paperwork currently used for each provider visit, and to monitor the program and fiscal effects of clinic restructuring and changes under way in the service system (e.g., impact of 30/50 reduction for children with serious emotional disturbance and their families).

More details for these three domain areas as well as detailed re commendations for the other domains appear in Appendix 6.

Recommendations from Recipients Hospitalized in OMH Forensic Psychiatric Centers

In support of integrated care across forensic settings and hospitals, recipients overwhelmingly recommended more family involvement. They urge that facilities hold family days, offer education programs that help family to support wellness of their loved ones (to the degree the recipient desires), and more integrated treatment planning with family members. Moreover, they point out that upon admission to a forensic psychiatric center, families may benefit from education on what to expect and how they can support recovery.

Integrated care, they recommend, may also be achieved by supporting hospitalized inmates to strengthen their skills to cope with stress and chaos in their immediate environment as well as programs to promote wellness, recovery action planning, and work skills development. Recipients also asked for more peer-run programming to increase learning and vocational development opportunities. Of note, recipients urged that their environments be infused with hope, a focus on bringing out each person's strengths, and a staff educated to understand the value of person-centered care and therapeutic support for recovery.

Using non-treatment time productively is of concern to recipients and they made recommendations in a number of areas. They asked for balance between treatment/group time and non-treatment time so they obtain the most therapeutic benefit from treatment and are not "worn down" by nonstop structured treatment or, for people with bipolar disorder, experience symptoms from too much stimulation. They urged that time be provided to maintain physical health (e.g., strength training). They pointed out the chance for wellness through positive non-treatment individual, group and social opportunities such as karaoke, Latin music, movies, lectures on recovery and resiliency, concerts, board games, video games, drumming, and spiritual counseling.

Recipients also pointed out the role of people in recovery in supporting their peers during hospitalization. They emphasized the importance of improving one's community, sharing insights and reinforcing rehabilitation and recovery, aiding people in special housing units through peer support, and helping their peers to reflect upon actions and genuinely make amends.

Recommendations from recipients hospitalized in forensic psychiatric centers also appear in Appendix 6.

Input from Advisory and Advocacy Groups

Input from advisory and advocacy groups reflects in part the perspective of each group and its priorities. Of note, because of OMH was involved in the procurement for Phase 1 of the implementation of the BHO initiative, the Office of Planning was unable to meet with a number of advocacy groups during the period of restricted communications. Groups were invited to submit feedback in writing during this period.

Given the extensive input received across the Strategic Framework domains, the summary here focuses on treatment and support recommendations for Medicaid redesign. These include:

- Having standards of care rooted in the values of recovery, resiliency and the rights and dignity of individuals and developing within each health home a therapeutic milieu focusing on strengths rather than deficits
- Relying upon the most accepted therapies that are proven or informed by scientific evidence.
- Not losing sight of the treatment and support needs of all New Yorkers diagnosed with mental illness regardless of who pays for services
- Attending to the critical nature of discharge planning and providing bridger services during the transition from hospital to rehabilitation in the community
- Utilizing performance indicators that show outcomes following discharge and for monitoring engagement in treatment and supports (e.g., re-hospitalization rates)
- Ensuring that services provided under BHOs for children, youth and their families are based upon the principles espoused in the Child and Adolescent Service System Program (CASSP) and Children's Plan
- Supporting the development and recognition of family/peer competencies and credentialing that builds on the recognition that peer and family support build trust, improve engagement in treatment, and improve outcomes
- Ensuring that children's services under BHOs respect the principle that children are not little adults, but rather they are individuals who require a much different approach than adults and require the participation of parents and families in treatment and support
- Strengthening the LGU Coordinated Children's Services Initiative (CCSI) infrastructure and provide incentives for the delivery of integrated and coordinated treatment and supports across systems of care
- Increasing mental health courts serving rural areas and diverting people with serious mental health conditions from the criminal justice system
- Working toward the creation of a BHO managed "carve-out plan" that has at its core the integration and improved coordination of behavioral health (mental health and

substance use) treatment services that are linked to appropriate health, housing and social support services

- Ensuring that people who become engaged in behavioral health treatment in health homes have good access to treatment and services when indicated **and** good access to leaving treatment and services when they no longer are necessary (providing the right dose of treatment at the right time)
- Structuring peer services so they are provided through independent peer providers, with expertise in connecting people to appropriate supports and also helping people to connect to medically necessary treatment services
- Fully integrating trauma-informed care into the service array of health homes
- Advocating with the federal government for greater state flexibility in using client-directed services funding (i.e., Money follows the Person) for improved community care
- Having dialogues to reframe safety and risk by drawing upon the work of Mead and relying upon approaches that build on our strengths and not our deficits (e.g. seeking safety through mutually responsible relationships in which people feel safe disclosing discomfort and sharing risk).
- For people at risk for negative consequences of not receiving behavioral treatment, meaningfully engaging them in services without the use of force or coercion

See Appendix 7 to review recommendations across the Strategic Framework domains.

Written Public Input Received via the Transformation Mailbox or the Statewide Public Hearing

In late July, OMH invited the public to provide input into this year's Statewide Comprehensive Plan for Mental Health Services. Stakeholders were encouraged to submit their concerns and recommendations in writing and also to attend the public hearing and dialogue with Commissioner Hogan on September 13.

