Mental Health Association in New York State, Inc.
Glenn Liebman, CEO
Jeffrey Rovitz, Board Chair

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Response to DSRIP Independent Assessor: Mid-Point Assessment Report

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Glenn Liebman, CEO

The Mental Health Association in New York State (MHANYS) is a not for profit mental health agency comprised of 26 affiliates in fifty counties throughout New York State. Many of our members provide community based mental health services and have worked for years to keep people in the community and out of hospitals and correctional settings.

As part of our organization's mission, members are also very involved with anti-stigma efforts, education, training and advocacy in their communities.

As mental health advocates, we believe that the PPS networks can deliver better integrated health care by embedding behavioral health as an integral service across all sectors of health care. We were pleased to see that all 25 PPS's identified 3 a.i. as one of their initiatives. Breaking down a siloed system of care is in the best interest of all individuals with mental health related issues.

Our organization has been very supportive of the collaborative PPS model evidenced by our robust member involvement with their various PPSs lead agencies around New York State. We strive for an integrated person centered approach with flexible dollars to enhance personal recovery through clinical services, peer support, family engagement, supported employment and supported education. We embrace the approach of recovery and community integration for which the waiver holds great promise

Unfortunately, in the two and a half years of DSRIP, we have not yet seen this vision come to fruition. There are certainly some excellent and innovative practices and emerging networks that hold possibilities for greater mental health integration. These innovations and best practices are best driven by collaborations with Community Based Organizations (CBO's) and PPS lead agencies. This collaboration must expand if we want to witness success in DSRIP milestones.

The first half of the five years has been driven by process. The rubber now meets the road as we move more aggressively into contracting and achieving programmatic milestones through working with the not for profit sector. We hold hope that this will create a sea change within the framework of DSRIP. Based on the comprehensive Mid-Point Assessment Report, we see three major themes that impact implementation.

1) **Role of Community Based Organizations in Provider Networks**
2) **Successfully Utilizing Workforce Funding**
3) **Training Needs**

A) Role of Community Based Organizations in Provider Networks:

A consistent theme throughout the report was the clear lack of provider engagement. According to the report, "While the PPS do not need to demonstrate 100% engagement of participants in a project until project milestone completion, it is important that the PPS demonstrate engagement with partners through project implementation efforts."

In Section IV of the report, the Independent Assessor (IA) makes a specific recommendation around partner engagement, stating, “A majority of the PPS are behind on their Partner Engagement goals at this point in DSRIP. Most PPS need to focus their attention and funding to engage key partners.” In addition, it was stated that, “The PMO and Hospitals have received over 70% of DSRIP funds to date across all PPS. PPS will need to fund their network partners at a meaningful level going forward.”

This recommendation was consistent with the findings across the PPS networks.

- Adirondack Health Institute - ‘The IA recommends the PPS develop a strategy to educate the CBO’s about their role in DSRIP’
- Albany Medical Center - “The IA recommends that the PPS develop a clear strategy of contracting with the CBOs”
- Alliance for Better Health Care - “The IA recommends the PPS to develop an action plan to increase partner engagement in particular for PCPs and Behavioral Health Partners”
- Care Compass Network - The IA recommends that PPS develop a strategy to increase partner and community engagement
- Central New York Collaborative - “The IA recommends that the PPS develop a clear strategy of contracting with CBOs
- Community Partners of Western New York - The IA recommends that the PPS develop a strategy to increase partner engagement throughout the PPS network
- Finger Lakes PPS - The IA recommends the PPS develop an action plan to increase CBO and other partner participation in the project
- Leatherstocking Collaborative Health Partners - “The IA recommends LCHP strengthen their community and partner education and engagement, in particular, with entities outside the lead entity,”
- Millennium Collaborative Care- “The PPS must develop a plan for more actively engaging its network partners across all projects to ensure the successful completion of project milestones
- Mount Sinai PPS - The IA recommends that the PPS develop a strategy to increase partner engagement across all projects being implemented
- Nassau Queens Performing Provider System - “The IA recommends the PPS develop a strategy to increase partner engagement to support the successful implementation of this project and in meeting the PPS DSRIP goals.”
- NYU Lutheran PPS - “The PPS must also create a plan to engage the requisite partners needed to successfully implement the milestones.”
- OneCity Health - The IA recommends that the PPS develop an action plan to increase partner engagement across all projects
- Suffolk County Collaborative - The IA recommends that the PPS review its Partner Engagement reporting and develop a plan for engaging network partner across all projects to ensure the successful implementation of DSRIP projects
- The New York and Presbyterian Hospital - The PPS needs to demonstrate effective collaboration with CBO’s and other resources to ensure appropriate access to substance abuse treatment
- Westchester Medical Center - The IA requires the PPS to develop an action plan to increase partner engagement. The plan needs to provide specific detail by each project for partner engagement.

