NACBHDD National Association of County Behavioral Health & Developmental Disability Directors
The voice of local authorities in the nation's capital

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NEWSLETTER

AUGUST 23, 2014

HONORING THE AMAZING LEGACY OF ROBIN WILLIAMS

Take action today on depression and substance use!

Robin Williams, an all-American icon, has died—needlessly!
Why? Because he suffered from severe depression and a substance use condition.

What can each of us do to honor Robin's amazing legacy?

We must insist that every health insurance plan cover screening and treatment for depression and substance use. We must assure that our own family members receive appropriate care when they suffer from these illnesses.

– RON MANDERSCHEID

Reprinted from Behavioral Healthcare

MENTAL HEALTH COPS HELP REWEAVE SOCIAL SAFETY NET IN SAN ANTONIO

[The following is a transcript of a story that was heard on National Public Radio's Morning Edition several days ago. Reported by Jenny Gold of Kaiser Health News, the report features NACBHDD's Leon Evans. For an audio version, go to: http://www.kaiserhealthnews.org/Stories/2014/August/19/San-Antonio-police-treat-mental-health.aspx*]*

Across the U.S., jails hold many more people with serious mental illness than state hospitals do. San Antonio is reweaving its safety net for the mentally ill — and saving $10 million annually.

It's almost 4 p.m., and police officers Ernest Stevens and Ned Bandoske have been driving around town in their unmarked black SUV since early this morning. The officers are part of San Antonio's mental health squad — a six-person unit that answers the frequent emergency calls where mental illness may be an issue.

The officers spot a call for help on their laptop from a group home across town.

"A male individual put a blanket on fire this morning," Stevens reads from the blotter. "He's arguing ... and is a danger to himself and others. He's off his medications."

A few minutes later, the SUV pulls up in front of the group home. A thin 24-year-old sits on a wooden bench out back, wearing a black hoodie.

"You're Mason?" asks Bandoske. "What happened to your blanket?"

Eight years ago, the next stop for someone like Mason would have been a hospital emergency room or jail. (Because of his condition, NPR is not using Mason's last name.) But the Bexar County jail, in San Antonio, was so overcrowded — largely with people with serious mental illnesses — that the state was getting ready to levy fines.

This sort of situation is not unusual: Across the country, jails hold 10 times as many people with serious mental illness as state hospitals do, according to a recent report from the Treatment Advocacy Center, a national nonprofit that lobbies for better treatment options for people with mental illness.

ALSO IN THIS ISSUE

Teddi Fins, MA, Editor

To deal with the problem, San Antonio and Bexar County have transformed their mental health system into a program considered a model for the rest of the nation. Today, the jails aren't full, and the city and county have saved $50 million over the past 5 years. The effort has focused on an idea called "smart justice" — basically, diverting people with serious mental illness out of jail and into treatment instead.

San Antonio's new approach starts with the kind of interaction Bandoske and Stevens are having with Mason. The troubled young man is hunched over, and his eyes dart back and forth between the two officers. He mumbles answers to the officers' questions, sometimes stopping to stare at a spot in the distance. For outsiders, it's hard to know what's going on, but the officers say they can tell Mason is hallucinating.

Bandoske kneels in front of him, trying to maintain eye contact and get Mason's attention." Are you hearing some voices right now?" Bandoske asks. "You are, aren't you? What are the voices telling you?" Mason is silent, but Bandoske persists. "Hey Mason, you're seeing something that I'm not seeing. What is it?"

These officers seem more like social workers than law enforcers. Stevens says that's a huge change from his early days on the police force.

"We had absolutely no training 20 years ago in the police academy on how to deal with mental health disturbances," recalls Stevens.

Back then, the police were repeatedly arresting the same people; many not only had a serious mental illness but were also addicted to drugs or alcohol, and were often homeless. And whether they went to the jail or the ER, it was expensive for everyone — the jails, the hospitals and the police department that had to pay for overtime while cops waited at the hospital.

San Antonio's response was to require all officers to take a 40-hour course called Crisis Intervention Training, to learn how to handle mental health crises.

But even with strong programs, there's only so much that training alone can do; there's still the problem of where to take patients like Mason.

San Antonio tackled that problem, too. People who commit a felony still go to jail, regardless of their mental status. And those who need extensive medical care are taken to the hospital.

But for patients like Mason, San Antonio built another option: the Restoration Center, a separate facility with a full array of mental and physical health services.

The center was the brainchild of **Leon Evans**, director of San Antonio's mental health department. When he took over the department 14 years ago, Evans says not one of the county or city agencies and nonprofits that deal with mental illness was talking to another. The jails, hospitals, courts, police and mental health department all worked in separate silos.

"People who fund these services only look at their little, small piece of the pie and whether there is a return on investment," says Evans.

So, with the help of a county judge, Evans worked to get the funders together to talk about the money they were all spending on mental health. Once they stopped looking at mental health as an isolated expense, the groups realized they were spending enormous sums of money and offering poor care. Pooling their resources instead, they found, could offer significant savings.

Everyone contributed funding to create the Restoration Center. It offers a 48-hour inpatient psychiatric unit; outpatient services for psychiatric and primary care; centers for drug or alcohol detox; a 90-day recovery program for substance abuse; plus housing for people with mental illnesses, and even job training. More than 18,000 people pass through the Restoration Center each year, and officials say the coordinated approach has saved the city more than $10 million annually.

