

National Association of County Behavioral Health and Developmental Disability Directors

The voice of local authorities in the Nation's capital

NEWSLETTER

FEBRUARY 27, 2014

PEERS AND LEADERSHIP:

AN EXCERPT FROM THE WHITE PAPER "US PEER LEADERSHIP AND DEVELOPMENT"

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SUMMARY

The future is here. *2014 is the year of the peer.*

The implementation of the Affordable Care Act (ACA) provides us, the integrated health community, the opportunity to define, develop and grow a system of solutions that meet our needs. In economics, the cycle of poverty is the "set of factors or events by which poverty, once started, is likely to continue unless there is outside intervention." (Citation: http://en.wikipedia.org/wiki/Cycle_of_poverty)

This proposal focuses on leadership development for the future of a truly integrated approach to recovery and rebirth for millions of Americans trapped in this cycle of poverty. Evidence-based practices with Certified Peer Specialists (CPS), Recovery Coaches (RC) and Community Health Workers (CHW) all demonstrate improved health outcomes when interventions are delivered through individuals with shared life experience. We introduce the development for a workforce of professionals whose shared life experiences open the door to end the cycle of poverty by creating a recovery-based workforce who have empowered themselves using the principles of Recovery Based Practices.

We present a framework to shift the stereotypical discriminatory images of people living with behavioral, physical, and economic challenges by creating a peer-based leadership development model providing valued added supports by integrating the strengths of the CPS, RC and CHW service delivery in integrated care solutions. It focuses upon adult behavioral health, addictions and trauma recovery systems of care.

Creating a national Recovery Based Workforce Development plan establishes and legitimizes the lived experienced service provider as a healthcare occupation recognized by the United States Department of Labor (DOL) and as a healthcare provider category through the Centers for Medicare and Medicaid Services (CMS).

INNOVATION & EMERGENT ROLES

Experts agree peer specialists are the most successful new component to improved outcomes for people recovering from mental illness and addiction and/or breaking the cycle of poverty. "They are a terribly important new addition to the workforce," says Bob Glover, director of the National Association of State Mental Health Program Directors. "When peers are involved, outcomes are dramatically better across the board," he says.

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Teddi Fine, MA, Editor

Currently, there is limited coordination between roles and responsibilities for three different types of peer providers. These peer providers include: CPS who focus on behavioral health; RC focusing on substance abuse and addiction and CHW focusing on physical health. Each group has separate training and certification programs although there is great overlap, with necessary cross-training in the served demographics and populations. We require a structured approach to integrate the strengths of each program while creating a career ladder for peers at any stage of recovery.

Creating a workforce of Lived Experience Integrated Care Professionals combines the strengths of stand-alone groups and provides the second step on the peer workforce development ladder without discounting or devaluing the important work each individual group performs. We can create and expand workforce opportunities for individuals with personal experience living with behavioral disorders, addiction or poverty recognized by the DOL.

ACTION STEPS

The initial 4 action steps to the process include:

- **Step 1** – Establish the National Collaborative Partnership for the US Peer Leadership & Training Institute and Program;
- **Step 2** – Establish the University Program & Partnership for the US Peer Leadership & Training Institute and Program;
 - Establish a US university to house the US Peer Leadership & Training Institute and Program. Currently identified universities which have established and that are leading psychiatric rehabilitation, community integration, Consumer Operated Services Provider (COSP’s) research/development, peer supports/services emerging best practices, direct technical, training and assistance supports include, but are not limited to: (a) Johns Hopkins University; (b) Rutgers University; (c) Temple University; (d) University of Arizona; (e) University of Missouri; (f) University of Texas at Austin; and (g) Yale University.
- **Step 3** – Analyze collective data to:
 - Create a Peer Driven/Led Task Force to research and identify certification programs for behavioral health, addiction and public/community health offered through public and private sector providers.
- **Step 4** - Evaluate Certification, Licensure and Accreditation Process

ACMHA’s College for Behavioral Health Leadership’s Peer Leadership Interest Group (PLIG) is hosting a peer leadership & management education and training program focusing on innovative and emergent roles of peers in integrated care solutions, March 25, 2014, Santa Fe, NM, just before the College’s 2014 Summit. Learn more at: www.acmha.org.

National Certification Licensure/Accreditation

- Ensures uniformity of core knowledge by LEPs at each provider level;
- Endorses a continuing professional development and credibility;
- Advances uniform standards and scope of practice;
- Promotes ethical practice;
- Values people with Lived Experience as an essential part of the healthcare team, and;
- Establishes an education and career path for individuals committed to helping others by sharing “Lived Experience” in addition to education and training.

FORMER PRESIDENT LAUNCHES NEW PTSD ASSISTANCE PROGRAM FOR VETERANS

Former President George W. Bush has just announced an initiative he is undertaking in collaboration with a coalition of education centers, corporations, nonprofits and government entities to help veterans more readily transition to civilian life and to aid in the treatment of PTSD. Working under the aegis of the Bush Institute, a public policy center he and his wife Laura founded, the former President hopes to help reduce the unacceptably high rate of unemployment among returning Iraq/Afghanistan war veterans. Further, later this spring, Institute researchers will release suggestions on ways to better treat and help erase the stigma often associated with PTSD and other emotional disorders.

HEALTH CARE PROVIDERS PARTNER TO PROVIDE MENTAL HEALTH CARE

[The following news story by Elena Watts was published January 25, 2014, in the Victoria (TX) Advocate. Republished here with permission. NACBHDD thinks it provides a wonderful model of partnering for integrated care.]

