Rachel Breidster: Hello, and welcome to "Public Health Live," the third Thursday breakfast broadcast. I'm Rachel Breidster, and I’ll be your moderator for today. Before we get started, I would like to ask that you please fill out your online evaluations at the close of today's program. Continuing education credits are available after you complete our short posttest and your feedback is helpful in planning future programs. We encourage you to let us know what topics are of interest to you and how we can best meet your needs. As per today's program, we will be taking your questions throughout the hour. You can call any time on our toll-free at 1-800-452-0662 or you can e-mail us at any time throughout the hour at phlive.ny@gmail.com. Today's program is Mental Health in New York State, Changes and Challenges for Public Health. Our guests are Kelly Hansen, the Executive Director of the New York State Conference of Local Mental Hygiene Directors, and Glenn Liebman, the CEO of the Mental Health Association in New York State. Thank you both very much for being here.

Glenn Liebman: Thank you.

Kelly Hansen: Thank you.

Rachel Breidster: So, before we get started, I think we would all agree that this is sort of a new thing, where public health is starting to really pay attention to mental health and make efforts towards integration. So, before we begin this conversation, I think it's important to make sure we all speak the same language. So, Kelly, would you take us through a couple of the acronyms or common terms that tend to be used in your field and that our viewers might hear throughout the presentation today?

Kelly Hansen: Sure, absolutely. There's always a new acronym list whenever you go into a new field. So, some of these are self-explanatory. The piece I want to focus on is behavioral health. And in our world, behavioral health encompasses both mental health and substance abuse.

Rachel Breidster: Okay.

Kelly Hansen: The recognition that approximately 40% of individuals with a mental illness also have a co-occurring substance abuse disorder. The directors of community services. These are the individuals, who are members of our organization, the Conference of Local Mental Hygiene directors, and the audience may know our folks more commonly as the County Mental Health Commissioner. We're established in mental hygiene law and statute. And the other term that we'll go to next is local governmental unit, which is very much a statutory term but is essentially the entity that is responsible for oversight and management of the mental hygiene system, which locally is mental illness, substance abuse and developmental disabilities. Others are the state agencies and then a DAI, disabilities advocates, this is an advocacy organization that filed suit against the state regarding conditions in the adult homes; and I think Glenn will be talking about that group as well. Moving to the Managed Care and Medicaid piece. Managed care organization, I think that's pretty self-explanatory. BHO, Behavioral Health Organization, is essentially a product line of a MCO but with specialty in behavioral health. The Medicaid Redesign Team is relevant in that it had a behavioral health sub group which I had participated in with a number of colleagues in terms of developing what we wanted to see and what we thought was really important in moving the benefit to managed care. DSRIP, I think everyone's heard of DSRIP by now. I don't know anyone who hasn't, as much as you may have tried. Again, this is a program that New
York State is pursuing under the 1115 waiver, using the money over five years from the federal government to transform the health care system and the safety net. NCQA, this is a national organization that credits bodies and is relevant here in that it accredits Patient Center Medical Homes.

Rachel Breidster: Great. Thank you so much for laying the groundwork for the conversation. Now that we’ve gotten that out of the way, Glenn, what is your feeling a little bit? You work for the Mental Health Association in New York State. Can you start by telling us a little bit about your organization?

Glenn Liebman: Sure, Rachel. And I really appreciate the opportunity. Mental Health Association of New York State is comprised of 30 affiliates in 52 counties throughout New York State. Largely, what we do is we provide community-based mental health services and most of our affiliates, but we also do work in terms of educating the public about mental health services; we also do a lot of advocacy both at the local and state levels. And here in Albany, in our state offices, we’re very involved, and in a myriad of many mental health issues, everything from parents with psychiatric disabilities to veterans to geriatric, mental health. You name it, we’re very involved in terms of advocacy, and we are very involved in the public mental health system as well. So, you’re going to be hearing from Kelly later around the MRT and the redesign and DSRIP and everything else. We’re also very involved in those public policy discussions as well.

Rachel Breidster: Great. Tell us a little bit about the history of your organization.

Glenn Liebman: Sure, sure. The history of the Mental Health Association, it's actually a wonderful history. It was—originally, the person who discovered the movement or, you know, developed the movement was a gentleman named Clifford Beers. Brilliant man, Yale educated, ended up, in 1900 ended up in the Connecticut mental health system and ended up in the Connecticut what they called back then in the asylum. And he was there for two years because of his depression. And he came out of there and he wrote his autobiography, which is still in print today, and it was a best-seller at the time, and it really opened the door about the treatment of people with mental health issues, even back then. So, it really sent out a strong message about the conditions of the facilities and the conditions, the way the people were treated. They were treated like a subhuman. And so, after the book came out, there was this whole push to develop the movement, and that's originally how the mental health association movement was started. So, there's a very strong identification with recovery and people moving forward in their lives and really about—you know, he was a man ahead of his time in talking about things like community services and people, what happens when they left the hospital. So, he was really a man of great vision. And to this day, we're still very involved with that whole—the whole influence of his movement is what's great about the mental health association movement, is that we're looking not only for, you know, the specific advocacy pieces that we, you know, advocate for, but we're also looking for the greater good of the mental health system as a whole.

Rachel Breidster: And so, you say it's a really positive history. In the recent history, in the last 25 years, there's been quite a bit of change in reform, as I understand it.

Glenn Liebman: Mm-hmm.
Rachel Breidster: Can you talk a little bit about that?