When Mason arrives at the center, nurse Catherine Riojas checks him in immediately. She gives Mason a physical and helps him get settled in an inpatient psychiatric unit that keeps patients for 48 hours.

And then, about 15 minutes after the police officers walked through the door of the center, they're heading out again, ready to get back on the street.

"OK, Mason, good luck," Stevens calls to the young man, and waves. "OK, buddy? Hope you feel better."

NOTE: A second part of the story was reported on NPR as well. It provides greater detail about the history of the Restoration Center and the special leadership provided by NACBHDD's own "Bear of Bexar County," Leon Evans. To read that story or listen to the audio, log on at: http://www.kaiserhealthnews.org/Stories/2014/August/20/San-Antonio-model-mental-health-system.aspx. *Together, the stories have led to growing interest in the model from leaders in communities around the country, many of whom want to tour the facility and learn more about how it could be adapted to their communities.*

BITS FROM DC

Dear Colleagues:

As our summer begins to draw to a close, we always look forward to upcoming fall events and activities. I have several to announce here.

On September 25, Kevin Campbell of Oregon and I will be participating in a major HHS Webinar on "Promoting and Measuring Well-Being and Health-Related Quality of Life: A Healthy People 2020 Spotlight on Health Webinar". Well-being and health-related quality of life are exceptionally important concepts for self-management and health-activation, particularly within the context of new insurance and care opportunities created by the Affordable Care Act. Please plan to join us for this signal event. Click here to register: **Register Now**.

On October 14 and 15, we will have the exceptional privilege of holding our Fall Board Meeting at the Carter Center and Presidential Library in Atlanta, GA. This will not be a traditional Board Meeting. Rather, the entire meeting will focus on key issues facing the counties, our approaches to addressing these key practice and policy questions, and what steps we should be taking going forward. As a special feature, we also will host a panel of senior managers from the Centers for Disease Control and Prevention (CDC) who will describe their program activities focused on persons with behavioral health and ID/DD conditions. Other special guests also will be invited. On October 14, we will host a reception and dinner at the Center, and tours of the newly renovated Presidential Library will be offered. I hope that you will plan to join us.

It is not too early to mark your calendar now for our 2015 Legislative and Policy Conference, which will be held in Washington, DC, on Monday – Wednesday, February 23 –25, at the Cosmos Club.

Please enjoy the remaining, waning days of your summer.

Ron Manderscheid, PhD
Executive Director

RWJF CULTURE OF HEALTH PRIZE: NOMINATIONS SOLICITED

Since 2013, the Robert Wood Johnson Foundation (RWJF) has offered an annual *Culture of Health Prize*, which awards $25,000 to individual communities each year that are improving health in innovative ways.

RWJF recently released its 2015 Call for Applications for the 2015 Prize. While the 2013 and 2014 awards recognized 6 communities apiece, the 2015 Prize will honor up to 10 communities. To be eligible, communities must be designated as a town, city, county, tribe or tribal community or region (such as contiguous towns, cities, or counties) in the US.

Phase I application are due on September 17, 2014. Winners will be announced in the fall of 2015. For more information, go to: http://www.rwjf.org/en/grants/funding-opportunities/2014/rwjf-culture-of-health-prize.html

COMINGS AND GOINGS

- **NEW FACES AT HHS.** Secretary Sylvia M. Burwell named both **Leslie Dach** and **Kevin Thurm** to newly-created Senior Counselor positions in her office to further strengthen the HHS management team. Dach brings more than 25 years of business, policy, communications and executive management experience, most recently as Executive Vice President of Corporate Affairs for Walmart Stores. Under his leadership, Walmart partnered with First Lady Michelle Obama's *Let's Move!* campaign on a series of initiatives to make food healthier and more affordable, and launched a $2 billion program to help end hunger. He will work, in part, on the execution of the second Open Enrollment period for the Health Insurance Marketplace. Thurm, whom readers may remember as Deputy Secretary for HHS in the Clinton Administration, will work with senior staff on a wide range of cross-cutting strategic initiatives, key policy challenges, and engagement with external partners. Both will report directly to the Secretary.
- **HHS REGION II. Jackie Cornell-Bechelli** has been named HHS Region II Director, serving New York, New Jersey, Puerto Rico, and the US Virgin Islands. As a regional director, Cornell-Bechelli will serve as a key representative of Secretary Burwell in working with federal, state, territorial, local, and tribal officials on health and social service issues, including implementation of the Affordable Care Act.
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- **NEW CMHS CONSUMER OFFICE DIRECTOR. Keris Myrick** has been named Director of the Office of Consumer Affairs at SAMHSA's Center for Mental Health Services. A former NAMI president and non-profit executive, she is known for her innovative and inclusive approach to mental health reform and the public disclosure of her personal story of lived experience with serious mental illness. Most recently, she served as President and CEO of Project Return Peer Support Network, a Los Angeles-based, peer-run nonprofit, which manages over 100 self-help groups in Los Angeles County, a peer-staffed Warm Line, a Spanish language community peer and family center, and a Peer Run Crises Respite Home.

REGISTER NOW: FALL NACBHDD BOARD MEETING

Don't forget to register for our Fall Board Meeting which will be convened at the *Carter Center in Atlanta, GA*, October 14-16, 2014. Make your reservation at the Sheraton Atlanta for the nights of October 13-14 at a special rate of $132/night (plus tax). Call 1-800-325-3535 and identify yourself as part of the "NACBHDD Board". Make your reservation by September 24. For more information on the meeting, contact NACBHDD.

