

National Association of County Behavioral Health and Developmental Disability Directors

The voice of local authorities in the Nation's capital

NEWSLETTER

NOVEMBER 2011

TECHNOLOGY AND TELE-MEDICINE PLUS

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Chester Gould changed *Dick Tracy* forever with the introduction of the 2-way wrist radio. This communications device, worn as a wristwatch became every child's must have crime fighting tool and an absolute necessity in making the world a better safer place. The Dick Tracy wrist watch was introduced on January 13, 1946. This seminal communications device, worn as a wristwatch by Tracy and members of the police force, became one of the comic strip's most immediately recognizable icons, and could be viewed as a precursor to a later technological development known as the cell phone. Today, *USA Today* estimates that "smart phone" ownership is approaching 50% worldwide.

Telemedicine is defined as the use of medical information exchanged via various technologies from one site to another via electronic communications including videoconferencing, e-health, patient portals, remote monitoring, nursing call centers and more.

In 1950 one of the earliest telepsychiatry events occurred between a state mental hospital and the Nebraska Psychiatric Institute using a microwave link. In Texas, the University of Texas at Galveston (UTMB) began telemedicine in the early 1980s for the treatment of county inmates via telemonitors from jail cell to doctors screening rooms. As Executive director of a local Texas community mental health center we have begun using telemedicine in Walker, Liberty and Montgomery Counties, the seat of the Texas Prison system for treatment of prisoners. The Center also began providing opportunities for persons being served to establish a supported network, provide treatment input and recommendations to the treatment team via televideo. Other centers began using telemedicine in rural and frontier areas with the advent of yet another technology known as "skyping" (a software application that allows users to make voice calls over the Internet). Ever increasing technology improvements such as greater capacity via larger data pipelines (T1-lines) meant higher quality video in greater detail.

Technology's evolution also meant increasing access to more affordable tools, greater equipment accessibility, ease of use and cost effective solutions. Video conferencing meant that patients did not have to be "transported", inmates did not have to be "escorted" and crisis centers could have medical staff available 24/7 while being hundreds of miles from the physical site. In addition to direct treatment, additional uses for the telemedicine platform surfaced such it's use for continuing medical education, real time staff training, continuous monitoring and the parallel evolution of the "electronic medical record (EMR).

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Teddi Fine, MA, Editor

Now merging, physical and behavioral healthcare combine to provide a whole “health care” approach. This integration is improving. This means we can start putting the mind and body back together. Behavioral health/physical health care plans for all regions are being developed in rural and urban communities. Criminal justice is leading the way by using the telemedicine approach to provide treatment and streamline the judicial process resulting in, expedited court processing (i.e. in competency to stand trial), less jail time or no jail time at all.



New initiatives with health care reform are pressing against the need to adapt and improve. Still, we know that persons with mental illness die 25 years sooner than the general population. This is ideal, perfect timing to develop an integrated health plan to use telemedicine and make use of the progress technology has manifested. For fiscal years 2008 and 2009, the Texas legislature allocated \$82 million dollars for a state wide crisis redesign for services with the goals of: improved accessibility, improved standards of care, community involvement, consumer choice, services providing a less restrictive treatment environment and which lessen the burden on hospitals, jail and law enforcement. One could say that all elements above which could be more rapidly achieved via enhanced telemedicine.

So, what’s the bottom line? What are the benefits of using telemedicine? Let’s look at a few:

- Improved access: covers previously unserved or underserved areas
- Improved quality of care: enhanced decision making through collaborative efforts
- Reduced isolation of healthcare professionals: peer and professional contacts for patient consultation and continuing education (staff development)
- Reduced costs: reduced necessity for travel and optimum use of resources.

The Dick Tracy watch had at its imagined core a televideo communication base instantly connected with far away resources and support crime fighting collaboration. At this writing (Fall 2011) our Center is working to extend it’s tele-medicine/televideo base, support a mobile optimized web site (for use on all cell phones), implement an “app” link for mobile phones, establish a tablet based telemedicine process (using IPADs) for mobile crisis assessments, provide easy text message donation links and providing “quick read (QR) direct code mobile links for quick access to service information.

Perhaps moving forward with mobile, we will all be sitting at a table talking on our watches and improving the future of health care delivery and making the world a better place.

BITS FROM DC



Dear NACBHDD Colleagues:

We have just returned from a very successful Fall Board Meeting in Albany, New York. Highlights include the activation of our ID/DD Committee under the leadership of Chad VonAhnen; initiation of the redesign of our website, including links to social media and more focused distribution of NACBHDD materials; and initial planning for our 2012 Legislative and Policy Conference. *(Please hold March 5-7 (Monday to Wednesday) for this event. More information will follow shortly.)*

We thank Kelly Hansen of the NY Conference of Local Mental Hygiene Directors for joining us and describing developments in NY State, and we look forward to working with her much more closely in the future. We also appreciate meeting other members from the NY Conference, and having the opportunity to share a joint reception with them.

As I write this on November 20, it now appears very likely that the Supercommittee will fail in its assignment to identify \$1.5 trillion in federal budget cuts. Clearly, we have been advocating every day that any cuts do not fall disproportionately on those who are disabled or who are elderly. If we move into the sequestration phase of the budget cut debate after the holiday, the very same vigilance will be required. I will keep you posted on these developments.