16 of the 25 PPS were identified as needing remedial steps to engage CBO's as core members of the PPS. This is not a surprise to MHANY as most of our members are part of PPSs in their communities, and despite being part of the network, many members have not been meaningfully engaged or seen funding flow from the lead agencies.

In a survey to our members, several voiced concern that though they are part of PPS networks and provide vital services that can reduce the stated goals of reducing unnecessary hospitalizations, they have not had any contracts with their PPS to insure implementation.

We urge the State to work with the PPSs to insure that downstream providers receive funding for projects that address needs in their community around training, education and support. Through the leadership of the MHAs and other Community Based Organizations, there is a lot of work that is being done around peer support, family engagement, supported employment, education, crisis services and training. All of these tools are utilized to keep people in recovery in their communities and out of the hospitals.

In addition, many of our members are concerned that the lead PPS will replicate the successful models that we have implemented in our community mental health programs. These models that have been created by MHAs and other CBO's are successful because we have worked for many years with the population of people who are being impacted. Most CBOs have been embedded in their communities for many years and know the people they have been working with. A replication of their efforts by the lead agency would not provide the results or meet the expectations of the DSRIP.

When you are an individual in need in a mental health care setting, are you better off working with a long experienced mental health provider, who knows how to engage people in the community that are released from prisons and jails, discharged from hospitals, have been homeless, coming out of adult homes or living with aging parents or are you better off building an entirely new system that has not built up credibility or support in the community? I believe the answer is obvious and speaks volumes as to why you want to insure a contractual relationship between the lead agencies and existing CBO's.

A concern raised from doctors is that when a mental health issue is detected that there be adequate and timely referrals to mental health providers. In order to have successful integration through 3 a.i., you need a robust network of behavioral health providers to respond to referrals. This can be best accomplished through contracts with existing downstream behavioral health providers.

Specific Recommendations:

1) The State should play a stronger role in ensuring that there is a better, more systemic financial flow to not for profits from the PPS lead agencies. The State must monitor and incent PPS lead agencies to insure contracts with CBO's to enhance milestones and metrics.

B) Workforce Development:

It is clear from the recommendations of the Independent Assessor that workforce issues are of great concern.

The specific DSRIP language states:

1.08 Billion for other Medicaid redesign purposes---this funding will support Health Home development, and investments in long term care, workforce and enhanced behavioral health services.

The recommendations of the Independent Assessor as stated in the report, "The IA recommends the PPS develop a plan to address the workforce challenges with licensed behavioral health specialists and care coordinators"

MHANYS Perspective:
There is $1.08 billion from DSRIP funding earmarked for the workforce. To this point, it is unclear what if any of the funding has been expended. Despite this available funding, there continues to be a workforce crisis in New York. The not for profit mental health sector has received only two Cost of Living Adjustment in the last eight years. One of them was last year when there was a rate increase for not for profits that amounted to only .02 percent

The financial impact to this sector in regard to the minimum wage increase dramatically impacts both the financial stability of an organization and its ability to retain a quality staff. Not for profits are the safety net for the community. Too not provide equitable funding results in less effective services for those most in need.