HILL HAPPENINGS: THE GOOD, THE BAD, AND THE UGLY

- **CONTINUING RESOLUTION…AGAIN**. Before heading home for the August recess, House Speaker Boehner indicted he expects the House to take up a continuing resolution in September that would fund the government until some time shortly after the November election. Boehner said he expected the funding bill would keep the government operating into the lame-duck session after the midterm elections.
- **VA IN THE NEWS**. President Obama has signed a $17 billion measure to help reform the Department of Veterans Affairs. The bill sets aside $10 billion for veterans to seek care at non-VA facilities. Another $5 billion would go toward hiring additional medical staff at Veterans Affairs facilities, and let the department enter into leases to use other medical facilities at 27 sites around the country. Earlier, the Senate unanimously confirmed Robert McDonald as Secretary of the Department of Veterans Affairs. He is a former Army officer and corporate CEO.
- **BIPARTISAN SUPPORT FOR ABLE ACT**. With over 300 House supporters and the backing of 75% of the Senate, in a rare showing of collaboration, the ABLE Act (Achieving a Better Life Experience) is likely to be approved in September in a rare show of bipartisanship. If adopted, the bill would enable people with disabilities to save an extra $14,000 a year in a special savings account that could be used to cover expenses such as transportation, housing and education, all promoting independence and community-based living. Currently, people can lose Medicaid and SSDI eligibility if they save more than $2000 a year or earn more than $700 a month – both disincentives to getting work or going to school.
- **DISABILITY CONVENTION CLEARED BY SENATE PANEL.** On July 22, the Senate Foreign Relations Committee voted 12-6 in favor of ratification of the Convention on the Rights of Persons with Disabilities. Treaty ratification would allow the U.S. to play a critical role in accelerating the progress of ensuring that all people with disabilities have access to health care, education, transportation and employment opportunities vital to fully participating in all aspects of life. During the current recess, urge your Senators to support adoption of the Convention which failed by a mere 5 votes in 2012.
- **PROPOSED CHANGE TO THE IMD EXCLUSION**. Representatives Tim Ryan (D-OH) and Marcia Fudge (D-OH) have introduced the Breaking Addiction Act (H.R. 5136). Current Medicaid law specifies that Medicaid payments are not allowed for individuals ages 21-65 who are patients in a 16+ bed facility primarily engaged in providing treatment or care to persons with "mental diseases," which, under federal rules, includes persons with substance use disorders. The exclusion means that Medicaid beneficiaries often cannot get clinically appropriate residential care, leaving state and local governments to try to fill in the gaps. The Breaking Addiction Act would create a demonstration program in 8-10 states under which up to $300 million in Medicaid funds over 5 years could be used to fund residential substance use disorder treatment services in facilities larger than 16 beds. It would also require the Department of Health and Human Services to evaluate the results of the demonstration and report to Congress on the need to modify or repeal the IMD exclusion to improve access to residential services for individuals enrolled in the Medicaid program.

NARMH 2015 Conference Proposals Solicited

It's time to submit proposals for papers and other presentations at the 2015 National Association for Rural Mental Health conference in Honolulu, HI, July 30-August 2, 2015. The conference will bring together rural community stakeholders from practice, research sciences, and policy to discuss the path ahead for rural communities in the face of the changing health/mental health environment.

Presentation themes to consider include: veterans; child & adolescent; forensics/correctional; substance abuse; research; cultural based deliveries; systemic infrastructure (health care reform); compact migrant issues; trauma informed care; geriatric mental health; and other themes.

Proposals can be submitted online by December 1, 2014, at www.narmh.org. For more information after visiting the website, please contact Lu Ann Rice, NARMH event planner at luann@togevents.com or 320.202.1831.

Over the Fence: Behavioral Health Students and Recent Graduates Take on the NARMH, Washington, DC, and Mary Wakefield!

Flor Cano-Soto, LMSW, and Helene Silverblatt, MD
Department of Psychiatry and Behavioral Sciences, University of New Mexico

There were many exciting highlights to this year's National Association for Rural Mental Health meeting in Washington, DC. One that has made a difference to 15 University of New Mexico students interested in careers in rural mental and behavioral health was the opportunity they had to present posters at the NARMH meeting, describing their experiences doing service learning projects with a wide array of mental health providers and agencies in rural and underserved communities in New Mexico.

These students were funded by the UNM Health Sciences Center Office for Diversity which hosted the 2014 Mental and Behavioral Health Academy (MBHA), through a supplemental grant received from the Department of Health Resources and Services Administration Health Careers Opportunities Program (HCOP). The MBHA is one of several health career pipeline programs offered through the HEALTH NM (Hope, Enrichment, and Learning Transform Health in New Mexico. What made this opportunity unique was the focus specifically on mental and behavioral health careers. The MBHA was offered in partnership with the UNM HSC Department of Psychiatry and Behavioral Health Sciences - Community Behavioral Health Division and New Mexico AHEC.

The MBHA provided an opportunity for college juniors, seniors and recent graduates interested in mental and behavioral health to participate in a hybrid program that included standardized test preparation, academic enrichment through guest speakers and panel presentations, and rural clinical immersion experiences. The Academy focused on recruiting students from diverse backgrounds and rural communities. We had students representing the entire state, from tribal communities in the far northwestern corner of New Mexico to primarily Hispanic communities near the border with Mexico. For some, it was their first trip outside the land of enchantment to our nation's capital. Many had never been to an important national meeting or had never had the opportunity to talk about their interests in a formal environment.