We also have been working very hard to avert the SAMHSA budget cuts for 2012 proposed by the House Budget Committee. These cuts of almost 10% would be devastating to the discretionary programs operated by SAMHSA, including many that relate to county operations. We have been systematically calling all members of the

House Mental Health Caucus to register our strong objection and to solicit their support in opposition to the proposed cuts. I will keep you informed as this issue develops further.

Please accept my very best Thanksgiving wishes for you and your family, and for your colleagues. Despite all of our difficulties as a Nation, we really do have much for which to be grateful.

Ron Manderscheid
Executive Director, NACBHDD

IMPORTANT OPPORTUNITY FOR COUNTIES: HHS HEALTH CARE INNOVATION CHALLENGE

The Department of Health and Human Services has made \$1 billion available in grants for innovative healthcare projects that test creative ways to deliver high quality medical care and save money. The Health Care Innovation Challenge is being funded by the federal healthcare reform law and managed by the Centers for Medicare and Medicaid Services (CMS). Critically **counties are eligible; mental and substance use disorders are specifically identified as targets.** Three-year awards will range from \$1 million to \$30 million.

Awards will be made in March 2012 to applicants who can implement the most compelling new ideas to deliver better health, improved care and lower costs to people enrolled in Medicare, Medicaid and the Children's Health Insurance Program, particularly those with the highest health care needs. The Challenge will support projects that can begin within 6 months; projects that focus on rapid workforce development will be given award priority.

Proposals are encouraged to focus on high cost/high-risk groups including those populations with **multiple chronic diseases and/or mental health or substance abuse issues**, poor health status due to socio-economic and environmental factors, multiple medical conditions, high cost individuals, or the frail elderly. Each grantee project will be evaluated and monitored for measurable improvements in quality of care and savings generated.

According to the Department, all proposals should include the following elements:

- *Workforce Development and Deployment.* Models should include innovative development and/or deployment of health care workers. The review process will favor innovative proposals that demonstrate the ability to create the workforce of the future.
- *Speed to Implementation.* Models must be operational or capable of rapid expansion within 6 months.
- *Model Sustainability.* Proposals should define a clear pathway to sustainability and should consider scalability and diffusion of the proposed model.

Interested parties of all types who have developed innovations that will meet the goals of improving care, lowering costs, and creating health care jobs are welcome to apply. Examples of the types of organizations expected to apply are: provider groups, health systems, payers and other private sector organizations, faith-based organizations, **local governments**, and public-private partnerships. Certain organizations are eligible to apply as conveners to assemble and coordinate groups of participants. Conveners could serve as facilitators or could be direct award recipients. States are not eligible to apply under this funding opportunity.

For more information, go to the Health Care Innovation Challenge web site: www.innovation.cms.gov.

Important deadlines:

- Letter of Intent: **December 19, 2011**
- Applications due: **January 27, 2012**
- Anticipated Award date: **March 30, 2012**

NOTE: If you are interested in applying, please send NACBHDD a note to let us know. We will be organizing a call to discuss the opportunity at greater length and to create a mechanism to help you with applications.



HOLD THAT DATE

The 2012 NACBHDD Legislative and Policy Conference will convene at 12 noon, Monday March 5, and continue through lunch on Wednesday March 7. The conference will be at the Phoenix Park Hotel on Capitol Hill in Washington, DC

SAMHSA GOES REGIONAL

For the first time in its almost 20 year history, SAMHSA will have a presence in each of the 10 Department of Health and Human Services (HHS) Regional Offices. This new configuration is intended to help ensure that a voice for behavioral health is present in the regions along with that of the other HHS operating divisions. Two of the Regional Administrators currently serve in SAMHSA's Headquarters - Kathryn Power, Director of the Center for Mental Health Services and Dennis Romero, Acting Director of the Office of Indian Alcohol and Substance Abuse, Center for Substance Abuse Prevention. The new Regional Administrators include:



- Region 1, Boston, MA: A. Kathryn Power, Director, Center for Mental Health Services, SAMHSA.
- Region 2, New York, NY: Dennis O. Romero, Acting Director, Office of Indian Alcohol and Substance Abuse, CSAP, SAMHSA
- Region 3, Philadelphia, PA: Jean Bennett, senior advisor to HHS Assistant Secretary for Administration; former HHS regional office disaster coordinator.
- Region 4, Atlanta, GA: Stephanie McCladdie; Director, Prevention Services, Alabama Department of Mental Health.
- Region 5, Chicago, IL: Jeffrey Coady, national behavioral health consultant, Medicaid Integrity Group, CMS.
- Region 6, Dallas, TX: Michael Duffy; Deputy Assistant Secretary, Office for Addictive Disorders, State of Louisiana.
- Region 7, Kansas City, MO: Laura Howard, Deputy Secretary, Kansas Department of Social and Rehabilitation Services.
- Region 8, Denver, CO: Charles Smith, Director, Division of Behavioral Health, Colorado Department of Human Services; Deputy Commissioner, Mental Health and Substance Abuse, State of Colorado.
- Region 9, San Francisco: Jon Perez, national behavioral health consultant, Indian Health Service.
- Region 10, Seattle, WA: David Dickinson, Director, Division of Behavioral Health and Recovery, Department of Social and Health Services, State of Washington.

