Local Behavioral Health Systems in New York State
Office of Alcoholism and Substance Abuse Services (OASAS)
Office of Mental Health (OMH)

June 20, 2016 10:00 – 11:00 a.m. Eastern
Division of Long Term Care Webinar Series

Housekeeping

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Speakers

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Objectives

- Identify steps in the discharge planning process
- Define the role of Health Homes in discharge planning
- Be able to name at least three resources available from the Office of Mental Health (OMH) or Office of Alcohol and Substance Abuse Services (OASAS)
  - Referrals for Mental Health
  - Discharge Resources
Agenda

- First Steps
- The Role of Health Homes
- Managed Care
- Overview of Office of Mental Health (OMH)
  - Referrals for Mental Health
  - Discharge Resources
- Office of Alcohol and Substance Abuse Services (OASAS)
- Conclusion

Improving Health Outcomes

- Person-Centered
- Recovery Oriented
- Continuum of Care

What is the first step?

- Check the individual’s insurance coverage:
- Managed care plan: the plan can assist with discharge planning and identifying behavioral health referrals
- No insurance Coverage (Fee-For-Service): The Local Government Unit can assist with identifying behavioral health resources
Managed Care

Types of Managed Care

- Commercial
- Medicare
- NYS Public Managed Care Programs
  - Medicaid Managed Care
  - Family Health Plus and Family Health Plus Premium Assistance Program
  - Child Health Plus
- Medicare/Medicaid (Duals)
  - Managed Long Term Care: PACE, MAP, Partial Cap
  - FIDA (Medicare Advantage + MTLCP)
  - Medicaid Advantage
- Special Needs Plans (HARP, HIV/SNP)

The Role of Health Homes for Individuals with Behavioral Health Conditions
Is the Individual in a Health Home?

If yes, the Health Home Care Manager should assist with discharge planning and behavior health referrals.

What is a Health Home?

- A ‘Health Home’ is not a place
- Provides care management – care managers work collaboratively with various service providers, sharing information to develop a comprehensive plan of care, to make sure the patient gets the care & services they need to stay healthy
- Supports provision of coordinated, comprehensive medical and behavioral health care to patients with chronic conditions through a network of physical health, behavioral health and social services

Health Home Verification

- When getting Medicaid Managed Care approval for services, hospitals and inpatient services should verify if the patient is in a Health Home and has a Care Manager
- Discharge planning starts during admission – gather information about whether the patient has a Health Home Care Manager
  - Managed Care Plans are starting to notify Health Homes if a patient has been admitted to the hospital or inpatient setting so immediate coordination of services can occur
Health Home Care Managers Provide

- Comprehensive Care Management Services
- Care coordination and health promotion
- Comprehensive transitional care (e.g., inpatient discharge, jail to community)
- Patient and family support
- Referral to community and social support services (e.g., housing, legal, food)
- Use of Health Information Technology to link services

Health Homes

- Designated by NYS Department of Health (DOH)
- Oversee assignment of eligible adults to care management
- Referrals for care management are made through various sources including:
  - NYS DOH data
  - Community providers
  - Medicaid Managed Plans for eligible members (includes HARP)
  - Health Homes to care management contracted providers

Health Home Care Management Eligibility

- The individual must be enrolled in Medicaid
- Medicaid members eligible to enroll in a Health Home must have:
  - Two or more chronic conditions (e.g., SUD, Asthma, Diabetes, Heart Disease)
  - One chronic condition – HIV/AIDS or serious mental illness
- The Medicaid member must be determined appropriate for Health Home services. An individual must be assessed and found to have significant behavioral, medical, or social risk factors to deem them appropriate for Health Home services
- Health Home is an optional State Plan service
Health Home Referral

- At discharge, if a Health Home is not already noted, contact the Medicaid Managed Care Plan to notify them that discharge planning process has begun and to verify if there is a Health Home Care Manager already involved

- If a Health Home Care Manager is not already assigned, determine whether the patient meets the eligibility criteria
  - If you believe the patient meets Health Home eligibility, make a referral to the local Health Home:
    - Talk with the patient about Health Home services
    - Get patient consent to make a referral for Health Home services

Office of Mental Health (OMH)

- Loosely defined as providers and services operated, regulated, certified, or funded by State OMH
- Categories of Mental Health services are:
  - Inpatient
  - Outpatient
  - Emergency
  - Residential
  - Support
- Individuals served in public mental health system have mental illness or serious emotional disturbance (i.e. diagnoses and functional impairments due to the mental health diagnosis)