OMH requested that individuals and organizations across the five OMH regions declare their priorities for our changing health care environment. Specifically, OMH posed the following questions to elicit input:

- As New York moves toward managing mental health and addiction treatment services and increasing integration of behavioral and physical health care, interim regional BHOs will be established beginning in Fall 2011 to facilitate the transition to care management and to improve appropriateness and continuity of inpatient care. What suggestions do you have for this interim period?
- What should OMH and members of the Behavioral Health Subcommittee of the MRT take into account as it considers strategies for integrated, managed behavioral

(mental health and substance abuse) services, for co-locating behavioral services with physical health care, for integrating peer supports, for guiding the development of health homes, and for other innovative approaches to improving the coordination of physical and behavioral health care?

- What do you suggest to ensure truly integrated care? That is, what recommendations do you have to bring physical and behavioral health care together to improve the health and quality of life for people engaged in care?
- What elements would you like to see included—or not included—as part of managed networks of behavioral care, as well as in health homes?
- What suggestions would you offer to move New York closer to evidence based, person-centered, family

What follows is a summary of a number of recommendations from the public hearing and written submissions:

- While the current operating environment is changing and OMH awaits approval of clinic restructuring provisions, the three mental hygiene agencies and Department of Health should articulate how the Medicaid managed care BHO and health home approach all fits together. Reform, for example, is not just for Medicaid, but impacts care for people not receiving Medicaid. Reform efforts must be seen within the context of the entire delivery system and attention must focus on access to care for people lacking health insurance.
- Attention needs to be given to the culture of change; it will take more than “care coordinators” to significantly change the interactions among consumers with multiple co-morbidities, primary care providers, specialists, and hospitals and to achieve the kinds of behavioral changes needed to assure adherence to complex medical regimens.
- Don’t lose the focus on early identification, screening, assessment, and engagement of children and families in clinic care. Look to success among the cohort of clinic plus providers and lessons learned.
- Continue planning to meet the needs of children and their families with more interagency planning, particularly the roles played by other child-serving systems, including education, child welfare, and juvenile justice, which are not funded by Medicaid dollars.
- Ensure that new payment models respect the independent nature of family-run peer-to-peer, family support and compensate these programs, which are as important as the traditional “medical” model services.
- Provide a child in crisis or in need of hospital care with a friendly, peaceful, and caring facility, where the child can be monitored while the proper medications are found and the family can readily be close by and aid recovery.

- Ensure that health services to homebound individuals are addressed under reform so that their needs are adequately met.
- Build in peer services to the contracting process and include peer-led support and education programs, including wellness management and health coaching, in health homes now and as part of NYC special needs plans when they are established in two years.
- Maximize the integration of primary and behavioral health care by (1) educating primary care physicians and other network providers about mental illness; (2) training primary medical staff to care for people with mental illness (e.g., working effectively with people who have behavioral disorders, avoiding relapses, managing medications); and (3) improving access to medical information through electronic medical records at all points of care.
- Prepare the workforce to value and bring its behavioral health expertise to the primary care environment.
- Improve the integration of mental health and substance abuse care so providers do not just talk about providing such care, but actually do address both mental health and substance abuse needs comprehensively and holistically.
- Ensure that services are culturally and linguistically competent.
- Look to proven programs such as Compeer to meet the social need for friendship using the needs of individuals.
- Ensure that gaps in care for youth in transition to adulthood with serious emotional challenges are addressed.
- Continue to work with other State agencies to leverage resources that lead to housing opportunities for people with serious behavioral disorders and particularly to address the need for diversion and crisis housing.
- Look to lessons learned in other managed care systems and adopt those that fit well with providing integrated care (e.g., call center to triage care, folding primary care practices in mental health, developing a network of preferred provider hospitals, incorporating behavioral billing codes into primary care settings, using the Patient Health Questionnaire-9 (PHQ-9) to measure symptoms over time).
- Base clinical interventions on the best scientific evidence (e.g., treating first episodes of psychosis with safe, caring environments, ongoing coaching, careful medication management) and continue research efforts that help to narrow the gap between science and practice.
- Reduce the regulatory burdens that impede the ability of providers to work collaboratively.

Appendix 8 provides a full overview of recommendations received from the public via the OMH mailbox and the yearly public hearing.

Behavioral Health Care Recommendations from the Medicaid Redesign Public Hearings

The MRT, created by Governor Andrew M. Cuomo, conducted a comprehensive examination of New York's Medicaid system, holding six regional public hearings in January and February of 2011. The hearings were designed to solicit suggestions from the public and stakeholders on ways to eliminate waste and inefficiency while improving quality in the Medicaid program. The Medicaid Redesign Team invited public input directly in writing, via the web site, or during these hearings. The Team received more than 800 recommendations, a number specific to mental health and behavioral care.

Suggestions and recommendations related to behavioral health care were elicited as part of the public hearing process. Across all regions, these recommendations organized into the following content areas: care coordination, service quality, service access, reimbursement setting and rates, and oversight and regulatory reform.

Overall, many of the recommendations offered in February have become more developed over time by stakeholders, as evidenced by the preceding summaries. Importantly, however, what came through in the recommendations is the importance of preserving the safety net for the State's most vulnerable citizens in a culturally and linguistically competent manner, ensuring that regions of the State have flexibility for designing BHOs that reflect local need, and learning from the lessons of other states that have experience with redesign of integrated Medicaid and other behavioral health services.

Appendix 9 provides behavioral health recommendations gleaned from the MRT public hearings.