The Regional Administrators will move to each of the regional offices between November and January; they will report to Anne Herron, Director, Division of Regional and National Policy Liaison, Office of Policy, Planning and Innovation, SAMHSA.

With the move of CMHS Director Power to Region 1, Paolo del Vecchio, long-time CMHS Associate Director for Consumer Affairs, has been tapped by SAMHSA Administrator Hyde to serve as acting CMHC Director.

APA LAUDS BURKE CENTER (TX) MENTAL HEALTH EMERGENCY CENTER

Established in 2008, the Burke Center's Mental Health Emergency Center (MHEC) has been honored with the American Psychiatric Association's top national Gold Achievement Award for Community-based Programs for bringing innovative, cutting-edge, comprehensive psychiatric emergency services to the 12 rural East Texas counties it serves, including Trinity, Polk and San Jacinto counties. Providing intensive, emergency mental health care in a nonhospital setting, the Center serves a population of 370,000 over 11,000 square miles.

The APA award specifically recognizes the MHEC's use of both an onsite multidisciplinary team of nurses, licensed counselors, case managers, and mental health technicians as well as a cadre of psychiatrists available through teleconference. The use of telepsychiatry makes possible a level of services often not available in rural areas and also reduces the need for inpatient referrals to distant facilities.

Burke Center CEO Susan Rushing said the award was the result of the collaborative efforts of stakeholders from across the region. "We live in a medically under-served, mental health shortage area," said Rushing. "By creating partnerships with the State, counties, cities, hospitals, law enforcement, as well as the TLL Temple Foundation, we were able to come to the table and find a solution together to make things better for people in crisis."

Burke Center



HELP FRAME NACBHDD HEALTH REFORM EFFORTS

In a first-of-its kind meeting on September 13, 2011, representatives from the Boards of the NACBHDD and the Association for Behavioral Health and Wellness (ABHW) met to explore areas of shared interests, and concerns about both national health care reform and managed behavioral healthcare organizations (MBHO) and their relationship to the public sector mental health system. It was agreed that in our rapidly changing healthcare service delivery environment, new needs and opportunities would arise for the 2 organizations to address together.



To begin, the NACBHDD and ABHW agreed to seek submissions from their members to provide examples, for example of new working partnerships, new financing strategies, and innovations in clinical and administrative practices, that shed light on excellence in current activities at the interface of MBHOs and public sector providers.

To that end, **we ask you to submit examples of projects, programs, innovations, collaborations, etc. focused on at least one of the following categories:**

- Efforts at improving efficiencies and measuring outcomes that help to better ***demonstrate the business case for specialty behavioral healthcare*** and the return on investment for purchasers and payers of these services.
- ***Innovations in care management***, care coordination/integration, accountability, outcomes, etc.
- ***Payment/finance reforms*** including but not limited to pay for performance, case rates, capitation, risk adjustment/risk sharing, contracting/purchasing, etc.
- ***Innovations in providing ‘wrap-around’ services*** (e.g. Assertive Community Treatment (ACT), Therapeutic Behavioral Services (TBS), Intensive (field-based) Case Management) etc. and other evidence-based practices to a broad population of individuals beyond those typically served by the public sector.
- ***Integration/coordination*** of specialty behavioral health and primary care and disease management.
- ***Increasing role of peer support services*** and other self-help efforts to promote and support consumer and family ‘self-management’ in both the primary care and specialty behavioral health setting.

Within each focus area, we are particularly interested in projects that are developing working relationships between health insurance companies and NACBHDD/ABHW members.

Your submission should be no longer than 2 pages, and it should include (a) title, (b) goal, (c) activities, (d) impact and (e) cost.

Once we have reviewed your responses, each organization will compile the findings in a brochure for use to educate representatives of state health insurance exchanges, the health insurance industry, policy makers, employers, state and local governments, regulators, providers, consumers, researchers, media and health delivery entities about the contributions being made daily by the behavioral healthcare industry.

We appreciate your early attention to this request. Responses are due at NACBHDD by **January 6, 2012**. If you have any questions please contact either me at rmanderschedi@nacbhd.org or Pamela Greenberg at greenberg@abhw.org

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

- **Government Goes On.** On November 17, following a House 298-121 vote, the Senate joined suit (70-30) and cleared a conference report on a fiscal 2012 spending package, sending it for President Obama’s signature. The “minibus” package contains 3 of the usual 12 annual appropriations bills: Agriculture, Commerce-Justice-Science and Transportation-HUD. Critically, it also included a continuing resolution to keep the rest of the government operating at current levels through December 16.
- **House Committee Decidedly un-CLASS-y.** On November 15, the House Energy and Commerce Subcommittee on Health advanced legislation to repeal the long-term care program included in the health care law—the CLASS Act—one month after the Administration announced it was suspending the program’s implementation. Democrats plan a myriad of amendments at full committee, in the hope of salvaging the CLASS Act.
- **Supercommittee Deadlock: Now What?** With the collapse of the work of the Supercommittee to find \$1.2 trillion in funds through cuts and tax changes, will the sequester, which promises even more draconian cuts to programs across the government, actually take place? Not necessarily. Remember, the sequester will not take effect until January 2, 2013. So, in the meantime, Congress could send a bill to the President to repeal or



modify the sequester. According to pundits, that's an increasingly likely scenario, but efforts to restore cuts in the sequester already underway have been declared DoA by the President. Some are suggesting a return to consideration of the Simpson-Bowles Commission recommendations. Time will tell.