Glenn Liebman: Sure, sure. Well, you know, it's very interesting, Rachel, because what I see—and I've been doing this for about 25 years—and what I've really seen happen in terms of changes is we have really—what's been incredibly strong is the whole recovery movement, the whole peer movement, people's peers, individuals themselves who have had psychiatric disability who have recovered and moved forward in their lives, working with other people who themselves have psychiatric disability. And we've seen really the spurring of the peer movement. You know, the phrase initially 20, 25 years ago, was “nothing about us without us”, and it's still true today, even more so. So, when you're having public policy discussions with the administration, with the legislature, the key piece is really the discussion around what's important to peers, what do peers want, what do peers need. And you see it in terms of their influence in treatment plans and everything they're doing, you know, in terms of their, you know, anything that they're doing, it's already got to be driven by peers, it's got to be person-centered, and you really see that reflected even in public policy. So, when we're talking about DSRIP and when we're talking about Managed Care, we're really talking about the value of peers in many ways and I think that's a wonderful movement forward in terms of public policy.

Rachel Breidster: Certainly. And also, I think one of the changes is around the role of the family, is that correct?

Glenn Liebman: Yes, yes. The family movement, which is the movement I came from—I used to be director of the NAMI New York, which is the National Association of Mental Illness, the New York State chapter. And again, what we saw in NAMI and in other family movements, families together is another, is that you're really seeing the voice of the family also involved in public policy. Because you know, as family members, we're in the first line. We see exactly what's going on. We want to be part of the discussion, part of the debate. And I think that that's really been reflected in recent years in terms of the influence of family members. And I just have to say that—and this just happened—the founder of the Family Movement in New York State, Muriel Shepherd who was my mentor and a wonderful human being, just passed away yesterday. So I just wanted to mention that, because she was clearly one of the greatest people I've ever met.

Rachel Breidster: Well, good that you’re here honoring her legacy and trying to promote awareness about mental health, certainly.

Glenn Liebman: Sure.

Rachel Breidster: Now, one of the driving forces behind some of the changes we've seen is the 1993 Reinvestment Act. Can you talk about that and some of its implications?

Glenn Liebman: Sure. Rachel, it really was a revolutionary step, because if you look back over the history of the mental health system in New York State, and I was going to talk about this a little bit as well, you see that, back in the early ’50s, there were 93,000 people in psychiatric facilities. By the time of reinvestment in 1993, there were 10,000. So, what happened over the years? The institutionalization happened. Many people ended up in the streets. It was very—it was an experiment, though the motives
were positive. Unfortunately, it was not reflected in positive outcomes for individuals with psychiatric disabilities because there were not enough services out there. So, thankfully, reinvestment happened. It would have been great if it was in 1953 as opposed to 1993, but still, the reality was that reinvestment did happen. And what it did was it took the money from the closing of the five state hospitals, took that money, reinvested it into the community, $215 million, which was annualized. So, basically, that money was used to create some of the recovery services that are so—that we’re all so familiar with now, some of the peer services, some of the family services, housing, and children’s mental health services, all those kinds of services that now in some ways we take for granted. They were all kind of spurred; many of them were spurred by the reinvestment movement. And the other great piece—there are a few great pieces about the reinvestment movement. One of them was it had the entire mental health community working together, you know, the Mental Health Association, NAMI, the Congress of Local Mental Hygiene Directors, New York Association Psych Rehab Services, the whole amalgam of mental health services all working together; ACA, various organizations working together for the common goal of doing the right thing by individuals with psychiatric disabilities in terms of bringing them into the community. I think it also created a much broader role for families and recipients of mental health services, because what it did was it greatly influenced the community services boards and the subcommittees of the community services boards included family members and individuals with psychiatric disability. So they were actually empowered to working with the counties and providers to actually make decisions about where money should be spent in most local areas.

**Rachel Breidster:** I mean, that certainly sounds like a well-planned, well organized way of making things happen.

**Glenn Liebman:** Yes.

**Rachel Breidster:** So, you talked about some of the shifting for the funding of services, and some of those services you said are the housing, peer services. Could you talk about the importance of some of those?

**Glenn Liebman:** Sure, sure. There was definitely a—you know, there's this whole movement in recent—as I said, there was the movement that started with reinvestment—actually, it started earlier with local assistance, but it was really reframed with reinvestment 22 years ago, and what it did was, it insured more housing in the community. You can't have enough housing for people with psychiatric disability. We know housing is integral to recovery, so that sort of spurred the whole housing expansion, which New York State has done a really good job at. There's got to be more housing, but New York State has done more than virtually every other state in the country in terms of the expansion of housing, but there clearly has to be more. Peer services, as I talked about, has really expanded. Children's mental health services, family support, crisis services, which many families are desperately in need of.

**Rachel Breidster:** Sure.

**Glenn Liebman:** You know, if you were to label the top priorities of many family members, they'll tell you crisis services and they'll tell you housing, because a lot of their individual loved ones with psychiatric disability are still living at home, and a lot of these parents are in their 70s, 80s, 90s and they still have their child living at home with them and want to see housing in the community. So, there
clearly needs to be an expansion of those services, and there was through reinvestment. Now, what happened? Unfortunately, was you know, the reinvestment was set aside for several years. It was not the continuous funding stream that we had envisioned for reinvestment 22 years ago. So you know, because of that and a lot of other factors, there were not enough services and not enough funding going into the community. This year for the first time in many years, there was actually an expansion of reinvestment services, which is wonderful. So, the state has put out—basically, it's going to be the expansion; and again, it's diverting existing money, taking the money from the closing of 495 beds over the next, you know, next year, to basically include $25 million in funding for community service dollars that largely are going to be reflected for the expansion of housing and peer services. Even 22 years later we're still fighting for the same amount of money and the same, you know, for the funding for the programs as well.