A conversation between two Crossroads leaders seated next to each other at a meeting about Medicaid has sparked a partnership that is expected to benefit the community. Gulf Bend Center and Citizens Medical Center have joined forces to streamline the delivery of health care services with a system that benefits patients, health care providers and taxpayers.

"The most important part of the association between Gulf Bend and Citizens is to set up the foundation for a model of integrated health care with a wholistic [sic] view of the needs of the patients," said Dr. Nestor Praderio, geriatric psychiatrist and owner of Psychiatric Consulting Service in Aransas Pass. Praderio oversees inpatient psychiatric units in Aransas Pass and Corpus Christi and treats patients with mental health issues in the Crossroads by televideo.

At the Medicaid meeting, David Way, associate executive director of Gulf Bend Center, shared his ideas about integrative health care with Stephen Thames, hospital administrator for Citizens Medical Center, to secure a letter of support for his proposal.

Thames offered more than his endorsement. He offered hospital space and medical professionals. The \$1.2 million project, funded by a Texas Department of State Health Services grant and an in-kind match from Citizens Medical Center, began in January. Citizens Medical Center provides space on the sixth floor of the hospital for the six-person outpatient extended observation unit as well as a nursing staff.

In turn, Gulf Bend Center provides licensed counselors and social workers to assess and treat patients with behavioral health issues. Diagnoses and treatment by a psychiatrist are available as needed by televideo.

Short-term and long-term treatment plans include counseling and symptom management. The average stay in the unit is 13 hours, but patients can stay as long as 48 hours.

"Emergency rooms and jails have served patients with behavioral health issues for lack of better alternatives," Way said.

"Patients would spend three to four days in the ER or on the floor without care - just supervision - until we could locate a psychiatric bed somewhere else," Thames said.

"Hospitals were not designed to take care of the mental piece of the health care equation," Thames said.

"Many of the patients' crises are situational, which would not require admission to a psychiatric unit if other safe, structured options existed," Way said.

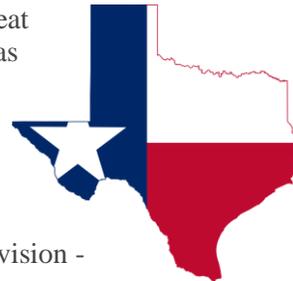
"About 94 percent of hospitalizations for mental health issues are preventable," said Donald Polzin, executive director of Gulf Bend Center.

"The outpatient extended observational unit reduces costly emergency room admissions and avoidable hospital admissions and readmissions," Thames said.

"The goal is to have first responders bypass the emergency room entirely by delivering patients with behavioral issues to the crisis assessment center," Way said.

The crisis assessment center operates from 8 a.m. to 7 p.m. at Gulf Bend Center and in the hospital's observational unit the remainder of the day.

"We want this to be a model for integrative health care for the state," Way said.



THE VALUE OF INTEGRATED CARE: AN EDITORIAL

[The following January 25 editorial by the Editorial Board of the Victoria Advocate that appeared as a commentary on the Elena Watts story is published with permission.]

Mental health care is an important part of the medical services that many people will need at some point in their lives. In Victoria, we have a strong medical community that includes two award-winning hospitals and many different clinics. Now, two of those health care providers are working together to improve mental health care options in the Victoria community. Citizens Medical Center and Gulf Bend Center have announced a partnership aimed at coordinating care to better treat mental health issues in Crossroads patients. This project would build an alternative avenue to care that people need.

According to the National Institute of Mental Health, about 26.2 percent of adults in the United States are diagnosable with mental health problems in a year. Of those cases, about 22.3 percent - or 5.8



percent nationally - are severe. The number of diagnosable cases of lifetime prevalence rises to 46.4 percent of the population. Of the people who have a disorder in any given year, about 36 percent are receiving treatment, but about 12 percent of those with a disorder are receiving only minimally adequate treatment.

With such a large percent of the population struggling with mental health issues, our health care providers need to step up treatment options that address the problem from the beginning. Many mental health issues can manifest in physical symptoms. At a Tuesday meeting with members of the Victoria Advocate Editorial Board, representatives from Citizens Medical Center and Gulf Bend Center, including Citizens CEO Stephen Thames and Gulf Bend Executive Director Donald Polzin, shared their plans for a partnership and how it will affect mental health services in the Crossroads.

This plan will help save money for both Citizens and Gulf Bend by better utilizing available resources, according to a news release provided at the meeting. "Previously, patients would come to the emergency room for treatment of physical symptoms of their behavioral health needs, and the hospital would have to keep them there until the symptoms were treated, but the root cause was not always addressed," Thames said. This partnership would allow coordination between the Gulf Bend Center personnel and Citizens Medical Center to offer treatment for the cause instead of simply treating symptoms that are likely to resurface because of the patient's untreated behavioral health issues.

The partnership is also aimed at establishing a community learning collaborative for all health care providers, public and private, to learn from one another. One major development that is coming is the Gulf Bend Center's Wellness Community, which will be an apartment community designed to give mental health patients an environment removed from the settings that are part of their mental health problems, according to a news release. This would be a step between hospital care and returning to the outside world for patients to adjust and learn healthy lifestyle behaviors before returning to everyday life.