- **Veterans Mental Health to be Considered.** After returning from the Thanksgiving recess, both House and Senate Veterans' Affairs Committees will be exploring issues related to veteran mental health. The Senate Committee will convene a hearing on November 30 titled "VA Mental Health Care: Addressing Wait Times and Access to Care." And on December 10, the House VA Health Subcommittee will hold a hearing on preventing veteran suicide.

NOMINATIONS WANTED....

ACMHA: The College for Behavioral Health Leadership seeks nominees for 4 awards recognizing outstanding contributions to the College and to the behavioral health field:

- Timothy J. Coakley Behavioral Health Leadership Award
- The King Davis Award for Emerging Leadership in Promoting Diversity and Reducing Disparities
- Walter Barton Distinguished Fellow Award
- Saul Feldman Award for Lifetime Achievement

The awards, with the exception of the Barton award, are open to both ACMHA members and non-members. For more information about each award, criteria for nomination, and a nominating form, call ACMHA at 505-822-5038 or e-mail to executive.director@acmha.org. **The deadline is December 31, 2011.** The awards will be presented during the ACMHA Summit, March 21 – 23, 2012 in Charleston, SC.

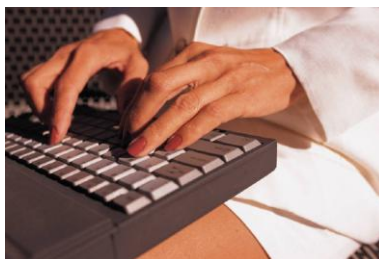
PROVIDING EMERGING LEADERS WITH TIMELY INSIGHTS INTO CONTEMPORARY ISSUES

USING SOCIAL MEDIA

Katie Bess, MSW

The NACBHDD Board of Directors met on October 23-25, 2011, at the Desmond Hotel in Albany, NY. Attendees included county and state association directors from the mental health, substance use and intellectual disabilities fields. One of the seminal issues discussed was the need to identify and educate emerging political and program leaders about policy and advocacy issues regarding behavioral health and intellectual disabilities. A key concern was how to facilitate communication in ways that give these emerging leaders insight into the rapidly evolving health care system. It was agreed that the social media represent an important, evidenced-based conduit for achieving that aim.

Today is a new era in which social media, including the Web and mobile technologies, have turned communication into an interactive dialogue, surpassing the days when telephone, letters, and in-person communication were the conventional ways to interact. Today, we can have social interaction no matter where we are in the world, with just a mobile *smart* phone. We are moving into a period where social media is taking over and changing the way in which we communicate. *How can we use*



this new and expanding resource to educate emerging leaders coming into the field?

Today, with approximately 800 million users on Facebook and the average person connected to 80 community pages and events, a single post of information distributed on the site has the potential to be passed on to all Facebook user's who are interested in that particular organization as well as other related organizations on the Web. Social networking sites, such as LinkedIn, provide opportunities for professionals to post their resumes and connect with other colleagues. This network also allows people to meet potential clients and browse for employment opportunities. Adding a group to the LinkedIn website will let others in your field know about current issues your organization is addressing and also offers a forum for interacting with colleagues in the behavioral health and developmental disability field. Most importantly, it provides the emerging leaders a place to connect with experts in the field and to benefit from their perspectives.

According to a 2010 report by the U.S. Department of Education on the *Evaluation of Evidenced-Based Practices in Online Learning*, students that participated

in online learning had on average a better understanding of factual information than classroom-based instruction with the two being equivalent in terms of procedural learning. Today, many people in the fields of behavioral health and developmental disabilities are using *eLearning*, as well as webinars and other educational courses. *eLearning*, a database providing online education, can be added to websites or posted on social networking sites to provide easy access for individuals interested in a range of contemporary topics. Many businesses and organizations are using a web *eLearning* component to

provide accredited educational courses for their staffs. This is another tool to help educate future leaders on current behavioral health and developmental disability topics with curricula prepared by experts in the field.

The emerging data on social media suggest that social media provides a new and exciting opportunity to mentor and train new generations of professionals. Compared to other approaches that require face-to-face and time-specific trainings, social networking is less costly and affords flexibility not previously available to organizations and their members.