Rachel Breidster: Excellent. So, let's shift gears a little bit. I mean, we've talked about, certainly, those different services and the shifting in funding. One of the things that I know your organization, one of your aims is the movement to end discrimination. I mean, that's a big charge. So, talk to us about that.

Glenn Liebman: Sure. And again, this is really significant because we look and we say that stigma is the 500-pound gorilla in the room. As much as we've talked about fighting the stigma of mental health over the years, of mental illness over the years, unfortunately, whenever there's a terrible incident that happens with somebody with a psychiatric disability, that gets ramped up, when in reality, we are 12 times more likely to be victims of violence than perpetrators of violence. But unfortunately, that misconception is still out there about people with psychiatric disabilities.

Rachel Breidster: Sure.

Glenn Liebman: So you know, it affects every part of the discussion, and a major part of that was public policy discussion. So, when we move forward with the movement to end discrimination, a lot of it started with insurance, you know, the issues around insurance discrimination. We've looked at that and we've said—this is going back many, many years, over several campaigns—to say, wait a second here, you know, how do you cover physical health in one way but you cover mental health completely different in terms of, you know, in terms of cost, in terms of financing, in terms of, you know, qualitative and non-qualitative standards? You've got to change that. So, there was a whole movement in New York State spurred by a gentleman named Tom O'clair, also one of my heroes. Tom was the father of a young boy named Timothy. Timothy completed suicide at the age of 12. For five years, Tom and his wife, Donna, were fighting to get services for Timothy; and unfortunately, they were unable to get the services they needed because there was no equality between mental health and physical health in terms of insurance coverage. So, New York State rallied around it and, again, many advocates worked together with Mr. O'clair, and we had Timothy's Law that was created in 2006. And basically, what Timothy's law did was it said that mental health benefits are the same as physical health care benefits. And what was great about that, it was significant in many of our minds, was equalized co-pays. What essentially that means is if, for example, if you were seeing a therapist, psychiatrist, psychologist, social worker, you were paying on a sliding sliding scale. So it may be $30 on the first visit and by the fifth visit, you were paying $180. In the physical world, if you break a leg or whatever, you go to physical therapy, paying $30, $30, $30, or whatever it is. This changed everything in terms of co-pays.
Rachel Breidster: Sure.

Glenn Liebman: Co-pays became equalized, and other benefits became equalized as well. So, that was a huge spurring forward of the whole movement to end discrimination. And then as time has gone on, with the Affordable Care Act—and you know, there was a national parody that was passed as well, the diminishing wealth fund bill, also a significant step forward that also included substance abuse services, which the original parody in the New York State Timothy's law did not include. So, this included substance abuse as well. And what was great about the affordable care act, and I think the biggest victory for mental health advocates was that behavioral health parody is an integral part of the Affordable Care Act. And this past November, the final parody regulations were established, and those parody regulations, though they haven't yet to be tested yet, are incredibly significant in terms of the qualitative and the non-qualitative pieces around, you know, parody in terms of physical health and mental health. So, for a brief example, if there is—say you have a physical illness and you're on a nonformula for your medication needs, so there's no formulary in place. As long as that's the predominant illness, then same thing is transferrable in terms of your mental health issues as well, so there shouldn't be preauthorization either. And that's just one of—there are so many significant ramifications to that, everything from that to tobacco cessation to everything is really significant. And we were talking about the whole theme of this, about the integration between physical and mental health. This is a huge step forward.

Rachel Breidster: Certainly. And it also seems like a step forward in terms of access. I mean, financially, for people being able to access services with some of the parody that's been brought about by these changes, that kind of screams at me that, you know, this is a way to see more access to services is by reducing the cost, reducing some of the barriers and helping people to get the treatment that they need.

Glenn Liebman: Yep, yep. You're absolutely right; it's a very good point. Again, one of the ten essential health benefits of one of the ten essential benefits as part of the ACA is mental health, and that—alone is...

Kelly Hansen: Substance abuse as well.

Glenn Liebman: Right. Right.

Kelly Hansen: In addition, in New York State, the attorney general is keeping a very close eye on how parody is being implemented by the health care plans in New York. And I’m for getting the name of the plan right now, but there was recently a large settlement in terms of how they were implementing parody and applying those coverage determinations that Glenn was talking about.

Rachel Breidster: Support coming from New York organization as well.

Kelly Hansen: As well, absolutely.
Glenn Liebman: And it was huge, because again, they used the new parody regulations as part of their—in part of the settlement discussions. In the settlement agreement, they do talk about the new parody regulations, so it's going to be a powerful force for years to come.

Rachel Breidster: Great. Now, talk to us a little bit about the reforming of adult homes.