NYS Mental Health System
Mental health services available to anyone

- Existing State Plan Benefits Moving into Medicaid Managed Care:
  - Mental Health Inpatient Rehabilitation
  - Mental Health Clinic
  - Partial Hospitalization
  - Personalized Recovery Oriented Services (PROS)
  - Assertive Community Treatment (ACT)
  - Continuing Day Treatment (CDT)
  - Comprehensive Psychiatric Emergency Program (CPEP)
  - Intensive Psychiatric Rehabilitation Treatment (IPRT)
- Medicaid Managed Care Only Services:
  - Crisis Intervention
  - Licensed Mental Health Practitioner Services

Licensed OMH Clinics – A Key Entry Point

- Clinic is a set of services provided by qualified staff at a licensed site or satellite location
- Services may include:
  - Assessment
  - Diagnosis
  - Treatment planning
  - Psychotherapy
  - Medication management
- Every county has at least one clinic, some have multiple
- Approximately 75% of people who received OMH licensed clinic services in 2013 had serious mental illness

(MOH Patient Characteristics Survey, 2013)

Mental Health can also be provided

- In some Department of Health (DOH) regulated settings, including:
  - Primary care settings
  - Clinics (Article 28)
  - Federally Qualified Health Centers (FQHC)
- In private mental health practices, including:
  - Private licensed professionals in Psychiatry
  - Psychology
  - Social work
  - Mental health counseling
Social Determinant Assessment

- Housing
- Food
- Electricity
- Social Supports
- Interactions with other social services (law enforcement, CPS, etc.)

If social determinant needs are discovered, contact the LGU or the Department of Social Services for assistance.

Referrals for Mental Health

Newly Diagnosed or Untreated Mental Health Condition

- When a mental health condition is identified or suspected at the time of discharge, refer to PCP for assessment, diagnosis and coordination of care.
- Contact the LGU and/or managed care plan if there are specialty services that could be beneficial to the individual upon discharge.
The Local Government Unit (LGU) is responsible for assuring appropriate mental health (MH) and substance use disorder (SUD) services for county residents.

- Vary in size - from 1 to dozens of staff – and in function
- Oversee the county’s MH service system and, in some cases, operates or funds MH services
- Oversees the county’s SUD service system and, in some cases, operates or funds SUD services

### Existing Mental Health Condition

**Is the individual already engaged in OMH system?**

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<tr>
<th>Yes</th>
<th>No</th>
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<tr>
<td><strong>Coordination with existing treatment teams</strong>, mental health care managers, and pharmacist.</td>
<td><strong>Contact OMH Connects 1-800-342-0927</strong></td>
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<td><strong>Engage the designed health team</strong></td>
<td><strong>If enrolled in managed care contact the managed care plan for OASAS referrals</strong></td>
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<td><strong>LGU can help you understand local access to support and services</strong></td>
<td><strong>Alcoholics anonymous, recovery groups, and friends discharge plan with consent from the individual</strong></td>
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**Office of Alcoholism and Substance Abuse Services (OASAS)**
• Depending on the level of need, an individual could be referred to the following services (from most to least intensive):
  • Withdrawal and Stabilization Services
  • Inpatient Treatment Services
  • Residential Treatment Services
  • Outpatient Services

• Services designed to provide range of options for people who are intoxicated or incapacitated by their use of alcohol and/or substances
• Purpose of services is the medical management of withdrawal and crisis stabilization

• Acutely ill from SUD
• With or at high risk of having severe withdrawal complications

• Intoxicated by alcohol and/or substances
• Mild to moderate withdrawal
• Unable to abstain without withdrawal complications
Medically Supervised Outpatient Withdrawal and Stabilization Services
• Intoxicated by alcohol and/or substances
• Mild to moderate withdrawal
• Stable environment
• Unable to abstain without withdrawal complications

Medically Monitored Withdrawal and Stabilization Services
• Intoxicated by alcohol and/or substances
• Mild withdrawal with situational crisis
• Unable to abstain without withdrawal complications

Inpatient Rehabilitation
• Indicated if individual is unable to participate in, or comply with, treatment outside of a 24 hour structured treatment setting:
• Has not been able to lessen symptoms of SUD in less intensive settings
• Physical or mental complications, e.g. psychiatric, pregnancy, or other medical problems that require 24 hr. observation
• Lacks judgment, insight and motivation such as to require 24 hr. supervision
• Home environment is not conducive to recovery

Residential Services
• Services designed to help persons who lack a safe and supportive residential option in the community to achieve changes in their substance use disorder (“SUD”) behaviors within a safe and supportive setting
• Services may focus treatment on one or more of the following treatment/recovery elements: stabilization, rehabilitation, or community reintegration
Stabilization
- Stabilize withdrawal symptoms, severe cravings before referral/transition to another level of care
- Requires physician and clinical monitoring