HHS NEWS AND NOTES

- **Integrated Care Resource.** There's a new federal resource to help integrate primary and behavioral health care, the SAMHSA-HRSA Center for Integrated Health Solutions website. It features clinical, operational and financing tools to develop integrated care models — primary care in behavioral health, behavioral health in primary care, and person-centered health homes. Users also can connect with national experts and each other to share solutions and best practices. Go to: <http://www.integration.samhsa.gov/>
- **New ACO Advance Payment Model Deadline Set.** As reported in last month's newsletter, in October, CMS announced a new Advance Payment Model for physician-based and rural ACOs selected to participate in the Medicare Shared Savings Program. Selected ACOs will receive advance payments that will be recouped from shared savings they earn. The Advance Payment Model will NOT require a notice/letter of intent as part of the application. But organizations interested in applying for the Advance Payment Model must complete separate applications for the Shared Savings Program and the Advance Payment Model. An application template will be available on the Advance Payment website later this fall. Go to: (<http://www.innovations.cms.gov/initiatives/aco/advance-payment/index.html>)

Advance Payment Model application deadlines:

- ✓ **April 1, 2012 start date** (applications accepted between January 3 - February 1, 2012)
- ✓ **July 1, 2012 start date** (applications accepted between March 1 - 30, 2012)

For information about all CMS ACO initiatives, visit www.cms.gov/aco.

- **Educating about Substance Use by People with Physical or Sensory Disabilities.** A SAMHSA issues brief gives health care professionals who work with people with physical or sensory disabilities information about substance use disorders, including risk factors and warning signs; screening; types of substance abuse services; and strategies for helping clients. Go to: <http://store.samhsa.gov/product/SMA11-4648>
- **Guide on Teen Alcohol Use.** A new National Institute on Alcohol Abuse and Alcoholism (NIAAA) evidence-based guide can help health care providers identify children and youth (ages 9-18) at risk for alcohol-related problems, provide brief counseling, and refer them to appropriate treatment if indicated. Developed with the American Academy of Pediatrics, *Alcohol Screening and Brief Intervention for Youth: A Practitioner's Guide*, has brief risk assessment resources. Go to: <http://www.niaaa.nih.gov/Publications/EducationTrainingMaterials/YouthGuide>



LEGAL HAPPENINGS

- **Supreme Court to Hear ACA Challenge.** After almost 18 months of legal battles at the district and appellate levels, the US Supreme Court will weigh in on the Constitutional challenge to the Patient Protection and Affordable Care Act (ACA) launched by Florida and 25 other Republican-controlled states and the National Federation of Independent Business, the largest of a number of current court



challenges. The case is not just the largest; it also is the only suit that actually proposes that the entire law, not just the individual mandate, be tossed out. While the vast majority of conservative and liberal-leaning appellate justices have affirmed the constitutionality of the law, the Supreme Court's ultimate decision remains in doubt. Complicating the picture, the Court has decided to hear arguments on every single element of the Florida challenge to the ACA, including the law's provisions that broaden Medicaid coverage to people at up to 133% of the federal poverty level. The states' challenge calls the Medicaid expansion "coercive" and unconstitutional. Five-and-a-half hours of time have been set aside for arguments that most likely will occur in March; a decision may come as early as just after Memorial Day.

- **DC Appellate Decision Backs ACA.** While the lawyers gear up for a U.S. Supreme Court battle, a 3-judge panel of the US Court of Appeals for the District of Columbia has handed down a 2 to 1 decision that held the individual insurance mandate to be constitutional and within Congressional authority to regulate interstate commerce. Judge Laurence H. Silberman, who wrote the court decision for the majority, is an influential conservative appointed by President Reagan. To date, only one appeals court has rejected the mandate, with but three of the 12 appellate judges in all weighing in against the mandate. All will be moot, when the US Supreme Court renders its opinion.
- **Reconsidering Ruling on Veterans' Mental Health Care.** The 9th Circuit Court of Appeals will reconsider a 3-judge ruling ordering major reform by the US Department of Veterans' Affairs in the care of recent returning veterans with PTSD and other emotional injuries of war. Two veterans groups bringing the suit allege system-wide treatment failures to help lower a staggering suicide rate among returning veterans.

NORFOLK VA CSB DIRECTOR SAYS GOODBYE VIRGINIA, HELLO KANSAS

Maureen Womack, director of the Norfolk (VA) Community Services Board, is leaving her post at the end of the year. She has accepted a new position as director of the Johnson County Mental Health Center, near Kansas City, KS.

In a communiqué to her staff about her departure, she wrote: "Norfolk CSB has shown remarkable resolve in providing quality care in the face of many challenges. This was a very difficult decision, and although I am excited about the new opportunity, I am sad to leave."

Womack previously was executive director of Davis Behavioral Health in Davis County, Utah, and also held behavioral health leadership positions in Mississippi and Alabama. In Norfolk she has been credited with helping promote greater accountability in program, budget and policy direction.

No decisions have been made by the CSB on how her position will be filled; much may rest on whether the CSB is made part of the Norfolk city government.



LA COUNTY MENTAL HEALTH TO GET NEW EHR SYSTEM

Thanks to an agreement approved by the Los Angeles County Board of Supervisors, Netsmart Technologies, Inc., will be developing a state-of-the-art electronic health record system, known as the Integrated Behavioral Health Information System (IBHIS) for the Los Angeles County Department of Mental Health (LACDMH). This is yet another step by the Department in its efforts to eliminating paper health records. Not only will it put the County ahead of the curve toward care coordination mandated by the ACA, but also it will be in compliance with the Health Information Technology for Economic and Clinical Health Act, avoiding penalties for not having electronic health record systems in place for Medicare providers by 2015.