Glenn Liebman: Sure, sure. This was another movement in New York State, a very positive movement the way we look at this for adult home residents. We talked about the 1950s when we had 92,000 people in psychiatric facilities. Where do these people end up? Many ended up homeless, many ended up in, unfortunately, the criminal justice system, many ended up in adult homes in New York City, you know. So, there were 12,000 people in adult homes over the years with psychiatric disability, and that number has pretty much stayed in place over the years. As somebody passed away, then somebody else with a psychiatric disability ended up in these adult homes. Some of the adult homes were well run, even with a small amount of money, but many were in deplorable conditions, and people were living in that kind of care and it was an awful situation. At times, you know, I did a series of exposes about adult homes 12, 15 years ago. So, there is an organization that brought a lawsuit at DAI, which Kelly referenced, brought a lawsuit, moved it forward in terms of saying that people who are adult home residents who have a psychiatric disability are able to live in the community with appropriate supports: can live in community housing, can live in integrated care, living productively in the community moving towards recovery, which is our goal. So, through a series of lawsuits, through the department of justice being involved, through the credit of the Cuomo administration, there has been a settlement of this lawsuit. And in this year's budget, there's 1,500 beds specifically identified for adult home residents to move forward into the community, and that's just one-third. There's going to be, I believe, about 4,500 beds that will ultimately move into independent housing for individuals from adult homes. So, they'll be moving into the community over the next several years and there's going to be in-reach and outreach. So, these individuals will be told about the ability to move, they'll be told about what the impact of independent housing would be for them. You know, this is the importance, again, of working with peers. Peers will explain this to them. And that's significant so people are not going in and just saying I'm going to move tomorrow.

Rachel Breidster: Sure.

Glenn Liebman: They will have the information in hand. So, that's going to be very significant.

Rachel Breidster: Excellent. Are there certain populations where efforts are being focused?

Glenn Liebman: Yes. There are a lot of populations, certainly, that we're involved in and other advocates are involved in as well. Such as returning veterans is a huge issue. We see it every day. We’re well aware of the true heroes in our society and what they've done for us, and we're trying very hard for both them and their families to get the appropriate mental health services that they need. So, there have been a lot of new initiatives in recent years to kind of help returning veterans. And what we've seen, and we've done a lot of work with veterans, our members have around the state, and what we’ve seen is there is so much, again, the word stigma. The stigma associated with seeking mental health services is huge. For somebody from the military to seek mental health services is perceived as a weakness, unfortunately.
So, what we try to do is get away from kind of calling us the mental health association, mental health, and really focusing on the funding from the legislature for the Joseph Dwyer funding, which is in 11 counties throughout New York State, which actually the local Mental Hygiene Directors are involved in as well, and those 11 counties are doing peer-to-peer services. So somebody who is a returning veteran, to share their experiences with those individuals and help them seek services in a nonjudgmental, non-mental health kind of way. So, it's a huge factor in terms of turning around the stigma of psychiatric disabilities for veterans.

Kelly Hansen: That relationship is so powerful, too, because the military is a whole different language, whole different world. So, to have a peer who can understand, I know what you're talking about, I know your acronyms, I've been where you've been, I understand and I know.

Rachel Breidster: That message—

Kelly Hansen: Extremely powerful.

Rachel Breidster: Sure.

Glenn Liebman: Yeah.

Rachel Breidster: Now, can we talk quickly about the educational efforts being done? I mean, stigma is a big issue, so what are we doing in terms of education efforts?

Glenn Liebman: There is a lot of education going on and we are working hard. We look at the pillars of education as the key to ending the stigma of psychiatric disabilities. So, what's great about, again, our organization, is yes, we're involved in the public mental health system and in DSRIP and managed care and everything else and we've certainly weighed in our strong opinions on those ends, but also educating the general public about mental health services as well. We have several initiatives out there, one of which is Mental Health First Aid. We’re actually doing a training today. Mental Health First Aid is an innovative program that came out of Australia. Basically, it's an eight-hour training program that's available to anybody, the general citizenry, anybody can take this course. And basically, what it does is, much like Red Cross, you're responding to a physical crisis, Mental Health First Aid responds to a mental health crisis. So, if you or your loved one or someone you know has a crisis, this goes through, and it's not a clinical tool. It doesn’t say, okay, this person has bipolar disorder or anything like that. It’s really kind of a general, kind of individualized piece to identify when somebody has a psychiatric issue. But it also impacts mental health literacy. And it’s a great tool and helps on the stigma of mental health issues. We also have a program, mental health education in schools, we have legislation that’s out there that basically would educate students from a young age, from you know, early on through the end of high school, to educate them about mental health services. It’s not a mandate bill, but it's an educational bill to say we should be teaching mental health when we have a health curriculum. Clearly, as the discussion is moving forward, public policy is changing at the macro level. We've got to change it at the micro level, and I think that's what we're trying to do through our education piece. Finally, we have the mental health check-off bill for public awareness. This is a bill we've long been fighting for. Basically, there are ten checklists in the United States around everything from breast cancer awareness to the Adirondack
park agency and several others. And basically, this would add to it. There will be a tax check-off for mental health public awareness, which as we know, as we see, one in four individuals in this country have a psychiatric disability. If you add their families, their friends, all of us are impacted by mental health issues.

Rachel Breidster: Sure. And so, certainly, the educational efforts you're doing are significant, and we need a lot more information, both in the general population, but especially in the field of public health. So, if our viewers want more information on the topics you've talked about today, are you available for them to contact you? Is there a website for their information?

Glenn Liebman: Sure, absolutely. And we urge people to contact us any time. This is what we do, provide public education and awareness. Our state organization right here in Albany, our website is www.mhanys.org. It also has a link to our 32 affiliates around the state, and we can certainly provide any information that people need.

Rachel Breidster: Thank you so much, Glenn. That's terrific.

Glenn Liebman: Thank you very much. I appreciate it, Rachel.

Rachel Breidster: Sure. Now, Kelly, let's hear a little bit from you. If you would start off by telling us about the role and responsibility of local mental Health commissioners and the Public mental health system and how that came about.