Rehabilitation
- Structured environment
- Limited potential for independent living
- Significant functional impairment
- Monitoring, support and case management

Reintegration
- Community living experience
- Limited supervision and/or case management
- Transition to long term recovery and independent living

Outpatient Services
- Designed to help people who live independently within their community achieve changes in their substance use disorder ("SUD") behaviors in a safe and supportive setting
- Includes the following services:
  - Intensive Outpatient Services
  - SUD Outpatient Rehabilitation
  - SUD Outpatient non-intensive
  - Integrated Outpatient Services
  - Opioid Treatment Services

Intensive Outpatient Services
- Time limited – usually less than 6 weeks, for minimum 9 hours per week
- Array of services, structure and support to achieve and sustain recovery
- Focuses on:
  - Relapse prevention
  - Coping skills training
  - Motivational enhancement
  - Drug refusal skills
SUD Outpatient Rehabilitation
• 3-5 days a week, at least 4 hours per day
• Basic vocational/pre-vocational skill development
• Development of social and functional skills
• Monitoring of identified healthcare issues
• Assessment of support system

Substance Use Disorder Outpatient, Non-intensive
• Able to comply with treatment outside of a 24 hr. supervised setting
• Stable living environment
• For those with SUD and their family and/or significant others
• Adequate social/interpersonal skills to derive benefit from treatment

Integrated Outpatient Services
• Meets above criteria but treats Mental Health, SUD, and/or Physical Health issues in one setting

Opioid Treatment Programs
• Opioid use disorder – physiological dependence on opioids for at least previous 12 month period
• Use of methadone or other approved medications
• Provides support services such as:
  – Medical
  – Counseling
  – Educational
  – Employment services
Assessment for Levels of Care

- LOCADTR 3.0 - Level of Care for Alcohol and Drug Treatment Referral
- Designed for treatment providers and referral sources working with clients with substance use disorder (SUD)
- Utilized by OASAS providers and Managed Care Plans in determining the best level of care for a client with a SUD
- LOCADTR 3.0 - meant to ensure all clients in need of treatment for SUD have access to care and are placed in the most effective and least restrictive setting appropriate to the individual’s needs

Other OASAS Services

- Impaired Driver Services – there is a list of OASAS approved providers of clinical services for impaired driving offenders
- Gambling Treatment
- Smoking Cessation
- Prevention Programs
  - Alcohol Awareness Program
  - School Based
  - College Services

Pulling it all together
Comprehensive Elements for Discharge Planning

• Physical Health Referrals
• SUD referrals
• Mental Health Referrals
• Health Home Coordination
• Identification and coordination of natural support systems
• Identification of social determinants and barriers for follow up and solutions, for example: transportation to and from appointments, housing, food, etc.

“Every meeting or discussion with someone is an opportunity for better coordinated care!”

QUESTIONS?

Resources
OMH Resources

- NYS Office of Mental Health Customer Relations: 800-597-8481
- OMH Provider Directory: http://bi.omh.ny.gov/bridges/index
- OMH Regional Field Offices: https://www.omh.ny.gov/omhweb/aboutomh/fieldoffices.html

OASAS Resources

- NYS HOPEline at 1-877-846-7369
- OASAS Field Offices: https://www.oasas.ny.gov/pio/regdir.cfm

OASAS Resources (cont.)

- OASAS Addiction Treatment Centers: http://www.oasas.ny.gov/atc/index.cfm
- OASAS Recovery Centers:
  - Brooklyn Community Recovery Center, 347-382-9995
  - Friends of Recovery Delaware, Delhi, and Otsego, 607-267-4435
  - Rochester/Monroe Recovery Network, 585-328-8230
General Resources

- Conference of Local Mental Hygiene directors (LGUs):
  http://www.clmhd.org/contact_local_mental_hygiene_departments/

- NY Connects - https://nyconnects.ny.gov/contact-us

- Crisis Information: Connect with LGU for crisis response line or national suicide prevention HELPLINE 1-800-273-TALK

Health Home Resources

- Contact Information List for Health Homes by County:
  http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/contact_information/county_list.htm (copy into browser)

- Health Home Program Brochure – downloadable:

- Chronic conditions list is available at:
  http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/eligibility_criteria_hh_services.pdf (copy into browser)

- Eligibility Requirements:

For more information contact

Division of Long Term Care:
http://www.health.ny.gov/health_care/medicaid/program/longterm/

https://www.nyconnects.ny.gov/home

OMH: https://www.omh.ny.gov/

OASAS mailbox: PICM@oasas.ny.gov