"We are excited that the Board of Supervisors has approved this agreement," said LACDMH Director, Marvin Southard, DSW. "This will allow us to apply the most advanced technology to support the work and partnerships that create hope, wellness and recovery in the lives of clients and their families."

AROUND THE STATES: AN UPDATE

- **All State Interactive Map on Implementation of Health Insurance Exchanges**



Available. The National Conference of State Legislators (NCSL) has created an interactive map to show State actions to implement health insurance exchanges. The map shows implementation legislation or executive actions related to the exchanges and it provides detailed information on the efforts for each State. To view the map, visit <http://www.ncsl.org/?tabid=21388>

- **Florida.** While fighting to overturn the federal health overhaul, the State is preparing to launch its own insurance marketplace early next year that looks like a distant cousin of the ones being created under the federal law. We'll learn more as the effort takes shape.
- **Georgia.** Under a settlement with the Justice Department, Georgia must close State hospitals that house over 9,000 people with mental illnesses and 750 with developmental disabilities and move them into community-based care. The model the 2-year-old Department of Behavioral Health and Developmental Disabilities is crafting includes community treatment teams, supported housing and employment, wellness centers and peer-support programs. Community-based services will link to a statewide system of comprehensive mental health service, a system still under development. Can model become reality? Stay tuned.
- **Illinois.** The Chicago city council unanimously approved the mayor's controversial budget that, among other sharp cuts, will close 6 of the city's 12 mental health clinics and privatize all of the City's community primary care clinics, many of which serve the most economically challenged neighborhoods. The cutbacks are likely to result in layoffs; they already have spawned sit-ins at City Hall. This past week, opponents of the plan spent 10 hours in a City Hall sit-in.
- **Kansas.** A major revision of the State Medicaid program will place all Medicaid beneficiaries into private, managed-care plans. This change would affect primarily older adults and persons with disabilities whose care is currently provided under a fee-for-service system. Low-income families already are served by private managed care plans.
- **Massachusetts.** To help over 100,000 low-income people with mental illnesses, substance abuse disorders and intellectual disabilities better navigate the maze of disconnected health and support services available to them through Medicaid, Medicare and other sources the State is streamlining its systems of care. Hoped-for collateral benefits include improved quality and reduced costs.
- **Nebraska.** The State will not begin the process of creating an insurance exchange until after the Supreme Court rules on the constitutionality of the ACA individual mandate.
- **New York.** Notwithstanding the threat of premium increases, the Governor has signed into law a requirement that insurers in the state cover screening, diagnosis and treatment for autism spectrum disorders (e.g., behavioral care, and speech, occupational and physical therapy for toddlers).
- **Ohio.** Not waiting for the Supreme Court, a ballot initiative was approved on Election Day earlier this month to refuse to implement the ACA's individual mandate in the State. Bear in mind, however, federal law trumps state law or mandate. Final resolution is in the hands of the US Supreme Court.
- **Oregon.** Not waiting for the ACA's deadline, Oregon has begun establishing new accountable care organizations, but not exactly in the form and structure envisioned under the ACA. In addition to calling them "coordinated care organizations," the State aims to measure their success—to grade them on how well they improve Oregonians' health – reducing illness and health care costs of acute and chronic illnesses.
- **Puerto Rico.** After 12 years, Puerto Rico and the Department of Justice have ended a battle to improve health care for hundreds of children, youth and adults with intellectual disabilities who had been housed, abused and neglected in residential treatment facilities. The facilities that served over 700 persons with intellectual disabilities have been shuttered; residents have been transferred to new, community homes. A local judge will oversee compliance with the settlement.
- **Texas.** Over the coming months, the Texas House, charged with identifying ways to reduce the State's debt, will be examining the financing and delivery of long-term Medicaid services and examining both the infrastructure and funding for mental health services. Stay tuned; the issues may heat up.
- **Vermont.** The latest State projections suggest that by 2020, adoption of universal health care could cost between \$13,000-\$14,000 per resident—a cost of up to \$9 billion annually. However, the State plans to move forward nonetheless, since the current private insurance-based system would cost even more.



EMPLOYEE ASSISTANCE RESEARCH FOUNDATION CALLS FOR GRANT PROPOSALS

The Employee Assistance Research Foundation has called for research grant proposals. This second grand cycle is focused on workplace-related outcomes of EAP. Organizations such as tax-exempt educational institutions, agencies, or for-profit business entities (such as an LLC) that have access to an Institutional Review Board may apply.

The two-part application process includes

- Submission of a brief proposal; and
- For those approved for the second stage, a full proposal that may lead to an offer of a grant award. Grants will be reviewed by a committee consisting of Foundation board members, which includes distinguished researchers and clinicians.

Applicants have **until November 30** to submit brief proposals. For a copy of the call for proposals, go to this website: <http://www.eapfoundation.org/apply-for-grants/>



THE ESSENTIAL HEALTH BENEFIT: WILL ESSENTIAL BECOME MINIMAL?