Kelly Hansen: Absolutely. As I had mentioned before, the Directors of Community Services, DCS, Mental Health Commissioner are the individuals in each county who are responsible for oversight and planning of mental hygiene as we think of it, which also includes addiction, substance abuse and developmental disabilities. And I think it's important to remember why this particular role came about. And Glenn had referenced the institutionalization before. But in New York State in 1977, they created article 41 of the mental hygiene law that created a local-level, boots on the ground entity that was responsible for health services and how funding is being provided for the community, and this was as a result of, basically, the abject failure of deinstitutionalization in the late '60s and early '70s, when for lack of a better term, the doors were open and everyone waved good-bye with no continuity of care to the community or even the availability, adequate availability of community services, and also a real failure to meet the needs of those with serious mental illness. Now, some of the responsibilities also under article 41 deal with how you look at the system from a planning standpoint. And I know that a lot of our audience today is on the public health side and working on community health assessments. And you know, mental hygiene since 1977 has been doing local planning every year. And we do it in an integrated way with OMH, OSS, and OAWPPD, so we've gone from paper meeting process to an electronic system that's data informed and really sets out the priorities for that county and is also approved by the community services board in each county that Glenn had mentioned, which includes consumers and families and providers in the county.

Rachel Breidster: And, so you've been doing the local service planning for quite a long time. How many counties are really actively involved in this?
Kelly Hansen: Every county, its statute, every county in the state provides a local services plan. And in fact, once that plan is approved by the state, it rolls up to the state’s overall plan and it also allows the funding to flow, the local assistance funding to flow as well.

Rachel Breidster: Now, given the history, what are some of the major changes that are underway in the mental health system, and how are Medicaid Redesign and the Accountable Care Act driving these changes?

Kelly Hansen: There’s a tremendous amount of change going forward, so much that it’s hard for all of us to keep up with everything all the time. But Medicaid Redesign has been the real driver in New York State. And under the Accountable Care Act, the creation of health homes to do peer coordination between physical health and behavioral health has been a huge driver as well. But you know, the data’s pretty interesting, that—and this is what’s really kind of pushed the need and the issue for integration—that individuals with mental health and substance abuse disorders who are enrolled in the Medicaid program have higher rates of chronic conditions. We’ve known that. So, in 2010 dollars, 400,000 enrollees in Medicaid had a mental health and a substance abuse condition, but the Medicaid spend was $6.3 billion for that population; 1% of the enrollees are driving 20% of the cost.

Rachel Breidster: That data right there is sort of the perfect synopsis of why mental health is a public health issue, right? I mean, it’s not just the mental illness, but all of the other conditions. I mean, when you look at that dollar number and that figure, I feel like that really illustrates kind of the point that we’re driving home today.

Kelly Hansen: Exactly, that they’re all connected. And what the data also found is that a lot—when cost was broken down, a lot of what was driving it was not mental health substance abuse conditions, it was emergency department and hospital readmissions due to chronic conditions—lung disease, asthma, smoking. There’s a high rate of smoking among individuals with serious mental illness.

Rachel Breidster: Sure.

Kelly Breidster: Diabetes, as Glenn had mentioned, and also heart disease as well.

Rachel Breidster: Now, it’s interesting that you mentioned the frequency of hospital visits for people with mental illness, because this is an issue across the state and likely across the country. We had the opportunity to meet with staff from the Putnam County Department of Health, who shared their story of how high-frequency hospital visits helped them identify a problem and plan interventions.

Erin Pascaretti: My name is Erin Rae Pascaretti, I am the epidemiologist at the Putnam County Department of Health. Putnam County with a rural Suburban county located in the Hudson Valley, and we are less than 100,000 residents. And right now, we are considered one of the wealthiest counties in the state. We do have a few pockets of lower SES. In 2005, our health department started to realize that mental health was becoming more of a public health issue that we would have to start addressing. We started to meet with our hospital partners and our mental health partners who were noticing increases in emergency room visits. And so, we started in 2005 to include that in our community health
assessment. And in 2008, the New York State Prevention Agenda started to include mental health as a priority area. So, since 2005, we have continued to include mental health as one of our public health priority areas. As part of the community health improvement planning process, the health department is now a partner in the broader mental health coalition in our county. We also are members of the Veterans’ Task Force, and we are also members of the newly formed Suicide Task Force. And the hope is that by starting with the suicide, where we have made more inroads, we can also then address the stigma for mental health in general. In Putnam County, we have started “Safe Talk”, which is a program that is attempting to get more residents aware of their ability to intervene with family members or other individuals they might come in contact with so they would know how to talk to them about suicide or offering them assistance in where to get resources. We have also started to implement “Means Matters”, which is another best practice that attempts to educate gun shop owners as well as residents. If they have a family member or a friend or an individual that they know has access to a gun during a mental health crisis, to attempt to remove their access to a gun. The biggest obstacle for, I would think, a local health department in working with mental health is that we are not actively working with these residents. And so, what we in Putnam county have determined is that we are very able to assist when it comes to finding data, identifying new data sources, developing surveys, and basically, moving the community health improvement process along. And really, the fact that we have all of these great mental health partners, we rely on them to actually find the opportunities for us to provide our chronic disease opportunities, our smoking opportunities, which are also part of our community health improvement plan, and then to offer them help when they require it.

Rachel Breidster: So it’s great to hear, you know, we look at the data and we see, oh, there’s these high hospital visits, high admissions, but it’s great to hear, okay, you can identify that problem and then start designing interventions to really address the problem and move forward. Now, one of the things that comes up a lot in talking about any health issue, but especially in mental health, is the social determinants of health and the role that those play. So, would you talk a little bit about that?

