



Office of Alcoholism and
Substance Abuse Services

Office of
Mental Health

Office for People With
Developmental Disabilities

Inter-Office Coordinating Council 2015 Activities Report

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Background

The Inter-Office Coordinating Council (IOCC) was created under Section 5.05(b) of New York State Mental Hygiene Law (MHL). This report is submitted in accordance with Chapter 294 of the Laws of 2007, requiring the IOCC to issue an annual report on its activities to the Governor and the Legislature. A major aim of the IOCC is to eliminate barriers to accessing care and to improve coordination of services for people with disabilities, particularly those served across multiple agencies. This report highlights the collaborative efforts by the three state mental hygiene agencies in 2015 to address the needs of New Yorkers with co-occurring conditions.

Approval of Directors of Community Services

The Director of Community Services (DCS) is the chief executive officer of each Local Governmental Unit (LGU), which is the unit of government given authority under New York State Mental Hygiene Law to provide local mental hygiene services. There are 57 LGUs in New York- one in each county outside of New York City, a combined LGU for the five counties encompassing New York City, as well as a combined LGU for Warren and Washington counties. Section 41.09 of the law establishes the job qualifications of a DCS and Section 102.5 of Title 14 of the New York State Codes, Rules and Regulations requires the IOCC to establish procedures regarding the appointment of a DCS. These procedures can be found at:

<http://www.oasas.ny.gov/pio/collaborate/IOCC/proposedprocedures.cfm>.

Prior to approving the appointment of a DCS, the LGU must submit specific information to the IOCC for review and approval by each member agency. In 2015, the IOCC approved 11 permanent or interim DCS appointments for New York City and the following counties: Cattaraugus, Dutchess, Erie, Lewis, Livingston, Montgomery, Oneida, Onondaga, Tompkins, and Westchester.

Integrated Local Mental Hygiene Planning

Section 41.16(a) of New York State Mental Hygiene Law requires the Office of Alcoholism and Substance Abuse Services (OASAS), Office of Mental Health (OMH) and Office for People With Developmental Disabilities (OPWDD) to guide and facilitate the local planning process. The three state agencies collaborate on an integrated local planning process that LGUs use to better address the needs of people with co-occurring disorders who require services from multiple systems.

LGUs annually submit a single integrated mental hygiene service plan that addresses local needs in a more coordinated and integrated way. The plans are submitted electronically via the online County Planning System (CPS), a web-based tool that integrates all the local planning requirements of the three state agencies.

The Mental Hygiene Planning Committee guides the local planning process through a partnership of planning staff from the three state agencies, the Conference of Local Mental Hygiene Directors (CLMHD) and several counties. The Committee meets regularly to ensure that the local planning process supports efforts to make system-wide improvements in the quality of services and supports available to individuals, families, and communities.

The mental hygiene service plans ask LGUs to identify needs and priorities. In 2015, the issue areas most often identified as a “high need” across all populations were access to transportation and access to crisis services. Another high need issue area primarily affecting adults was access to supported housing. Several LGUs also identified workforce recruitment and retention as a high need issue area to be addressed. In 2015, 69 percent of all priorities identified in the local services plans addressed needs that crossed multiple disabilities, including 48 percent that applied to all three mental hygiene populations. The cross-disability priorities primarily focused on

care coordination and collaboration across multiple systems, particularly integrating behavioral health services and primary health care services.

Statewide Comprehensive Plan Collaboration

In 2015, OASAS and OMH held the fourth annual joint public hearing on their statewide comprehensive plans. The hearing was held at nine locations across the state via video teleconference technology, which enabled over 200 participants, and 20 individuals and organizations to testify before the Commissioners. Hearing site locations included Albany, Buffalo, Rochester, Syracuse, Manhattan, Staten Island, West Brentwood, Ogdensburg, and Binghamton; covering all the major regions of the State.

OASAS Commissioner Arlene González-Sánchez and OMH Commissioner Ann Sullivan, M.D. gathered input related to the development of their respective plans and ongoing initiatives to expand integrated care delivery that meets the unique needs of individuals with co-occurring substance use and mental health disorders. Among the topics discussed at the hearing were: Health Homes, regional planning, implementation of Behavioral Health Organizations (BHOs) Phase 2, recovery supports, opioid treatment expansion, peer recovery support and supportive housing.