We are excited to see all of these pieces developing in the Victoria community. Our health care providers have proven themselves to be excellent, community-oriented companies dedicated to offering the best care possible. This partnership and the building of the Wellness Community is a major step forward for mental health care in the Crossroads. We look forward to seeing the positive developments that come from this partnership. In time, we hope the Crossroads can be a place that is known for its effective mental health care from primary care physicians all the way up to our major hospitals.



BITS FROM DC

Dear Colleagues:

I hope to be able to greet many of you next week at our annual NACBHDD Legislative and Policy Conference in Washington, DC. Our agenda is full of topics and discussions to help each of you adapt to the monumental changes underway in healthcare. We will post the agenda and the power point slides to our new Website once the Conference has been concluded.



I want to use this occasion to express grateful thanks to **George Braunstein**, Executive Director of the Fairfax-Falls Church Community Service Board in Virginia, and **Deborah Wentz**, Executive Director of the New Jersey Association of Mental Health and Addiction Agencies, for their generous donations to NACBHDD at the end of 2013. We all appreciate their thoughtfulness.

Again this year, I will offer my Johns Hopkins University Leadership Course for Emerging County Leaders on June 19 and 20. If you would like to participate or nominate someone from your county, please let me know.

As the Polar Vortex descends on us tonight, I want to extend to you a traditional Irish wish: "May the warm sun always be on your face, and may the cold wind always be at your back."

Ron Manderscheid, PhD
Executive Director

WELCOME TO NACBHDD

We are delighted to welcome **Kyle Kessler**, Executive Director, Association of Community Mental Health Centers of Kansas, as a new NACBHDD colleague and partner. Kyle has over a decade of



experience in health and human services public policy. Prior to accepting his new position with the Association, he worked for a large behavioral health and child welfare provider, most recently as their Executive Vice-President of Public Affairs, managing their public affairs in five states.

Previously, Kyle served within the Kansas state government, including an appointment as Deputy Secretary for Public and Governmental Services within the Department of Social and Rehabilitation Services (SRS). In that position, he managed the agency's government affairs, communications and customer service functions. Kyle currently serves on the Boards of Directors of both the Kansas Head Start Association and Kansas Health Solutions. He holds Bachelors'

degrees in political science and history from Emporia State University and a Masters degree in Public Administration from Kansas State University. He and his wife, Mindi, a clinical marriage and family therapist, are the proud parents of two daughters, Grace and Molly.

COMINGS AND GOINGS

- **BAUCUS TO CHINA; WALSH TO SENATE.** With the confirmation of Senator Max Baucus as the President's pick as Ambassador to China, Montana Lieutenant Governor, John Walsh (D) has been named by Governor Steve Bullock to fill the now-vacated seat. Walsh is the latest in a series of appointments made during the course of the past 12 months resulting from vacancies in both the US Senate and House of Representatives.



TAKING THE TEMPERATURE OF BEHAVIORAL HEALTH

A new SAMHSA report, the *National Behavioral Health Barometer*, presents a set of key substance use and mental health indicators from population and treatment facility-based data sets, including rates of serious mental illness, suicidal thoughts, substance abuse, underage drinking, and the percentages of those who seek treatment for these disorders. The Barometer provides point-in-time and trend data reflecting the status and progress in improving key behavioral health indicators at both the national level, and for each of the 50 states and the District of Columbia.

The data indicate that, in at least some areas, the behavioral health of our Nation is improving. For example, the rate of prescription pain reliever abuse has fallen for both children ages 12–17 and adults ages 18–25 from 2007 to 2011 (9.2 percent to 8.7 percent and 12.0 percent to 9.8 percent, respectively).

Check out where your state stands. Go online and get the document at: http://store.samhsa.gov/product/SMA13-4796?WT.mc_id=EB_20140130_SMA13-4796



NARMH NOTES

- **NARMH IN DC FOR NACBHDD POLICY MEETING.** The National Association for Rural Mental Health (NARMH), now affiliated with NACBHDD, will be holding our Winter Board Meeting in conjunction with the NACBHDD Policy Conference in early March. This is the first year that NARMH Board Members will participate in a more formal way with this conference by attending leadership meetings and participating in visits to the Hill.
- **NEW EDITOR FOR NARMH JOURNAL.** *The Journal of Rural Mental Health (JRMH)*, the official journal of NARMH, is pleased to announce that Jim Werth, PhD, ABPP, was selected as the Journal's new editor. Dr. Werth currently serves as the Behavioral Health and Wellness Services Director for Stone Mountain Health Services, a federally qualified health center serving the westernmost counties of Virginia. He is also the Director of the East Tennessee/Southwest Virginia Pre-doctoral Psychology Internship Consortium. He came to Stone Mountain from Radford University, where he was the founding director of the now-APA-accredited Psy.D. Program in Counseling Psychology, which emphasizes rural mental health, cultural diversity, social justice, and evidence-based practice.

JRMH, published by the American Psychological Association, is a peer-reviewed journal, focused on rural mental health research, practice and policy. It publishes on a wide range of topics in mental health in rural and frontier regions, across behavioral health workforce sectors, in the US and internationally. *JRMH* is now developing a 20- to 30-member Editorial Board of individuals willing and able to review approximately 6 manuscripts a year when asked, and to return them with comments within 30 days. Please contact Dr. Werth (JRMHEditor@gmail.com) if you are interested in submitting a manuscript, participating on the Editorial Board, or interested in reviewing articles. *JRMH* encourages early career professionals and graduate students who want to obtain more experience reviewing to serve in this capacity.

DRUG USE AND SUICIDE LINKAGES?