Kelly Hansen: I’m glad you mentioned that. It’s interesting; in fact, there was a study a number of years ago that identified that individuals with mental health conditions die 25 years earlier than their counterparts without mental health conditions. And when you dig into the report, you see some of them underlying, real driving forces are the social determinants of health: poverty, unstable housing, et cetera. And the folks that we work for rarely need one service. It’s a combination of all. And what we see very often every day at the county level in the jail system is an overrepresentation of individuals with mental health in the criminal justice system, in jail, probation, state prison and parole as well.

Rachel Breidster: So, certainly, with the need for not only mental health services but assistance addressing those other issues, the social determinants of health, it seems pretty clear that mental health, physical health, public health, they’re all sort of inextricably related. Would you agree with that?

Kelly Hansen: Absolutely. We like to say ‘there is no health without mental health’. And the context in which we talk about that is in order to address issues with diabetes, obesity, et cetera, you need to look at the mental health and addiction issues as well and address those as well. We need to stop treating people from the neck up and neck down separately.
Rachel Breidster: That’s a great analogy; I have not heard that before and I’m glad we’re starting to do that here, having this conversation today.

Kelly Hansen: Absolutely.

Rachel Breidster: Now, I think in the field of public health, we’re seeing more and more counties beginning to realize that mental health is an integral part of public health. We will hear from Mike Piazza with services and mental health in Putnam County about their approach to mental health and integration.

Mike Piazza: Public health and mental health, or behavioral health, are very integrated in a number of different ways, and they intercept in a number of different ways. The first way is in prevention, the prevention of certain mental health or behavioral health conditions, such as, in our county we work together with the health department on suicide prevention and awareness and chemical dependency prevention. The opiate epidemic that exists in the state today would be less severe if we increased our prevention services. So, ways in which people can learn not to use drugs or alcohol and ways that people can learn what to do when they have a mental illness can intervene early in the disease. In addition, the intersection of the health department and the mental health department also takes place in the area of the fact that mental illness and chemical dependency are illnesses. They’re physical diseases. We don’t look at them that way very often, but they have a beginning, they have a course with and without treatment. Now, the only difference is that sometimes in the physical health world, the treatment would be only pharmacological with a drug. And in behavioral health, people with mental illness or chemical dependency, people can learn, although pharmacology is a big department in it, people can learn through therapy and through talking, ways to change their behavior. But we need to consider mental illness and chemical dependency as physical illnesses. This is a perfect time to discuss it. And the third reason why it’s very pertinent to talk about public health and mental health is that as pharmacology for mental health has grown, so have physical issues as a result. There are metabolic and cardiac conditions that result from the use of some long-term medications. So, the number of people who take an antipsychotic medication who develop diabetes or who develop cardiac conditions needs to be treated holistically. So, wellness and health is a goal of both the public health departments and the mental health departments from the area of prevention, intervention and treatment.

Rachel Breidster: I think, obviously, those of us at the table and the folks that we spoke with earlier all agree that, you know, mental health, physical health need to be integrated. How is the system set up currently?

Kelly Hansen: Right now, our folks generally get their care in two different areas. Behavioral health care is access to the mental health or substance abuse clinics, but physical health care is accessed through hospitals and emergency departments. Very little linkage to primary care, which is what we’re hoping will absolutely be accomplished under Medicaid Redesign in New York.

Rachel Breidster: And so, are there some examples you can share of efforts being made toward integration?
**Kelly Hansen:** Absolutely. In New York, as I mentioned, Medicaid Redesign Team has put forward the platform of care management for all. And right now, for those folks with the highest needs, in the highest risk, are not in managed care from the payment standpoint. It’s paid for by fee for service.

**Rachel Breidster:** Okay.

**Kelly Hansen:** So, every time a service is provided, you know, there’s payment for that. And you know, with Care Management for All and Medicaid Redesign, the entire benefit will be moved into managed care in 2015. So, the managed care organizations will be responsible for all of mental health and substance abuse conditions as well for all folks.

**Rachel Breidster:** And how does that tie in with the Prevention Agenda?

**Kelly Hansen:** The Prevention Agenda is interesting in that, you know; our office had worked on the team that looked at improving mental health and preventing substance abuse. And in looking at the plans that had come in, that were submitted, there were 14 counties that included 61 goals related to mental health and substance abuse issues. So, we see a lot of integration on the public health, mental health side. Also, under the ACA's authorization creation of health homes, which is a care coordination model that recognizes that there’s so much separation between services but care is very fragmented. And care coordination through health home is sort of a one-stop shopping to link people with services and provide that type of assistance to hopefully keep those services going and get better outcomes as well. There’s another piece that is kind of inside baseball for our folks, but you know, remember, we've had separate agencies in behavioral health. And in fact, Oasis was not created until the '90s. Prior to that—I’m dating myself, but alcohol and substance abuse were separated, DAAA and DSES. So, there's a real integration on that side and then also for work between the two agencies. But you know, one of the things that New York and other states had been working on was a single licensure for provider. You don't have a separate Oasis clinic, but then you have to, you know, you can treat the whole person who has a co-occurring disorder, and the state budget this year included some authority for us to kind of get out of our way and be able to really facilitate this treatment being accomplished.

**Rachel Breidster:** Great. Now, can you speak about Managed Care? What kinds of services need to be included?

**Kelly Hansen:** When the Medicaid Redesign Team, the Behavioral Health Work Group started, and it was a very comprehensive group of individuals in the state. It was chaired by then commissioner Michael Hogan and Commissioner Linda Gibbs from New York City. It was a really great group. And we identified priorities of what we thought were important to make sure we’re still in Managed Care. And one of the obvious pieces to us is that medical care alone is not enough. We need the rehabilitative services. What we're referring to is 1915-I services, peer support services that Glenn had mentioned. And that we can't go straight with a medical model and expect to get good outcomes that we really need to bring in the rehabilitative services and crisis services as well to be able to really serve the folks.