Integration Study

OASAS and OMH conducted a comprehensive study regarding the integration of the two agencies into one Behavioral Health Services Agency. The study included forums across the state to provide the addiction and mental health fields, along with stakeholders and the public, the opportunity to voice their opinions on the concept. Through this effort the two agencies determined that with the many other major initiatives and changes currently facing the fields of mental health and addiction an integration of the agencies would not presently add value for consumers. The two agencies will continue to work closely to enhance services, improve collaboration and remove any silos that create barriers to accessing the most appropriate and effective treatment.

Addressing Synthetics

In the fall of 2015, OASAS launched a public information campaign to warn and educate New Yorkers about the dangerous and potentially deadly effects of synthetic drugs, commonly called synthetic marijuana. OASAS, OMH and OPWDD worked collaboratively to share the information in public areas so that vulnerable individuals, including those who are homeless or mentally ill and may be at higher risk for using these substances, are informed about their health risks.

Behavioral Health Care Management

Governor Cuomo's Medicaid Redesign Team (MRT) initiative has implemented multiple changes to achieve the triple aim of decreasing costs, while at the same time improving quality and efficacy within the Medicaid program. As part of MRT, a Behavioral Health Workgroup was created to develop a framework to transition individuals with mental illness or Substance Use Disorder (SUD) to a care management structure that would improve patient outcomes, reduce inpatient hospitalizations and create a comprehensive, accessible and recovery oriented system that enables these individuals to thrive in the community.

The initial transition phase in the shift to behavioral health managed care began in 2012 when OASAS and OMH selected five Behavioral Health Organizations (BHOs) to monitor Medicaid fee-for-service behavioral health inpatient admissions. This phase included the development of behavioral health managed care requirements, including contract requirements for managed care plans, eligibility for specialized services, performance metrics and evaluation, use of peer services and interface with Health Home implementation.

In 2013, New York developed a new design for managed behavioral health care. Under the new design for behavioral health managed care, all Medicaid mental health, SUD and physical health benefits for adults 21 and older will be delivered through two models:

- **Qualified Mainstream Managed Care Organizations (MCOs):** The qualified MCO will integrate all Medicaid State Plan covered services for mental illness, SUDs and physical health conditions for all adults served in mainstream MCOs throughout the State.
- **Health and Recovery Plans (HARPs):** HARPs are qualified, specialized and integrated managed care products for individuals with significant behavioral health needs that require specific eligibility criteria to enroll in the program. In addition to the State Plan Medicaid services offered by mainstream MCOs, qualified HARPs offer access to an enhanced benefit package consisting of Home and Community Based Services (HCBS) designed to provide enrollees with a specialized scope of support services not currently covered under the State Plan, including: rehabilitation; crisis intervention; educational and employment support; and peer and self-directed services.

The MRT Children’s Behavioral Health Team designed a separate framework for children’s behavioral health and physical health services under managed care, in recognition of the additional complexity of systems accessed by children and families, and of the nature and span of some children’s behavioral health problems. OASAS, OMH, the Department of Health (DOH), and the Office of Children and Family Services (OCFS) are collaborating on the design of the new system.

Regional Planning Consortiums (RPCs)

OASAS, OMH, and DOH will work closely with RPCs regarding the ongoing operation of the managed behavioral health system. The primary function of RPCs is to promote the effective implementation of behavioral health Medicaid managed care services. Each RPC includes the LGUs in the region, and representatives of mental health and SUD service providers, child welfare system representatives, peers, families, Health Home leads, and Medicaid MCOs.

RPCs will work closely with State agencies to guide behavioral health policy in each region, address regional service delivery challenges, and recommend provider training topics. They will monitor feedback on access from providers and consumers and any data provided by the State. The RPCs will also promote cross system/community collaboration across the State, and assist with problem solving on issues that arise during and after the transition to behavioral health managed care.