According to a new SAMHSA report, adults using illicit drugs are far more likely to seriously consider suicide than the general adult population. While 3.9% of the nation's population age 18 or older had serious thoughts about suicide in the past year, the rate among adult illicit drug users was more than double at 9.4%.

The percentage of adults with serious thoughts of suicide varies by the type of illicit substance used. For example, while 9.6% of adults who used marijuana in the past year had serious thoughts of suicide during that period, the figure rose to 20.9% among adults who used sedatives non-medically. For more data, go to: <http://www.samhsa.gov/data/spotlight/spot129-suicide-thoughts-drug-use-2014.pdf>

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

- **HOUSE CONTINUES ACA REPEAL, REVISION.** House Republicans have introduced legislation and are conducting hearings focused on repealing the ACA's definition of fulltime employees (now set at 30 hours a week or more) and ensuring that emergency service volunteers are not treated as employees under the ACA. The legislation is designed to take another bite out of the ACA. At the same time, Republicans have asked the Government Accountability Office (GAO) to open investigations of 3 state-run ACA exchanges that they contend are failing disastrously: Oregon, Maryland and Massachusetts, states in which Democratic governors embraced the healthcare law.
- **Senators Propose ACA Alternative.** While House Majority Leader Eric Cantor (R-Va.) talks about taking the lead on crafting the GOP's ACA replacement and Senate Minority Leader McConnell has asked governors for their input, three Senators already have just stepped up with a specific proposal. The Patient Choice, Affordability, Responsibility and Empowerment (CARE) Act is a "blueprint" alternative developed by Senators Richard Burr (R-N.C.), Tom Coburn (R-Okla.) and Orrin Hatch (R-Utah). It would eliminate all of the ACA's federal rules, including the requirement to purchase insurance under the threat of penalty. It also would allow insurers once again to discriminate against people with pre-existing conditions. Perhaps the only provision that still remains is keeping dependents under age 26 on their parents' health plans, a fact that allowed the authors to argue that they weren't proposing a wholesale repeal of the ACA. The proposal already has been excoriated on the Senate floor by some Senate Democrats.



SHOP CVS

JEFF HOFFMAN, PHD.

CEO, DANYA INTERNATIONAL, INC

[Reprinted from the Dayna Blog]

The decision last week by CVS Caremark to stop selling tobacco products effective October 1, 2014, in over 7,600 pharmacies across the United States is a milestone for the tobacco control movement. CVS President and CEO, Larry J. Merlo, stated that this decision to end tobacco sales "is the right thing for us to do for our customers and our company to help people on their path to better health." This decision is said to cost CVS up to \$2 billion in tobacco-related sales per year, but will likely save tens of thousands of people from developing tobacco-related diseases and premature death.

President Barack Obama praised CVS' decision, saying it will save lives and reduce health care costs. He thanked CEO Merlo, stating that this "decision will help advance my Administration's efforts to reduce tobacco-related deaths, cancer, and heart disease, as well as bring down health care costs." However, what has received less attention is that President Obama also deserves substantial credit for this landmark decision. If it were not for the passing of the Patient Protection and Affordable Care Act (ACA) of 2010 and the tobacco screening and cessation services covered under the ACA, CVS most likely would not have been in a position to make this landmark health-conscious decision.

In general, the ACA mandates screening of all patients for tobacco use and requires that tobacco cessation counseling and medication be offered to patients across all private and public health insurance plans. Although the requirements for reimbursement of these services is not clearly or consistently defined across health insurance plans, CVS was able to make the financial calculation that they will be able to make up for the \$2 billion loss, and possibly even exceed it, through offering these cessation services and products in health clinics expanding within their pharmacies. CVS announced that they will launch a national smoking cessation program this spring, which will surely include offering a range of cessation services. This is not to detract from the positive actions CVS has taken. By making this bold move, they are now leaders of the pack, and they will indeed save many thousands of lives by this action. We applaud their decision and say, "SHOP CVS!" We can all show our support for the decision by buying their healthy products. We at Danya call for a SHOP CVS campaign to support their decision and hope that others will follow their example. Let's also give due credit to the Obama Administration for having the foresight to mandate tobacco screening and cessation coverage to promote health, save lives, and ultimately reduce health care costs from tobacco-related diseases.

The Danya Institute will be hosting the National Conference on Tobacco and Behavioral Health (NCTBH): *Interventions, Integration and Insurance* on May 19–20, 2014, at the North Bethesda Maryland Marriott, which will provide the tobacco control field an update on tobacco cessation and the ACA (<http://www.danyainstitute.org/national-conference-on-tobacco-and-behavioral-health-2014/>). Mark your calendars!