**Glenn Liebman:** And just to jump in real quick, Kelly’s absolutely right. The 1915(i) services we look at as the essential holistic piece of what we're talking about in terms of the individuals. When you're talking
about 1915(i) services, we’re talking about people moving on in their lives and recovering, employment services, care reference peer services, family services, and educational services. And many of our members provide those services on a regular basis, as do the counties, and these are the ones we look at and say these are traditionally the non-Medicaid-able services. We look at this as an opportunity to be able to take these services, integrate them with the existing services and create a much stronger service plan for an individual.

Rachel Breidster: Great. Now, can you tell us about how behavioral health managed plans will be different?

Kelly Hansen: Sure. In fact, the 1915(i) services will be available to a large number, but a specific number of individuals who based on the data are at the highest risk. They have high utilization; they have had previous history of inpatient hospitalizations or poor linkage to care. They haven't been engaged. So, those individuals will be enrolled in a specialty program referred to as a H.A.R.P. it's a health and recovery plan. And through the H.A.R.P. is where folks will have the strong care coordination and also have the ability to access the 1915(i) services. So, it's a real focus on folks that we know are highest risk and highest need.

Rachel Breidster: What are some of the principles of behavioral health design?

Kelly Hansen: We read these every time we have one of these meetings just to remind everyone why we're doing this and what's really guiding the way the program will look. But you know, person-centered care management, Glenn had mentioned this. The individual is 100% a partner in how this is developed. Integration, recovery-oriented services, patient consumer choice, absolutely imperative and another piece is we want to make sure there is adequate provider networks in the managed care, members of the managed care plan, to be able to provide services as well. So, as we go forward we have a timeline of—New York City goes live in January 2015. The rest of the state goes live June 15th. Then the kids system goes live in January of 2016. And that’s important because it recognizes that kids are not little adults, and their needs and the number of, you know, people that need to be involved, really need to plan for that and make sure that a system that's predominantly been underfunded for years, it's a real opportunity to be able to enhance kids services and bring in the school districts and foster care will be involved, family court, juvenile justice. Those kinds of things so, we're looking forward to a very robust coverage plan and integration for the kids in 2016.

Rachel Breidster: Great. Can you talk about some of the challenges that you might expect going forward?

Kelly Hansen: Yes. In fact, this is a whole kind of different ball game for everyone.

Rachel Breidster: Yeah.

Kelly Hansen: It’s transformation, and you know, it's quick, but it's such an opportunity here. And you know, one of the things that we're pleased about is a commitment from the state to really reinvest savings back into the community. Again, if we do this right and people have better outcomes and they're
more engaged in care, there will be savings to the Medicare program as a result, predominantly on the hospitalization side. There’s been a commitment on the part of the state to say we know there will be savings and we're going to reinvest them back into the behavioral health system. So, that's been a real core piece of where we're going and will really help. But that said, you know, there will be some challenges with Managed Care Organizations (MCOs). The MCOs have little experience with our population, our folks that we care about, and also the connection to community services. It’s not a criticism of the MCOs. They've never had to pay for this benefit before. It hasn't been in their portfolio, so they have a learning curve as well. So, it's up to us to work closely with them and say, this is what’s available; this is how it goes through. We’re also concerned about the impact on providers. Again, this will be a game-changer in terms of how clinics and other providers are paid. And one of the key points is, you know, you know managed care works when people get services and providers get paid. So, we have a lot of work to do to ensure that moves smoothly because we need to make sure that the safety net is there and services are available.

Rachel Breidster: Sure.

Kelly Hansen: You know, another big piece, housing, housing, housing. We just cannot say enough about this. And there's been a real commitment from the state and from the office of mental health to increase the number of housing slots and also through the Medicaid Redesign Team, but we’re not the only folks looking for housing, you know?

Rachel Breidster: Yeah.

Kelly Hansen: There’s a tremendous amount of pressure on what is a limited but growing stock. But the impact of those linkages between housing and stability and recovery is crucial. So, always a big part of our world.

Rachel Breidster: That’s true.

Kelly Hansen: And from a county standpoint as well, we're very concerned about the uninsured. Not everyone is Medicaid-eligible. Not everyone will be receiving care management and Medicaid services, and that responsibility falls to the LGU and to the state. And we've traditionally paid for those services through local assistance. And there’s a real, you know, commitment to make sure that the uninsured folks aren't lost in the discussion about Medicaid, Medicaid, Medicaid.

Glenn Liebman: One of the priorities I wanted to also totally agree with Kelly on is, you know when we were talking about reinvestment. We have to have a strong safety net in place. We still have to have local assistance dollars in place for the non-Medicaid population and the individuals who are going to fall through the crack. Unfortunately, there will be a percentage of people. We’re excited about the possibilities of managed care, but we’re also pragmatic enough to realize there will be some people that unfortunately are going to fall through the crack no matter what you do, and you have to that safety net in place for local systems to be essential.
Rachel Breidster: Absolutely. Absolutely. Now, in talking about challenges, we went up to Putnam County, heard from them about some of the challenges they're facing. So, let's take a moment to hear from Eric Feist. He spoke with us about some of the barriers of being a rural but not remote county and how they're trying to overcome some of those barriers and integrate mental and public health.