“NEARSIGHTED” IOM RECOMMENDATIONS FAIL TO CONSIDER LONG-TERM VALUE OF BEHAVIORAL HEALTH BENEFITS

Ron Manderscheid, PhD



While every element of health reform in the United States is important to the future of mental health and substance use treatment, several of these interrelated elements are absolutely critical, including the Medicaid expansion and State Health Insurance Exchanges (HIEs), the Essential Health

Benefit (EHB), and Accountable Care Organizations (ACOs).

Here is why: the Medicaid expansion and the HIEs will generate the financial resources for needed care; the EHB will define the floor benefit for the care to be provided; and ACOs will serve as the organizational engines through which higher quality, lower cost care delivery will take place.

For now, let's focus on the Essential Health Benefit. The Affordable Care Act (ACA) is very clear that:

- The EHB will specify the floor benefit to be offered to new enrollees through Medicaid (all adults up to 134 percent of the Federal Poverty Level (FPL) and through the insurance plans offered by the state HIEs (adults 135 percent FPL and higher).
- The Secretary of the Department of Health and Human Services (HHS) is to define this EHB.
- The EHB is to encompass 10 “essential benefits” including benefits for mental health care and substance use care which must be offered at parity with medical care benefits.

To begin this work, HHS issued a contract to the

Institute of Medicine (IOM), a unit of the National Academies of Science, to outline the framework and considerations necessary to define the EHB. The IOM has now issued its final report ([available here](#)).

As the IOM recommended, HHS has begun holding listening sessions to receive input from consumers, providers, and small businesses on the scope of benefits that should be encompassed in the EHB.

Here's where the issue gets more complicated. In defining the EHB, HHS must consider tradeoffs between affordability and comprehensiveness. The ACA offers some guidance on this issue, saying that the EHB is to be based on what is offered in private sector plans. The IOM went further still, recommending that the EHB be based on the average cost of current plans offered by small businesses.

This recommendation is a problem: Current small business insurance plans frequently do not include mental health and substance use care benefits, and most are not operated at parity because they are not required to do so under the Wellstone-Domenici Act of 2008.

Hence, our response to the IOM report must be clarion: Health plans offered by small businesses cannot be accurate reference points for the mental health and substance use components of the EHB. Instead, large private plans could serve as a much more accurate reference point. IOM also expressed considerable concern that the EHB be affordable.

While affordability can be defined in different

ways, the IOM chose to define it in terms of the cost of the insurance policy. To be frank, this is very nearsighted. The true costs of health insurance coverage must also encompass the very real costs that occur if needed care is not covered and therefore not provided.

For example, in the case of an EHB that fails to include mental health and substance use treatment, these costs would include those incurred as individuals suffering from mental health and substance use problems sought help in emergency rooms, got arrested and went to jails or prisons, or required other social or behavioral health services.

Another important consideration is balance. The ACA requires that the EHB have balance among

different benefits. To those in behavioral health fields, balance means two kinds of parity: parity between medical care and mental health care benefits and parity between medical care and substance use care benefits. To settle for anything less would only continue the disparities that behavioral health fields have suffered for generations. Parity also makes economic sense, because good mental health care and good substance use care can and do reduce medical care expenses.

As the development of the EHB discussion unfolds within HHS, it is essential that the voices of behavioral health be heard on the importance of two things: strong mental health and substance use care benefits in the EHB, both of which must be at parity with medical care benefits.

ON THE BOOKSHELF: RECENT POLICY PUBLICATIONS OF NOTE

- **Kaiser Commission on Medicaid and the Uninsured.** *Moving Ahead amid Fiscal Challenges: A Look at Medicaid Spending, Coverage and Policy Trends: Results from a 50-State Medicaid Budget Survey for State FYs 2011 and 2012* reports state Medicaid spending is expected to increase in 2012 by 28.7 percent. Continuing Medicaid budget pressure on many states likely will lead to more cost-saving measures in 2012 For more, go to: <http://media.navigatoread.com/documents/Kaiser+2011+Medicaid+Budget+Survey.pdf>
- **Mayo Clinic.** Written in everyday language, a set of 11 warning signs of adolescent mental problems can help parents distinguish between normal behavior and behavior or emotions that may signal early emotional problems. The aim: to catch potential problems early, when they can be most susceptible to treatment. For more, go to: <http://www.thereachinstitute.org/files/documents/action-signs-toolkit-final.pdf>
- **Commonwealth Fund.** *Electronic Consultations between Primary and Specialty Care Clinicians: Early Insights* outlines how e-consults can foster better communication among clinicians, improve continuity of care and reduce the need for in-person referrals. It also explores barriers to its adoption. Go to: http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2011/Oct/1554_Horner_econsultations_primary_specialty_care_clinicians_ib.pdf
- **Kaiser Family Foundation.** *The Uninsured: A Primer 2011* delineates characteristics of the uninsured and factors behind their number, implications for access and financial burden, sources of health coverage, role of Medicaid and potential impact on ACA. Go to: <http://www.kff.org/uninsured/upload/7451-07.pdf>
- **Harvard School of Public Health.** *Policy Makers Should Prepare for Major Uncertainties in Medicaid Enrollment, Costs, and Needs for Physicians under Health Reform* (October issue *Health Affairs*) reports that ACA Medicaid expansion could add 8.5-22.4 million to the rolls by 2019, driving up annual spending by an additional \$34-98 billion. Abstract: <http://content.healthaffairs.org/content/early/2011/10/24/hlthaff.2011.0413>
- **Commonwealth Fund.** *Promoting the Integration and Coordination of Safety-Net Health Care Providers under Health Reform: Key Issues* outlines ways to promote ACOs and medical homes among safety-net providers, overcoming disincentives to coordinated care for the uninsured. Go to: http://www.commonwealthfund.org/~media/Files/Publications/IssueBrief/2011/Oct/1552_Ku_promoting_integration_safetynet_providers_under_reform_ib.pdf
- **Kaiser Commission on Medicaid and the Uninsured.** *Medicaid's Long-term Care Users: Spending Patterns Across Institutional and Community-based Settings* profiles and articulates policy and cost implications of acute and long-term care users served by Medicaid, including elderly, disabled, dual eligible and other beneficiaries. Go to: <http://www.kff.org/medicaid/upload/7576-02.pdf>
- **Manatt Health Solutions.** *Overview of Proposed Exchange, Medicaid and IRS Regulations* describes the implications of draft IRS regulations on Medicaid, health insurance exchanges, and premium tax credits under