HHS AND OTHER AGENCY NEWS AND NOTES

- **THE LATEST ON ACA ENROLLMENTS.** According to HHS, approximately 4 million people have signed up for an insurance plan through federal and state-based Marketplaces since October 1. More than 1.1 million people enrolled in January, added to the 2.2 million who selected plans from October through December. Through the end of January, nearly 3.3 million people signed up to get covered for private insurance through the Health Insurance Marketplace. HHS also reports that a growing population of young, healthy and well-covered Americans is signing up for coverage. Nearly 1 in 3 enrollees since October 1 are under age 35. In January alone, enrollment among young adults between ages 18 and 34 grew by 65% - more than all other age groups combined.
- **ANOTHER ACA DELAY.** The Administration will delay the ACA employer mandate in until 2016 for businesses with between 50 and 99 employees. Employers with businesses in this size range will now have until January 2016 to decide whether to offer insurance to their employees or pay a penalty. At the same time, larger businesses would be barred from cutting their work force in order to fall under the threshold. However, companies with 100+ workers now must cover 75% of fulltime employees, not 95%, by 2015 to avoid a penalty.
- **2015 ACA OPEN ENROLLMENT DATE CHANGE REMINDER.** CMS has proposed a change in the 2015 annual Marketplace open enrollment period. It will begin on November 15, 2014, and extend through January 15, 2015. The aim is to give issuers additional time before they need to set their 2015 rates and submit their qualified health plan applications, give States and HHS more time to prepare for open enrollment, and give consumers until January 15, 2015, to shop for coverage.
- **AIDING JUSTICE-INVOLVED YOUTH.** SAMHSA and the MacArthur Foundation are targeting the behavioral health needs of youth in contact with the juvenile justice system. The initiative emphasizes (a) diverting youth with co-occurring behavioral disorders from the juvenile justice system; (b) incorporating screening and assessment throughout the juvenile justice system; (c) recognizing the roles of evidence-based practice, treatment and trauma-informed services; (d) increasing stakeholder collaboration to facilitate access to evidence-based community treatment and services; and (e) reducing overrepresentation of youth of color in the juvenile justice system. Up to 5 states will be



selected competitively to participate, based on the state's commitment to improving policies and programs for these youth. For more information, contact Karli Keator at the National Center for Mental Health and Juvenile Justice (866-962-6455).

- **NEW MENTAL HEALTH PRIVACY GUIDANCE.** HHS has released guidance clarifying how the HIPAA Privacy Rule protects individuals' mental health information and the circumstances under which the rule permits health care providers to communicate with patients' family members and others to enhance treatment and assure safety. The document addresses some frequently asked questions about when it is appropriate for a health care provider to share the protected health information of a patient who is being treated for a mental condition. It clarifies when HIPAA permits health care providers to communicate with a patient's family members, friends, or others involved in the patient's care, depending on whether the patient is an adult or a minor. In addition, it explains how providers may communicate to others when the patient presents a serious and imminent threat of harm to themselves or others. Read the guidance at: <http://www.hhs.gov/ocr/privacy/hipaa/understanding/special/mhguidance.html>

ESSENTIAL NEW ROLES FOR PEERS AND SERVICE RECIPIENTS IN THE WHOLE-HEALTH ERA

RON MANDERSCHIED, PHD

[Reprinted from *Behavioral Healthcare*, Access at: <http://www.behavioral.net/blogs/ron-manderscheid/essential-new-roles-peers-and-service-recipients-whole-health-era>]



The whole-health era being ushered in by the ACA will bring dramatic changes to the roles of peers and service recipients. We need to implement these new roles in the incubator of emerging medical and health homes.

Much attention currently is devoted to the dramatic changes that the Affordable Care Act (ACA) will bring to behavioral healthcare providers. The major ACA change agents are insurance expansion with parity and service reconfiguration due to integrated care. By contrast, virtually no attention is devoted to the equally dramatic changes that the ACA will bring to the roles of peers and service recipients. I would like to explore these latter changes here.

How the ACA will Produce Change. As a framework for this discussion, several features of the ACA need to be described. The ACA promotes whole health--considering all aspects of a person's health together--through person-centered care--considering the person to be the "true north" of their own care. In turn, person-centered care requires shared decision-making between persons and their providers, and shared responsibility both for one's care and one's health.

These important goals can be achieved through integrated care systems that combine primary care and behavioral healthcare. Such service systems may be organized either through medical homes operated by primary care entities or health homes operated by behavioral health entities. It is in the incubator of these new service contexts that we need to implement the

new roles for peers and service recipients.

In behavioral health, either for mental health or substance use services, the traditional peer role has been to engage and support a person with a behavioral health condition while that person receives behavioral health services. Frequently, this has occurred in public sector specialty service systems, particularly for persons with very severe conditions. Over the past decade, this effort has served to solidify the definition and range of actions of a peer supporter. The result has been funding of peer support services by the majority of states through the Medicaid Program.

New Peer Role Beyond Behavioral Healthcare. With the implementation of the ACA and integrated care systems, the role of peer supporter has the potential to undergo very significant expansion. Most dramatically, *an opportunity will exist for a peer to serve persons who have no behavioral health conditions.* Some will be persons with conditions ranging from simple medical ailments to diabetes or heart disease. Others will be people without any disease condition who are seeking to facilitate their own wellness through prevention and promotion services. Perhaps almost as dramatic, an opportunity will exist for peers to help improve wellness interventions for persons who do have behavioral health conditions, especially in a whole-health oriented integrated care system.

Emerging Service Recipient Role. Similarly, the ACA will provide an opportunity for all service recipients to take on a new role by seizing the initiative to help define and shape their own care. Very clearly, key concepts, such as person-centered care, shared decision-making, and shared responsibility, will be integral to these revolutionary changes in the service recipient role. One simply needs to imagine a person

with a severe heart condition taking on this new role to actually see how revolutionary these changes could potentially become.

What makes all of this very exciting is that the genesis of these new roles comes directly from modern behavioral healthcare, particularly its consumer movement. Because this is the case, we will have a once-in-a-lifetime opportunity to shape both of these new roles as the ACA is implemented. We must take this opportunity very seriously.