Eric Feist: We selected mental health as a result of a comprehensive community health assessment that we had, that started back in October of 2012. As part of that process, we've brought together various agencies, health and human services agencies from throughout the county, to sit down and start looking at what are the health issues that are challenging them as a county. And as a result, mental health emerged to the top of that. The mental health goals we've outlined for Madison County are three. The first goal is really to increase the number of service venues that are available in our community, because we're kind of a rural, but not remote, community. Accessibility and availability of services is a key concern, so how can we bring more services into the community through different venues? The second one has to do with increasing the number of providers that provide mental health services. We are designated as a mental health provider shortage area for the whole county. Our rural communities don't attend to attract providers because there's not enough population density to support practices. So, we're looking at some alternative ways of doing that. And then the third is just to increase awareness of the types of services that are currently available and as new services become available, making sure people are aware of those in terms of trying to bring providers into the community, there are a couple things we're looking at. One is, obviously, we're going to try to see if we can get providers to physically move into the community. That's always a challenge. Another alternative is instead of bringing them in physically, maybe virtually. And what I mean by that is using technology, telemedicine, telepsychiatry, where we can use the technologies very similar to skyping, where a psychiatrist can be at one end working, talking to a patient and doing an assessment using the technology, so they don't have to physically go to the doctor's office or the doctor coming here. And then the third is cooperating or coordinating with the schools that train our mental health professionals and seeing how we can create like a pipeline for the residents to come and train here, do their internships. It would provide us with services and, hopefully, it may entice them, once they see Madison County, to come, live and practice here. Some of the things we're doing to try to overcome or address the challenges that we've mentioned. One of the first things that we did that actually came out of our previous health improvement plan that will take a prominent role in helping us address the mental health issue was the formulation of a rural health network. The reason that was so important is that this rural health network now brings the entire medical, mental and health and human service agencies together, kind of under one roof, through their board. And they're able to sit down and these people can pretty much address 95% of all the services provided in the county. So, now they're all in a room together, talking about how we can best provide services. So, that was one of the goals we've achieved from the last improvement plan that will help us move into the next one. One of the challenges that we face as a rural but not remote community is with the changing health care industry, we’re seeing more regionalization of health care. The hospitals are going to their urban cores, and our hospitals in our community, which we have two, eventually, I believe, will be consumed by these larger regional health care systems. So, for us to ensure services and care is provided, our focus has been on ensuring primary and preventive care and dental and medical care. So, when we look at it that way, is how we can make sure we provide that care...
locally but plug our residents into regional health care systems. So, in order to do that, we see, we need strategically located locations or facilities within our community and school sites offer that. They're already strategically located. They already have the existing infrastructures. How can we use those facilities to provide services to the community? So, our major initiative it trying to find out how we can provide medical and dental services through these school sites in coordination with the providers.

Rachel Breidster: So, we had gotten a question from our audience that I'm just going to interject now, because it seems timely as we're talking about challenges. It was regarding some of the closing of the state's psychiatric centers. Can you talk about that a little bit for us?

Kelly Hansen: Yes. That's something we in the entire field are monitoring very closely, and it's a challenge in that, you know, the state system is downsizing. And Glenn had mentioned before that the cost to support state services; you can serve many more people in the community with the right services. And we should be serving people in the community wherever we can.

Rachel Breidster: Sure.

Kelly Hansen: So, as those beds start to phase down, that's where reinvestment comes in and the LGU, the county directors are working closely with the state to identify the services that are needed in the community in order to support folks as well. But in addition to the, you know, closure of some of the PC beds, what we're also seeing on the hospital side is closure of inpatient units and detox units as well. So, there's some Medicaid money to be reinvested in the community as well, because E.D.S. and inpatient units, tube for stabilization before someone can be transferred either to home or to a state psychiatric bed, if necessary, is a real crucial part.

Glenn Liebman:Briefly, if I could just interject for two seconds. Kelly's absolutely right. I totally agree about the reinvestment piece of it. It's also pre-investment. I think what the state is doing, wisely, is basically saying, before we take down the service, before we take down the hospitals and more beds, let's pre-invest these services. These services are the priorities as developed by the counties, by the regional centers. There were five regional centers created. So, they are closing hospitals, but there will be services available after people are discharged.

Rachel Breidster: Sure, and that seems like the perfect segue way to talk about, while we know there are many challenges ahead of us, some of the opportunities this will bring.

Kelly Hansen: Absolutely. I think one of the pieces that we're excited about is the fact that there will be this tremendous increase in access to primary care. And the number of people who will have coverage and can access benefits, which will be provided in parody, is very significant. So, we're looking forward to that, making sure that we do this right and helping the people that are expecting us to do a good job on this.

Rachel Breidster: All right. Well, thank you both very much. We're just about out of time, so I don't think we have time for questions from our audience today.

Kelly Hansen: Thank you.
Glenn Liebman: Thank you, Rachel.

Rachel Breidster: Thank you for all the information you've shared.

Glenn Liebman: We really appreciate it.

Rachel Breidster: Great. And thank you very much for joining us today. Please remember to fill out your evaluations online. Your feedback is always helpful to the development of our programs and continuing education credits are available. To obtain nurse continuing education hours, CMEs, CHES, and test credits, visit [www.phlive.org](http://www.phlive.org) and complete an evaluation and the post test for today's offering. Additional information on upcoming webcasts and relevant public health topics can also be found on our Facebook page. Don't forget to like us on Facebook to stay up to date. This webcast will be available on demand on our website within two weeks of today's show. Please join us for our next webcast on Work-Related Asthma. I’m Rachel Breidster. Thanks for joining us on "Public Health Live."