health reform, and examines minimum essential coverage, eligibility criteria, and enrollment. Go to: <http://www.kidswellcampaign.org/docs/other-resources/chcf-manatt-regs-analysis---august-2011.pdf>

- **Henry J. Kaiser Family Foundation.** *How Competitive Are State Insurance Markets?* Explores how market competitiveness will affect state policy decisions about insurance exchange design, rate reviews and market rules. Go to: <http://www.kff.org/healthreform/upload/8242.pdf>
- **U.S. PIRG Education Fund.** *Making the Grade: A Scorecard for State Health Insurance Exchanges* assesses and grades states on progress toward creating exchanges, including policies on governance, structure, negotiating power, consumer experience, and avoiding adverse selection. Go to: <http://www.uspirg.org/uploads/db/69/db69717a1ba8ce0ae4bd5d00bd586906/Making-the-Grade-vUS-WEB.pdf>
- **California HealthCare Foundation.** *California's 2010 Medicaid Waiver Stakeholder Process: Impact and Lessons Learned* discusses lessons and makes recommendations about the effectiveness, benefit and impact of a stakeholder advisory process used to develop the 2010 hospital financing waiver request. Go to: http://www.chcf.org/~media/MEDIA_LIBRARY/Files/PDF/S/PDF/Section1115MedicaidWaiverStakeholderProcess.pdf
- **Robert Wood Johnson Foundation.** *Reform in Action: Can Measuring Physician Performance Improve Health Care Quality* provides examples of how public reporting on facility and physician quality measures can change how care is provided (based on the Aligning Forces Quality Initiative). Go to: <http://www.rwjf.org/files/research/72929.5414.canmeasuring.pdf>

MARK YOUR CALENDAR

- **Ohio Association of County Boards-Serving People with Developmental Disabilities.** The 28th annual convention will be held November 30-December 2, 2011, Columbus, Ohio. For more, go to: www.oacbdd.org. To register go to: <http://www.oacbdd.org/forms/oacb-28th-annual-convention/>
- **National Association of State Alcohol and Drug Abuse Directors (NASADAD).** Next annual meeting, June 26-28, 2012, Hyatt Regency, Savannah, GA. Hold the date; more information forthcoming soon.
- **ACMHA-College for Behavioral Health Leadership.** Annual Summit, March 21-23, 2012, Charleston, SC, focusing on communities' role in promoting resiliency and recovery by creating social supports and networks. More information will be forthcoming on the ACMHA website, <http://www.acmha.org>
- **National Association for Rural Mental Health (NARMH).** National Conference, May 15-18, 2012, Anchorage, AK. For more, go to: <http://www.narmh.org/conferences/2012/default.aspx>
- **Michigan Association of CMH Boards.** *Improving Outcomes, Finance & Quality Through Integrated Information XXVIII*, December 1-2, 2011, Radisson Hotel Lansing, 111 N. Grand Ave., Lansing, MI 48933. For more, go to: www.macmhb.org click on to conferences and trainings.



ACMHA The College for Behavioral Health Leadership CULTIVATING LEADERS FOSTERING INNOVATION

A new **webinar** on community-collaboration to meet the needs of recently returning veterans, featuring Eric Hall, with the Geisinger Health System Reaching Rural Veteran's initiative, will be held on Thursday, December 15 (2 pm, EST). For more, go to the ACMHA website. After the December webinar, the series will take a hiatus while the organizers prepare for the ACMHA Summit. They will resume in May 2012, with the third annual series.

The 2010, 12-part critical issue webinar series that focused on the 2010 health reform legislation and its implications for behavioral health is now available online. Topics broadly span insurance, coverage, quality, payments and health information technology. Visit http://acmha.org/current_events_critical_issues.shtml to access the audio/visual presentations and accompanying PowerPoint slides from this outstanding series.