We will need to prepare for these landmark changes. Some of the actions that deserve our attention right now include:

- **Defining the new roles clearly.** We will need clear specification of the characteristics and actions that comprise the new peer role and the new service recipient role.
- **Developing user-friendly labels.** Because we are describing new roles, it is essential that they not be confused with current roles. As just an example, for peers, we probably should not be talking about a “peer supporter” but rather a “health supporter”. Similarly, for service recipients, rather than an

“engaged patient” or “service recipient”, we should be talking about a “health seeker”. Mind you, these simply are examples. Collectively, our field needs to evolve good, effective terms.

• **Training providers, peers, and service recipients to advocate for the new roles.**

Once the new concepts are developed, it will be imperative that our own providers, peers, and service recipients understand the new roles and begin employing them.

• **Exporting the new roles to primary care providers and medical service recipients.**

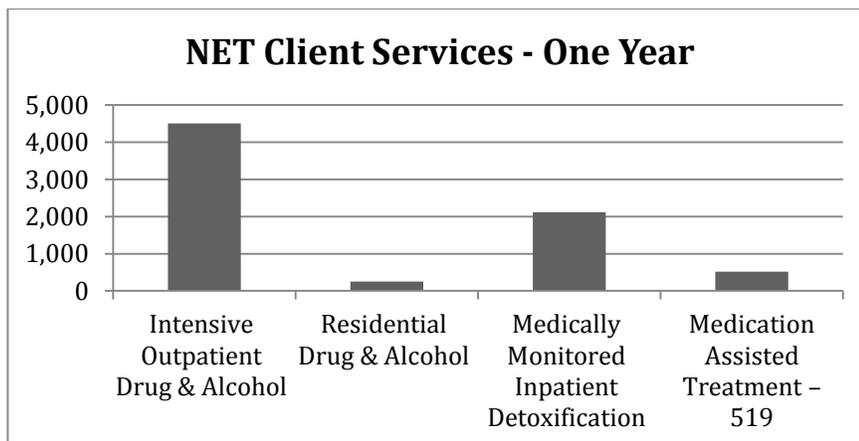
To reach their full potential, these new roles must be adopted by our primary care colleagues and medical service recipients. This transformation only can occur as we begin to work more closely together in the integrated care systems that are beginning to emerge.

These developments offer wonderful, progressive opportunities, as we address the challenges they bring. I am very confident that much ferment will occur in both of these new roles during 2014, and equally optimistic about the outcomes.

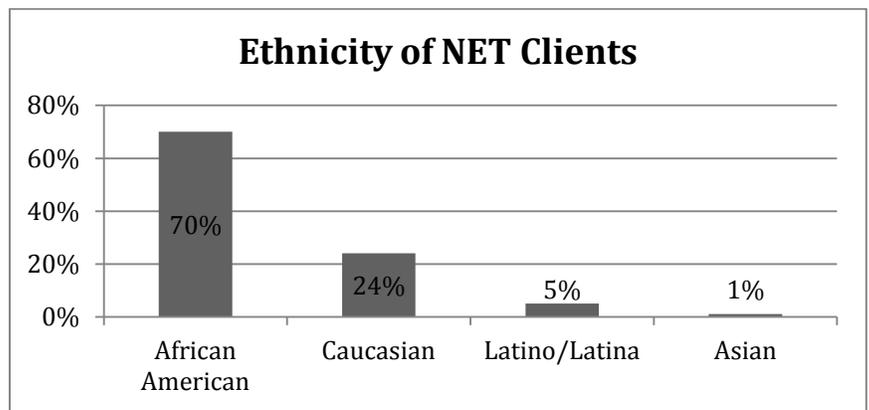
INNOVATION AND EXCELLENCE IN RECOVERY SERVICES

NORTHEAST TREATMENT CENTERS (PHILADELPHIA, PA)

NorthEast Treatment Centers (NET) is an innovative, comprehensive, integrated treatment and recovery center for individuals coping with disorders related to alcohol and other drugs alone or in combination with mental health disorders. NET opened as a residential drug treatment facility in the 1970s, by the mid-1980s had expanded to provide an array of outpatient and residential services, by the mid-90s was providing intensive outpatient services, and by the 2000s was working with forensic individuals and providing services in Spanish. NET is headquartered in Philadelphia, PA, and currently provides evaluation, treatment and recovery services to persons over the age of 18 at seven sites in Philadelphia and the Lehigh Valley. In the past year, services provided by NET through its Adult Behavioral Health Divisions have included:



All clients have been 100% below the Federal poverty level and Medicaid eligible. The ethnicity of NET clients is shown below.



NET's highly successful treatment approach is grounded in four **NET KEYS**:

- *A recovery-oriented system of care*: NET focuses on recovery support and long-term management rather than on viewing AOD disorders as diseases to be cured.
- *A client-centered and driven system of recovery*: NET's approach to treatment and recovery service provision is client-centered and client-driven rather than based on professional authority.
- *A highly developed peer culture*: Many services are provided by current or former consumers, and many staff are former consumers.
- *Development and support of responsible concern for the community and others*: Consumers are expected to foster a spirit of recovery and build recovery capital while reinforcing personal values needed to function in and give back to society.

A major transformation in NET's service approach and philosophy occurred in 2002 when it went from using a traditional medical model of addiction as a disease that can be cured to a model based on a recovery-oriented system of care with a menu of services and supports. In this model, AOD problems are treated as chronic conditions requiring ongoing intervention and support. Long-term recovery takes place in a culture of recovery that spans: pre-treatment engagement, recovery initiation and stabilization, and sustained recovery maintenance. A recovery-oriented system of care is designed to encourage, support and promote recovery before, during and after treatment.