Students were expected to approach the experience with a commitment toward scholarship and exploration. They were able to learn from many behavioral health fields including psychiatry, psychology, counseling, social work, clinical pharmacy, nursing, occupational therapy and mental/behavioral health policy. This 16-week Saturday academy culminated in their participation in the service learning project. After completing the project, the students were able to present their posters and experience to faculty at UNM as well as a preview and rehearsal for the NARMH Conference in Washington, DC. MBHA participants had the opportunity to meet with the chief of staff for New Mexico Senator Martin Heinrich and to share their experiences and support for the program. They also met the HRSA Administrator, Dr. Mary Wakefield, who was honored at the NARMH Conference with the Victor I. Howery Memorial Award.

We believe that these invaluable experiences gained through the Academy will enable the participants to better serve New Mexico with a deeper understanding of the mental healthcare needs as well as the social and environmental determinants of health. Participants also acquired an enhanced commitment to increasing health

equity across the State. One participant stated, "The panel sessions at the MBHA were very educational as they provided insight from healthcare professionals who have completed the paths we hope to follow." His colleague added, "but nothing compared with being able to meet and share ideas with mental health professionals from around the country and to meet Dr. Wakefield." Many NARMH members were equally impressed with the quality of the posters and the articulate, knowledgeable New Mexicans who will be following in our footsteps.

INVESTING IN THE SOCIAL SAFETY NET: HEALTH CARE'S NEXT FRONTIER

JENNIFER DECUBELLIS, Assistant County Administrator for Health, Hennepin County, MN
LEON EVANS, President/CEO, Center for Health Care Services, San Antonio, TX
[Reprinted with permission from Health Affairs Blog, July 7, 2014.]

The United States spends 250% more any other developed country on health care services, yet we are ranked below 16 other countries in overall life expectancy. A less frequently discussed statistic, however, is the degree to which the U.S. underinvests in social services: for every dollar spent on health care, only 50 cents is invested in social services. In comparison, other developed countries spend roughly $2 on social services for every dollar spent on health care. The U.S. is 10th among developed countries in its combined investment in health care and social services.

This imbalance has ramifications for the nation's Medicaid program, where just five percent of beneficiaries with complex health and social problems drive more than 50% of all program costs. Many individuals in this high-cost group have chronic complex medical, behavioral health, and/or supportive service needs, and in the absence of coordinated intervention, they tend to be frequent visitors to emergency rooms and have high rates of avoidable hospital admissions.

Ironically, the health care system bears the costs of underinvesting in social services, yet on its own, is ill-equipped to address many of the root causes of acute health issues such as poverty, homelessness, trauma, lack of accessible and affordable transportation, and social isolation. Effectively serving these so-called "super-utilizers" will be one of the keys to reining in the nation's health care costs, but doing so will require an approach that may ask the health care system to reach beyond its traditional boundaries into social services.

Designing Care Coordination Programs. Across the country, a growing number of innovators in the health care sector are designing care coordination programs to better serve low-income, high-need populations and begin to address the relevant social issues. They are doing so to respond to patients who regularly come into their facilities — like Michelle, a 30-year-old woman in Portland, OR.

Michelle was sexually and physically abused as a child by her father, joined a gang as a teen because it gave her a sense of belonging, and began drinking heavily to dull her anxiety and depression. Today, Michelle has difficulty navigating the health care system because she is easily overwhelmed by large numbers of people and is mistrustful of male providers.

Or like Sam, who at 50 carries diagnoses of Type II diabetes, hepatitis C, hypertension, congestive heart failure, renal insufficiency, asthma, morbid obesity, and depression. He has been clean for three years from an IV drug habit, but is homeless and has no friends or family to help him manage his care.

The challenge of effectively addressing the care needs of patients like Sam and Michelle has gained increasing attention over the past several years, in large part thanks to an array of innovative opportunities to improve care and curb costs introduced through the Affordable Care Act (ACA).

As highlighted in a 2013 CMS bulletin, Medicaid programs now have greater opportunity to support (i.e., pay for) an array of approaches, including health homes, accountable care organizations, and other innovative models, that help connect high-need populations to recommended services and ensure appropriate follow-up treatment. These models, as well as others that CMS' newly-created Center for Medicare and Medicaid Innovation is investing in, address the reality that many high-cost patients cannot be treated effectively in brief office visits.

Additional Policies Needed. While these emerging efforts are to be applauded, additional policies are required to fully and sustainably address the needs of this population. Specifically, efforts to improve the quality of care and reduce the costs of super-utilizers must:

- ***Recognize that much of what impacts health outcomes occurs outside of the health care system***. It is impossible to separate the health care needs of individuals like Sam and Michelle from their social circumstances, or even to effectively treat their physical and behavioral health conditions without concurrently — and in many cases initially — addressing their social needs. Effective interventions

must rely on access to non-health care services such as supportive housing, vocational training and transportation, among others.

An innovative example of health care and social service collaboration is the Center for Health Care Services (CHCS) in San Antonio, TX. Recognizing that a significant number of individuals in San Antonio's jails were entering the system due to untreated mental health or substance use issues, the organization cultivated a strong relationship with local law enforcement and created a jail diversion program that is lauded as a national model.