Recommendation:

1) Provide funding transparency for the workforce in DSRIP to insure that it prioritizes spending on behavioral health workforce

2) Use the DSRIP dollars as a five percent funding increase for the not for profit workforce over the duration of DSRIP. Most of the PPSs are populated with not for profit agencies so it would be consistent with the language and spirit of the waiver. Five percent increase in funding for not for profits would be approximately $155 million per year.

3) Utilize the DSRIP funding to help provide tuition reimbursements to mental health workforce. Replicate the successful Doctors Across New York Program but populate the program with behavioral health staff including direct care staff, supervisory staff and clinicians.

C) Mental Health Training

One of the other consistent themes brought up by the IA was the lack of training around mental health issues. The survey indicated that mental health was third to last in satisfaction in working with the PPS. Much of that can be generalized as an issue around getting vital funding to downstream providers, but another reason for the dissatisfaction may lay in the lack of knowledge in most provider communities about behavioral health and stigma associated with the illness.

One way to get around the stigma and lack of knowledge about mental health is through Mental Health First Aid (MHFA). MHFA is an eight hour training program designed for the general population

to educate them about mental health and how to best respond to a mental health crisis. This evidenced based model has been responsible for training close to a million people nationwide.

Specific examples among the PPSs in regard to lack of training in mental health were among the concerns voiced by the IA in seven different PPSs.

Recommendations:

1) Mental Health First Aid is especially relevant in implementation around 3 a.i, the integration of primary care and behavioral health services.

The IA report specifically says, “Project 3 a.i. is one of the most important projects in DSRIP thus it is critical that the project is implanted successfully”

Given the comments of the IA, it is very important that within this integration, there will be a new structure in regard to working with people with mental health issues. Many of the staff in primary care may not have dealt with this population of people in the past. Due to stigma and lack of information, they may have preconceived notions about these individuals. MHFA helps dispel myths while also providing support in responding to a mental health crisis

Hot Spots: All the PPSs, through their environmental scans, have identified areas of ‘hotspots’ where there are a higher percentage of individuals who end up hospitalized. Many of these individuals have underlying mental health issues. MHFA would be an ideal training to help support the workforce staff dedicated to working with individuals with the highest need in the community. This will greatly enhance their ability to engage individuals with mental health related issues.

2) Prevention Agenda: Domain IV of DSRIP is dedicated to the Prevention Agenda. Prevention funding has never been a staple of funding in behavioral health and that is why we were very pleased to see the Prevention Agenda highlighted as an integral part of PPS.

The fundamental key to prevention is education. Though not discussed on the IA review, it is clear that mental health education impacts virtually the entire prevention agenda whether talking about diabetes, asthma, heart disease, obesity or any other health related concern. Bringing a greater understanding of mental health to individuals in the DSRIP, through MHFA, will help lead to greater wellness strategies for population health, which is clearly a major objective of the Prevention Agenda.

We have also had conversations with the New York State Office of Mental Health and they recognize the importance of Mental Health First Aid as an integral training in working to dispel myths about mental illness and to help in responding to an individual in a mental health crisis.

Summary

1) Insure that the PPSs commit to providing funding to downstream providers so that those agencies embedded in their communities are properly incented to continue efforts to support the DSRIP goals. Also insure that not for profits can provide the programming without concerns that the larger PPS will replicate the programs and not fund existing downstream providers.

2) Utilize the Workforce funding of DSRIP to help provide funding incentives to not for profits including across the board pay increases for human services as reflected in the large number of network providers in the PPS. Also use PPS funding to provide tuition reimbursements for individuals in the behavioral health sector.

3) Insure that appropriate behavioral health training through is available through MHFA to respond to 3 a.i and also for Domain IV, The Prevention Agenda as well as for any other appropriate sector.

We thank you very much for your time and consideration.