This change shifted the focus of the treatment and recovery process from one based on the authority of professional staff to a partnership between persons in recovery (PIR) and clinical and peer staff. NET went from a collection of isolated service programs to a fully integrated culture of treatment and recovery in which staff, peer leaders, and clients collaborate to achieve the client's goals. This is accomplished by supporting the client's development of recovery capital, and the internal and external resources needed to initiate and sustain the recovery process. This approach is also characterized by expanded linkages with community-based services and organizations in order to support community reintegration and the process of lifelong recovery.

AROUND THE STATES: AN UPDATE

- **CALIFORNIA.** The State continues to lead in ACA implementation. It beat its 2014 ACA enrollment goals 5 weeks before the sign-up period closes. And Californians shopping for policies through the State Marketplace now can compare plans based both on cost and customer quality ratings. Perhaps some other states may want to emulate some of the best elements of California's ACA implementation plans.
- **KANSAS.** Kansas is moving ahead with a last part of its Medicaid expansion program that was of great concern to DD/ID advocates. Management of in-home services like health monitoring, and help with finances, employment and daily tasks that enable around 8,500 people with DD/IDs to live independently will be turned over to three private health insurance companies. This completes the privatization of the State's Medicaid program, KanCare. CMS approval for this last change included significant caveats and conditions. A 106-page CMS report outlines the special conditions that need to be met as a condition of that approval, including bimonthly monitoring and a requirement that the State meet specific additional service needs not now provided to around 1,700 with DD/IDs.
- **MARYLAND.** Maryland has surpassed its projections for Medicaid enrollment following enactment of the ACA. Over 121,000 Marylanders have enrolled by early February, over 11,000 more than projected to be enrolled by July 1, 2014. Apparently, a majority of the new enrollees did not have to apply through the troubled State marketplace; rather they were part of a program that automatically transferred them to Medicaid on January 1.





- **MISSOURI** . A federal judge has held that states refusing to run their own **HEALTH** insurance marketplaces under the ACA cannot impose additional requirements on ACA “navigators.” The US District Court judge held that by enabling the federal Department of Health and Human Services to build and offer the insurance marketplace, Missouri had ceded its ability to establish its own rules governing ACA navigators. Specifically, the state was instructed that it cannot either impose limits on what navigators can say when providing insurance advice or specify licensing requirements for such personnel. Missouri's law had barred "navigators" from discussing the "terms, benefits and features" of health plans on the exchange, putting it at odds with the workers' role as outlined in the ACA.
- **OKLAHOMA**. According to the State Department of Mental Health and Substance Abuse Services commissioner, without additional \$21 million in funding, as many as 7,000 of the 80,000 Oklahomans now getting mental health care could lose services. Further, as many as 70% of adults and 40% of youth in need of care (a total population of between 700,000 to 950,000 individuals) likely would never gain access to treatment. Among the programs that could be affected are the systems of care programs for children with serious emotional disturbances and the State’s drug court system.
- **OREGON**. A new Department of Justice report has found that Oregon lags in providing community-based care to people with serious mental illnesses. Funds for institutional care have actually risen, while community-based care has dwindled. Further, some community-based programs do not meet quality standards. The State says the report doesn’t reflect the almost \$60 million now being awarded in contracts specifically for community-based crisis and peer support services, supported housing and job services, and for teams of psychiatrists, nurses and social workers to provide individualized Assertive Community Treatment. Stay tuned.
- **UTAH**. According to the office of Governor Gary Herbert (R), after several years of delay, the State will now participate in the ACA’s Medicaid expansion for those earning up to 138% of the federal poverty level.
- **VIRGINIA**. Virginia State Senate voted to adopt Senator Creigh Deeds’ mental health measure that, if adopted by the House and signed by the Governor, would quadruple the current 6-hour limit on emergency custody orders for involuntary psychiatric evaluations to 24 hours. It also would establish an online psychiatric bed registry, to provide real time information about available beds in both public and private facilities. The legislation was introduced following the November death of Deeds’ son, who killed himself after stabbing his father multiple times. The younger Deeds had received a mental health evaluation under an emergency custody order the previous day but was released since no beds could be found within the 6-hour custody limit.
- **WASHINGTON**. *ACA news*: Medicaid enrollment in Washington State has grown so high so fast that the state already has met its April goal for new participants under Medicaid expansion. *New on integrated care*: A bill to align mental health care with drug treatment when it comes to public health care for the poor has been introduced in the legislature at the request of Governor Inslee (D). The measure comes in response to a CMS letter telling the State to change how it pays for mental health care and rebid mental health services. While the governor had hoped to give private insurance companies a chance to compete with counties for the care, that provision is not part of the legislation. It is thought that there may be legal impediments to such a bidding process. Ultimately, however, the governor hopes to combine behavioral health services with primary care, integrating care for earlier assessment, diagnosis and treatment and saving costs and lives.