Rather than incarcerating individuals who have been picked up for issues related to untreated mental health and substance use, officers may bring these individuals to CHCS facilities to receive detox services and psychiatric treatment, and to get connected to medical, housing and social support services. These efforts have helped save the community an estimated $50 million over the last five years through reduced recidivism and decreased emergency room utilization.

- ***Develop payment structures that encourage cross-sector collaboration and partnerships.*** As health care payment models evolve to promote greater accountability for providers to deliver better outcomes and lower costs, non-health care services like those mentioned above are essential tools. Thus, the next phase in the evolution of accountable care models should include accountability for outcomes beyond the health care sphere (such as housing status, incarceration and access to benefits) and should provide more flexibility to align or integrate financing across traditional silos.

  This vision, recently referred to as a "Totally Accountable Care Organization," requires the development of new coalitions within local communities and among partners that share responsibility for serving the underserved, including hospitals, clinics, housing providers, and jails. It also requires the support of policymakers at local, state, and federal levels to recognize this interplay across systems and promote opportunities for shared costs, savings, and accountability.

  In Hennepin County, MN, an innovative county-operated care coordination program known as Hennepin Health is bringing together multiple partners, including a local public hospital system, a federally qualified health center, the county's department of human services and public health, and the county-run Medicaid health plan. This unique structure fully integrates medical, behavioral health and social services, offering shared financial incentives for collaboration. This "joint accountability" model has allowed upfront investments to be made in cost-effective, sensible solutions that benefit all parties, such as the creation of a sobering center designed to keep individuals with addiction from cycling in and out of jails and emergency departments.

CHCS' and Hennepin Health's approaches offer a glimpse of how two health care innovators are supporting investments in social services to better care for Medicaid's highest-need patients. The reforms enabled by the ACA and the pursuit of Medicaid expansion in many states have created a prime opportunity to address the key role of social determinants on health outcomes and health care utilization – particularly for individuals with complex needs.

There is no magic bullet for solving all the challenges of the U.S. health care system, but broadening the context within which we provide care for super-utilizers can help to control cost growth across multiple public programs and improve the health and lives of some of our society's most vulnerable members.

INSURERS RETURN EXCESSIVE INSURANCE PREMIUM HIKES TO CONSUMERS

Readers will recall that the ACA requires insurance companies to spend no less than 80-85% of premiums on improving quality or on direct patient care or rebate the difference to consumers. Thanks to that cap and other ACA standards, consumers have saved a total of $9 billion on their health insurance premiums since 2011, according to a new HHS report. With savings of $4.1 billion in 2013 alone, some 6.8 million consumers are due to receive an average refund benefit of $80 per family. Since the rule took effect, more insurers are meeting the 80/20 standard by spending more of the premium dollars they collect on patient care and quality, and not red tape and bonuses.

10 Trends Driving the Future of Healthcare

Kevin Scalia, Executive Vice President, Netsmart

Change in healthcare is accelerating at the speed of thought and happening faster than any of us thought it would. Knowing how and why it's changing are important as counties that provide behavioral health and I/DD services navigate this new healthcare landscape. Here is very quick look at ten important trends to consider as you strategize for the future. They're in no particular order and are just a small sample of what could be a very long list:

1. Reduced Revenue. An estimated 60 million more people will be entering the system over the next ten years. But while numbers are going up, reimbursement rates are going down. Add the push-pull on revenue caused by quality goals of reducing inpatient admissions and lengths of stay if you have an inpatient unit, and providers stand to lose even more revenue. That means they'll need to grow sources of revenue in some way or reduce operational costs to make up the difference.

2. Increasing Operational Costs. Operating and capital expenses are increasing at a rate exceeding payment increases. Labor costs are also increasing faster than revenue. These pressures are driving provider consolidation as organizations are forced to reduce overhead and grow market share to drive revenue. This means counties will face new and different competition for provision of services. New types of partnerships are also emerging, many of which are hard to even anticipate at this point. Organizations also will be looking at technology and facility investments that can make them more efficient and improve consumer experience and satisfaction.

3. Mandate for Care Coordination. If I were doing these in order, care coordination would be at the top of the list. Here's why: The nation's current dual-eligible population is 8.1 million. Fifty percent of that population carries a diagnosis of severe mental illness. Twenty nine percent of adults with medical conditions have co-occurring mental health conditions. Sixty-eight percent of adults with mental health conditions also have physical health conditions.

With this large incidence of co-morbidity, the need for care coordination has never been greater, and new care models are rapidly emerging. Health Homes, Accountable Care Organizations (ACOs), and dual eligibles programs are forming, comprised of teams of healthcare professionals responsible for coordinating care across multiple providers. Health systems are aligning themselves to provide a continuum of care. There is a greater focus on prevention. There's also increasing demand for long-term care and skilled nursing facilities.

For care coordination to reach its full potential, care management needs to become a major focus. Care and services will need to be fully integrated; coordination between behavioral health providers and hospitals will be essential; population data analytics will take on even greater emphasis, as will sharing health information through health information exchanges (HIEs); and the transparency of costs and outcomes will be critical. It's a tall order, but the future of care coordination depends on it.

4. Changing Payor Priorities. Health plans are engaging in strategic initiatives as they define their futures. That includes acquiring and/or partnering with providers, focusing on population health, consolidating Medicaid plans, and managing self-insured populations. As a result, payors are looking for a lot from their providers, including comprehensive care for high-risk populations; cross level-of-care accountability; incorporation of community services into the delivery system; shared accountability and risk; the ability to leverage incentives; creative contracting; and transparent performance.