OPWDD Home and Community Based Services

As part of Medicaid redesign, OPWDD, in consultation with DOH, has continuously sought significant programmatic and fiscal improvements to the service system. Recent reforms lay the ground work for new, expanded options for community based services and system enhancements include:

- A “no wrong door” approach that enables people to access supports and services through multiple points of entry;
- Coordinated care organizations that assist individuals with the coordination of all of their Medicaid and Medicare services and other support needs;
- A quality framework based on personal outcomes and proven health and safety measures;
- An infrastructure that ensures fiscal sustainability while providing more flexible supports and service

- options to individuals in the least restrictive setting; and
- Expanded capacity to provide appropriate clinical, behavioral, and medical supports to more people in community settings.

These systemic enhancements will improve access to services and expand opportunities for choice and control over supports for individuals with developmental disabilities and their families. The goal of this system redesign is to serve New Yorkers holistically by providing the long-term supports traditionally funded by OPWDD, as well as physical health, mental health, substance use disorder (SUD) services and other supports across systems.

Integrated Outpatient Services (Integrated Licensing)

On January 1, 2015, regulations were adopted establishing standards applicable to programs licensed or certified by OMH, DOH, or OASAS that want to add to existing program services provided under the licensure or certification of one or both of the other agencies. The regulations promote increased access to physical and behavioral health services at a single site and foster delivery of integrated services.

These regulations were developed utilizing the principles of the OMH/OASAS/DOH Integrated Licensure Pilot Project that was implemented by seven providers in 15 clinic sites across the State. These principles are: (1) a provider can deliver the desired range of cross-agency clinical services at a single site under a single license; (2) the provider would need to possess licenses within their network from at least two of the three participating State agencies; (3) the site's current license would serve as the "host;" and (4) the desired "add-on" services would be requested via the State agency currently with primary oversight responsibility for such services.

Collaboration for Older Adult Populations

New York State enacted the Geriatric Mental Health Act in 2005. The law, which took effect in 2006, and was amended in 2008, created Interagency Geriatric Mental Health and Chemical Dependence Planning Council. The 19-member Council is chaired by OMH, OASAS, Division of Veterans Affairs, and the State Office for the Aging (SOFA) and includes members from OPWDD, DOH, and other agencies serving older adult populations. The Council is an interagency effort to advance geriatric mental health care and chemical dependence treatment.

In addition to the work on the Council, OPWDD maintains long-standing alliances with SOFA, OMH, and other State and voluntary agencies to encourage collaboration and improve service delivery and planning for older adults with developmental disabilities and their families. OPWDD continues to work with all of its partners to ensure continuous system improvements, increased equity of access to needed supports and services, and advancements in identification, prevention, and treatment for individuals with developmental disabilities, as well as outreach and support to their families.

Workforce Transformation

OPWDD is raising the performance bar for all direct support workers with implementation of a set of Core Competencies that are nationally validated. Throughout 2015, six Regional Centers for Workforce Transformation (RCWT) facilitated the implementation of new Core Competency standards and evaluation process for direct support workers across the service system. The RCWT are not physical entities however are collaborations of service stakeholders- service recipients, families, direct support workers, educators, supervisors, and administrators- whose sole mission is to build the performance capacity of its direct support workforce.

A competency is the ability to apply knowledge, skills, and ethics required to perform critical work functions. Their purpose is to advance positive human service outcomes and improve a consistency and portability of skills within the service sector. By April 2017, all Direct Support Professionals (DSPs) across New York State will be

working to maintain the same quality standards and will be evaluated with a consistent evaluation tool.

OPWDD collaborated with DOH, OMH, OASAS and SOFA to assemble focus groups and online surveys to assist the Centers for Medicare and Medicaid Services (CMS) validate its Direct Support Workforce Core Competencies. These same cross sector collaborations extended to participating in a statewide workforce workgroup focusing on Delivery System Reform Incentive Program (DSRIP) goals.

Moving Forward

The IOCC member agencies continue to work together to improve continuity and coordination of services for people with multiple needs. By improving coordination, streamlining access and redesigning services, OMH, OASAS, and OPWDD are enhancing care and supports for individuals and families throughout New York State. During 2016, the IOCC will continue fostering collaboration among its state and local partners so that New Yorkers with multiple disabilities receive integrated and coordinated services and supports.