HOPKINS SUMMER LEADERSHIP COURSE 2014

Dr. Manderscheid again will be teaching a county leadership course at Johns Hopkins University this summer (June 19-20, 2014, 8:30 am -12:30 pm), joined by Drs. William Eaton and Philip Leaf. The one-credit course, *Knowledge for Managing County and Local Mental, Substance Use, and Developmental Disability Authorities*, reviews key features of successful management of county and local authorities that oversee and conduct mental health, substance use, and developmental disability services. It also explores environmental factors that impact local operations, as well as facility with key tools to plan and implement services. Two principal environmental factors, i.e., National Health Reform and Medicaid, and two primary tools for management, i.e., strategic planning and needs assessment, are examined in depth. The course emphasizes practical knowledge so managers can apply the information immediately upon returning to their programs. Students are expected to bring practical problems to the course and to leave with useful strategies and tools for solving them. As in the past, Dr. Manderscheid will be seeking federal funding but, at this time, has no assurance that such funding will be available. For more information, go to: <http://www.jhsph.edu/departments/mental-health/prospective-students-and-fellows/summer->



ON THE BOOKSHELF: RECENT PUBLICATIONS OF NOTE

- **AMERICAN PSYCHOLOGICAL ASSOCIATION.** *Healthy Development Summit II: Changing Frames and Expanding Partnerships to Promote Children's Mental Health and Social/Emotional Development* focuses on the application of research to practice and policy in children's mental health. This summit and report detail on effective framing of the importance of child mental health for healthy development; collaboration across sectors; and specific feasible and actionable recommendations that could be implemented across disciplines to assure continued progress in promoting young children's mental health. Download the full report at: <http://www.apa.org/pi/families/healthy-development.aspx>
- **ROBERT WOOD JOHNSON FOUNDATION.** *Time to Act: Investing in the Health of Our Children and Communities* builds on the work of the 2008 Commission to Build a Healthier America. It presents the Commission's new insights into factors that result in health disparities, such as early childhood experiences; opportunities that communities provide for people to make healthy choices; and the mission and incentives of health professionals and health care institutions. To read or download the report, go to: <http://www.rwjf.org/content/dam/farm/reports/reports/2014/rwjf409002>
- **NATIONAL ACADEMY FOR STATE HEALTH POLICY/ROBERT WOOD JOHNSON FOUNDATION.** *Paving the Way to Simpler: Experiencing from Maximum Enrollment States in Streamlining Eligibility and Enrollment* details ways in which 8 states (AL, IL, LA, MA, NY, UT, VA and WI) have worked to streamline and simplify enrollment systems, policies, and processes for children and those eligible for health coverage in 2014, with the aim of reducing consumer enrollment barriers for consumers and administrative burdens. The experiences present lessons for other states that may be useful in efforts to improve efficiency, lower costs, and promote responsible stewardship of limited public resources. To download, go to: http://www.issuelab.org/resource/paving_the_way_to_simpler_experiencing_from_maximizing_enrollment_states_in_streamlining_eligibility_and_enrollment
- **OPEN SOCIETY FOUNDATIONS.** The product of a multi-university, interdisciplinary collaboration, *Methamphetamine: Fact vs. Fiction and Lessons from the Crack Hysteria* presents a critical examination of the available evidence on illicit methamphetamine use and its consequences in the US and around the world. It aims to dispel some of the myths about the effects of methamphetamine and other illicit drugs using the best available scientific data, ultimately promoting development of more rational policies for dealing with both legal and illegal amphetamines. To download the report, go to: http://www.issuelab.org/resource/methamphetamine_fact_vs_fiction_and_lessons_from_the_crack_hysteria
- **ISTITUTE OF MEDICINE.** In a follow-up to a previous IOM report, *Preventing Psychological Disorders in Service Members and their Families: An Assessment of Programs* assesses the evidence base for the Department of Defense's existing programs designed to prevent psychological impairment among returning service members, veterans and their families and makes recommendations about program development and implementation. To read the report, go to: http://books.nap.edu/openbook.php?record_id=18597



MARK YOUR CALENDAR

- **NACBHDD.** *Spring Board Meeting*, March 2, 2014, Cosmos Club, Washington, DC; *Legislative and Policy Conference*. March 3-5, 2014, Cosmos Club Washington, DC.
- **NARMH.** *Spring Board Meeting*, March 5, 2014, Cosmos Club, Washington, DC.
- **ACMHA.** *Leading the Future of Health: A Dialogue Different in the City Different*. [Annual Summit]. March 26-28, 2014, Eldorado Hotel & Spa, Santa Fe, NM. For information and registration options go to: www.acmha.org.
- **CALIFORNIA INSTITUTE FOR MENTAL HEALTH.** *Behavioral Health Information Management Conference*. April 23-24, 2014, San Diego, CA. For more information, go to: <http://cimh.networkofcare4elearning.org/EventDetail.aspx?pId=213&OrgId=223>
- **DAYNA INSTITUTE.** *Integration, Insurance, Interventions: A National Conference on Tobacco and Behavioral Health*. May 19-20, 2014, Bethesda, MD. For more information, go to: <http://www.danyainstitute.org/national-conference-on-tobacco-and-behavioral-health-2014/>
- **MICHIGAN ASSOCIATION OF CMH BOARDS.** *Improving Outcomes, Finance & Quality through Integrated Information*. June



5-6, 2014 Thompsonville, MI. Go to: <http://www.macmhb.org>

- **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
- **AMERICAN PUBLIC HEALTH ASSOCIATION.** Abstracts are being solicited for the AHPA's 142st annual meeting. November 15-19, 2014. Abstracts (due February 10-14, 2014, depending on topic) may, but need not necessarily, coincide with the 2014 theme *Healthography: How Where You Live Affects Your Health and Well-being*.
- **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.
- **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/>

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