5. Funding Challenges. As we all know, state budgets are in turmoil (although there are improvements in some states) and Medicaid costs are growing, creating pressures on the funding side. Medicaid expansion is exacerbating both of these problems, and counties will be impacted. Regulations and reporting requirements are also changing quickly, causing even more complexity for agency and program management.

6. Continuing Regulatory Changes. The bar for qualifying for Meaningful Use incentive funds for use of certified Electronic Health Records (EHRs) has been raised. When you layer in other regulatory changes in all sectors, it's a veritable pea soup. Additionally, privacy and transparency are often at odds, but are both critically important in providing effective care and services. Netsmart and key industry associations are advocating for changes in federal regulations to maintain patient privacy while enabling sharing of health information to facilitate coordinated care.

7. **Growing Consumer Centricity.** The Affordable Care Act is built around consumer centricity. It aims to put consumers more in control of their own healthcare and make them more educated buyers of healthcare services. This includes using social networks, wireless devices, telehealth and even smart homes to enable self-managed care

where appropriate. Counties and other providers need to be proactive in addressing this trend and utilizing new channels of consumer engagement.

8. Ubiquitous Technology. Care is being increasingly influenced by the technologies we use every day. Social media and mobile technology are core to the way we're living and working. Meaningful Use is driving the requirements of what providers have to implement. We're now seeing genome sequencing for as little as $1,000 that can predict the efficacy of treatment. Consumers want access to their own health records. Analytics are revealing provider value. Telemedicine is growing exponentially. That means health information technology is not only going to become even more prevalent, it is also going to consume more of providers' budgets over the next several years.

9. Challenging Workforce Relationships. Challenging employer-employee relations are coming, driven mostly by the increasing cost of labor and the share of healthcare costs more employees are being asked to pay. Providers are being judged (and even selected) based on consumer satisfaction. As a result, employers need to increase their focus on engagement and culture to satisfy and retain high-quality employees going forward.

10. Need for Forward-Thinking Leadership. Counties are facing myriad changes in the fast-evolving healthcare ecosystem. Regulations are changing, clients and the way they're paying are changing, employee relationships are changing and the technology is changing. Facing these challenges and others brought on by growth requires aggressive, forward-thinking leadership and a strategic roadmap for now and the future.

The Chinese philosopher Sun Tzu said, "In the midst of chaos, there is also opportunity." The same goes for county providers of behavioral health and I/DD services who expect to be leaders in the rapidly evolving healthcare marketplace. The changes are dramatic, but so are the opportunities. And those who address these and other emerging trends will be best positioned to make a positive difference in the lives of those they serve.

HHS and Other Agency News and Notes

- **Stakeholder Input Sought.** A CMS Request for Information (RFI) seeks input from stakeholders on an agency effort to test innovative models to increase the engagement of Medicare, Medicaid, dual eligible and CHIP beneficiaries in their health and health care. Comments must be received by 11:59 p.m. on September 15, 2014. For additional information, please visit the Beneficiary Engagement Model Opportunities web page and the RFI web page.
- **Health People 2020**. Well-being and health related quality of life are exceptionally important concepts for self-management and health-activation, particularly within the context of new insurance and care opportunities created by the Affordable Care Act. On September 25, from 12:30 pm to 2:00 pm, EDT, the HHS Office of Disease Prevention and Health Promotion will host a webinar, *Promoting and Measuring Well-Being and Health-Related Quality of Life: A Healthy People 2020 Spotlight on Health*. Both Dr. Manderscheid and Kevin Campbell (OR) will be participating. You can, too. Register now by clicking on this link: **Register Now.**
- **New Tribal Affairs Office.** Given the increasing interest in behavioral health issues of tribal nations, SAMHSA has established an Office of Tribal Affairs and Policy (OTAP) to bring together in one office several of the tribal functions within SAMHSA. Headed by Mirtha Beadle, now Deputy Director of the Center for Substance Abuse Prevention, OTAP will serve as SAMHSA's primary point of contact for tribal governments, tribal organizations, federal departments and agencies, and other governments and agencies on behavioral health issues facing American Indians and Alaska Natives in the United States. The Office will bring together SAMHSA's work on tribal affairs, tribal policy, tribal consultation, tribal advisory councils, and Tribal Law and Order Act responsibilities to improve agency coordination and meaningful progress.
- **ICD-10 Deadline Set**. The U.S. Department of Health and Human Services (HHS) issued a rule today finalizing Oct. 1, 2015, as the new compliance date for health care providers, health plans, and health care clearinghouses to transition to ICD-10, the tenth revision of the International Classification of Diseases. This deadline allows providers, insurance companies and others in the health care industry time to ramp up their operations to ensure their systems and business processes are ready to go on Oct. 1, 2015.
- **ACA Mental Health Services Funding**. HRSA has awarded $54.6 million in ACA funding to support 221 health centers in 47 states and Puerto Rico to establish or expand behavioral health services for over 450,000 people nationwide. Funds will help hire new mental health professionals, add mental health and substance use disorder health services, and employ integrated models of primary care. For a list of awardees, please see: http://www.hrsa.gov/about/news/2014tables/behavioralhealth.

- **DOD TRICARE CHANGE.** A final DoD rule has established TRICARE Certified Mental Health Counselors (TCMHC) as qualified mental health providers under the health insurance program that covers civilian health care services for active duty, reservist, and retired military personnel. The rule follows IOM recommendations for TCMHC education, examination, licensing, and experience requirements. TRICARE will continue to cover services from supervised mental health counselors and that no enrollees will experience a service disruption.

LISTEN EVER SO CAREFULLY! THE US HOUSE MENTAL HEALTH CAUCUS HAS DISAPPEARED VERY, VERY QUIETLY!

RON MANDERSCHEID, PHD

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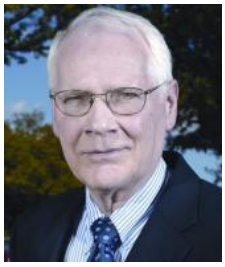

Today, we were shocked, utterly shocked and dismayed, to learn that the US House of Representatives Mental Health Caucus has disappeared. It is gone without a trace—no notice, no fanfare, no transparency. We must find out why and how it disappeared, so that we can hold those who are responsible fully accountable for this tragic and very misguided action.

The Mental Health Caucus has long been essential to our field. Out of the Caucus has come vital, landmark legislation. Notably, this has recently included the 2008 Mental Health Parity and Addiction Equity Act and key features of the 2010 Affordable Care Act. Just this year, we hoped to see the Caucus identify and put forward the positive and non-controversial features of the Ron Barber and the Tim Murphy mental health bills.

In our current divided, fractionated, and highly dysfunctional political system, the Caucus has served as a vital neutral ground where all sides could come together, hold respectful discussion, and compromise on essential mental health legislation. Such open discussion and compromise are critical features of American democracy. The American people want both, and we want them for our field as well. Now, that vital venue has been taken away from all of us. It simply has been snuffed out!

I ask you: What will we say to the Newtown Families who have lost loved ones? Will we tell them that the House leadership does not even care enough about them to host the Mental Health Caucus? What will we say to military veterans returning from Iraq and Afghanistan with traumatic brain injury and post traumatic stress disorder? Will we tell them that the House leadership has gone on to other more important matters? What will we say to the millions of Americans with mental health and substance use conditions who are seeking to have a voice in our democracy? Will we tell them that no one in the House leadership is listening?

Obviously, you know and I know that we must do much better than this for all Americans.

We must find out what has happened to the Mental Health Caucus and why it has disappeared. We also must find out who turned out the lights on open discussion and compromise, both vital features of our field. Once we have brought light and transparency to these questions, then we must act. We must hold those who have taken this very misguided action fully responsible. In our democracy, that means we must work for the removal of these persons from the House in the upcoming fall elections. Only then will we be able to restore the Mental Health Caucus to its critical role in our essential legislative work.

I ask you to please support these critical efforts.

AROUND THE STATES: AN UPDATE

- **MULTIPLE STATES.** To better address rising rates of opiate abuse, the governors of CT, MA, NH, RI and VT, are undertaking cooperative, regional treatment and prescription drug monitoring efforts. The states will pursue agreements to enable Medicaid enrollees to receive substance abuse treatment across state lines. The regional approach will implement cross-border data sharing and, as part of the strategy, will also develop coordinated regional and state-based substance abuse prevention campaigns.

- **FLORIDA**. The State Department of Children and Family Services has launched a Medicaid managed care plan exclusively for individuals with serious mental illness (SMI). Overseen by Magellan Complete Care, the plan is the first SMI-specific Medicaid managed care plan in the nation and is expected to cost $1.5 billion over five years while covering 140,000 enrollees. According to FDCFS, eligible individuals with SMI will be automatically enrolled in the plan and will have 90 days to opt-out in favor of another managed care plan.
- **INDIANA.** The State's Healthy Indiana plan has hit capacity and has received authorization from CMS to halt new enrollment. If current enrollment drops significantly, the State could resume accepting applications. Applications already in the pipeline will continue to be processed. The announcement comes while the State continues to negotiate a modified Medicaid expansion program with a two-tiered system including a consumer-driven savings account model.
- **LOUISIANA**. A Federal district court will hear a class action case on behalf of people diagnosed with mental illnesses and found not guilty by reason of insanity. They sued the LA Department of Health and Hospitals over their continued incarceration in a corrections facility instead of being placed in mental health facilities in a timely manner. The plaintiffs allege they have been denied access to mental healthcare while incarcerated, in violation of their right to due process.

- **MISSOURI**. Governor Jay Nixon (D) vetoed $144.6 million in the FY 2015 budget bills approved by the Missouri General Assembly, including $22.7 million intended for behavioral health provider payment increases, $2.5 million for an emergency mental health services pilot program, $1.3 million for autism diagnosis and treatment services, and $750,000 for detoxification services. The veto also discontinues a community re-entry program for inmates with behavioral health conditions.
- **NEW HAMPSHIRE.** The State has created the Veterans Behavioral Health Track Court, the state's first veterans' court. Located in Nashua, the court will handle criminal cases for veterans whose crimes are determined to stem from service-related substance abuse, trauma, or anger management conditions. According to the court's presiding judge, the court will focus on providing intensive treatment services to veterans and will include family outreach programs.
- **NEW YORK**. Governor Cuomo (D) has signed legislation to address growing rates of heroin and prescription drug abuse, including measures to expand treatment services, to expand substance abuse prevention efforts, to support law enforcement, and to allow pharmacists to issue naloxone prescriptions to certified treatment providers without specifying a patient.

ON THE BOOKSHELF: RECENT PUBLICATIONS OF NOTE

- **JAMA.** A viewpoint by Drs. Lloyd Sederer and Steven Sharfstein, Fixing *the Troubled Mental Health*, examines 3 issues: (1) What is affordable mental health care; (2) How should progress be assessed; and (3) What are the essential next steps? It also urges legislative action on a bipartisan solution to the still fragmented mental health system, a goal toward which NACBHDD is working. However, the authors do recommend the availability of limited-use involuntary access to services. For more, go to http://jama.jamanetwork.com/onlineFirst.aspx and access. doi:10.1001/jama.2014.10369.

- **INSTITUTE OF MEDICINE**. *Strategies for Scaling Effective Family-focused Preventive Interventions to Promote Children's Cognitive, Affective and Behavioral Health* summarizes findings of an April 2014 workshop featuring presentations on and discussion of successes and challenges experienced by developers and implementers of family-focused preventive interventions that have been successfully brought to scale; considerations related to the implementation of preventive programs in settings—such as pediatric practices and schools—that are emerging as important points of intervention; and the role of intermediary organizations in scale-up, among other topics. To access or download the report, go to: http://www.iom.edu/Reports/2014/Strategies-for-Scaling-Effective-Family-Focused-Preventive-Interventions.aspx
- **CORPORATION FOR SUPPORTIVE HOUSING**. *Housing is the Best Medicine: Supportive Housing and the Social Determinants of Health* examines the connection between supportive housing and health and the strategies needed to bring housing solutions to improve the overall health of the most vulnerable while building strong, healthy communities. Download the full document at: http://www.csh.org/resources/housing-is-the-best-medicine-supportive-housing-and-the-social-determinants-of-health/#sthash.QEx0fWnR.dpuf
- **ROBERT WOOD JOHNSON FOUNDATION.** *Health Information Technology in the United States* tracks the progress of the adoption of electronic health records (EHRs), the use of which in 2013 has quadrupled in hospitals to 58.9 percent from 2010 when the EHR incentive program was implemented. To read the report, go to:

http://www.rwjf.org/en/research-publications/find-rwjf-research/2014/08/health-information-technology-in-the-united-states.html?rid=mvb6J1BpysO3xUpHfM_szJPXLCSFxN1e&et_cid=50595

- SAMHSA Fetal Alcohol Spectrum Disorder (FASD) Center for Excellence. The curriculum, *Tools for Success: Working with Youth with Fetal Alcohol Spectrum Disorders (FASD) in the Juvenile Justice System,* has been updated and re-released to help train juvenile justice professionals in the recognition and treatment of FASD in juvenile offenders. Now available entirely online, the 6-module includes post-test questions to reinforce learning, and a certificate can be personalized and printed to show successful completion of the curriculum. Click here to visit the *Tools for Success* homepage.

MARK YOUR CALENDAR

- **HOGG FOUNDATION FOR MENTAL HEALTH**. Eighteenth Robert Lee Sutherland Conference, *The State of Mental Health Recovery: Research, Training and Practice.* September 8-9, 2014, Austin, TX. For more information, go to: http://www.hogg.utexas.edu/initiatives/rls_xviii.html
- **ASSOCIATION OF COMMUNITY MENTAL HEALTH CENTERS OF KANSAS/ KANSAS ASSOCIATION OF ADDICTIONS PROFESSIONALS**. 58th annual conference for behavioral health, *Implementing the Promise of Health Reform,* September 17-19, 2014, Doubletree Hotel, Overland Park, KS. For more information, go to: www.acmhck.org
- **NACBHDD**. Fall Board Meeting, October 14-15, 2014, Carter Center and Presidential Library, Atlanta, GA.
- **MN PSYCHOLOGICAL ASSOCIATION**. *Integrated Care in Rural Practice: Sixth Annual Rural Behavioral Health Practice Conference.* October 24, 2014. Attend the conference by webcast. Join the conference online, 8:00 am-4:30 pm, CDT. For more information and to register, go to: http://www.mnpsych.org/3786-2
- **AMERICAN PUBLIC HEALTH ASSOCIATION**. AHPA's 142st annual meeting, *Healthography: How Where You Live Affects Your Health and Well-being,* November 15-19, 2014, New Orleans, LA, Go to: http://www.apha.org/meetings/AnnualMeeting/
- **NACBHDD**. Spring 2015 board meeting, February 22, 2015, 1:30-530 pm, Cosmos Club, Washington, DC. Stay tuned.
- **ACHMA: THE COLLEGE OF BEHAVIORAL HEALTH LEADERSHIP.** *Healthy Behavior: Literacy and Activation, the Gateway to the Future of Health,* an event slated for March 24-26, 2015, St. Louis, MO, is being planned. To get involved, call or e-mail Sue Bergeson [susan.bergeson@optum.com; or 612/632-2998].
- **AMERICAN ASSOCIATION FOR THE TREATMENT OF OPIOID DEPENDENCE**. AATOD's next conference will take place in Atlanta, GA, at the Hyatt Regency Hotel, March 28-April 3, 2015. Stay tuned.
- **NARMH**. The 2015 National Association for Rural Mental Health Conference will be held in Honolulu, Hawaii, July 30 to August 2, 2015. This year's conference theme is "Ahupua`a: From the Mountains to the Sea."

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