Testimony on behalf of the

Members of the NYS Conference of Local Mental Hygiene Directors to

New York State Office of Alcoholism and Substance Abuse Services (OASAS)

and New York State Office of Mental Health (OMH)

Statewide Comprehensive Plan 2014-2018

Good afternoon Commissioner Sullivan and Commissioner González-Sánchez. My name is Scott LaVigne, LCSW-R, MBA, I am the Director of Community Services for Seneca County Mental Health Department and the Second-Vice Chair to the Conference of Local Mental Hygiene Directors and the Co-Chair of the Mental Hygiene Planning Committee. I am presenting testimony today on behalf of my DCS colleagues who lead the 58 local mental hygiene departments including the New York City Department of Health and Mental Hygiene.

As overseer of a publicly-subsidized system of mental hygiene services, we the Commissioners and Directors of Community Services:

- ✓ Have responsibility for the planning, development, oversight and implementation of behavioral health treatment services at the County/City level through active coordination with the three state Mental Hygiene agencies: Office of Mental Health, Office of Alcoholism and Substance Abuse Services, and Office for People with Developmental Disabilities.
- ✓ We provide direct services by operating public mental health and substance abuse treatment clinics.
- ✓ We operate SPOA- Single Point of Access, a streamlined coordinated application process for intensive mental health services and housing for adults and youth with psychiatric disabilities.
- ✓ We directly provide for or contract with numerous other critical services across different settings, including forensic mental health services in jails and the courts, including operation of Assisted Outpatient Therapy (AOT) programs, diversion programs, suicide prevention programs, crisis intervention programs, and Assertive Community Treatment (ACT) Teams.

As the parties responsible for the behavioral health care delivery system at the local level, we are excited about the state and national health care transformations underway to connect individuals with mental illness and substance use disorder with primary care and supportive services. These transformations acknowledge what the behavioral health community recognized long ago, that behavioral health is an integral part of health. These system redesigns have the potential to provide real opportunities to grow community services and build a more responsive community health care system. As science teaches us, for every action, there is an equal and opposite reaction and we must monitor and address new obstacles that emerge from the system transformations that are underway. We have 3 points we recommend be taken into consideration as you develop these Comprehensive 5.07 plans.

1. The Affordable Care Acts requirement that insurance plans cover mental health and substance abuse services as an essential health benefit opens up new access for many New Yorkers. Unfortunately many products on the Exchange have sky-high deductibles, co-pays and co-insurance which is severely limiting access to these covered services. Our clinics are struggling to serve individuals and families who have $2,000 or $3,000 deductibles with $40 or $50 co-pays. Affordability is key to access and expecting low or moderate income individuals or families to pay a $50 co-pay for each visit with a care plan seeking two visits a week amounts to an unaffordable $400 a month. Coverage is only good if it allows the person to access needed services. If the cost of using health insurance is prohibitive, people will forgo needed services resulting in the need for higher cost interventions down the road. The issue of the uninsured as well as those who are underinsured must be addressed if we are to provide successful interventions and realize healthier communities.

We are pleased with the inclusion of mental health and substance disorder priorities in the Prevention Agenda, Population Health Improvement Program and the DSRIP requirement that all Performing Provider Systems include behavioral health projects. These initiatives present new opportunities for collaboration on integration of behavioral health into primary care settings to reduce avoidable hospitalizations. Shifting behavioral care from primarily a hospital-based to a community-based system will require local monitoring to ensure that services are appropriate and adequate for individuals transitioning from OMH facilities to community residences and for

those assigned to Health Homes that their care is being coordinated.

2. DCS's are actively involved in Prevention Agenda and DSRIP planning meetings and collaborating with physical health providers about the many ways in which social determinants impact mental health outcomes. We know that the burden of mental illness is among the highest of all diseases, and behavioral disorders have a serious impact on physical health. As these various transformation plans and projects move forward, the state should monitor overall integration to ensure it is achieved both within and outside of hospital systems. We recommend that the 5.07 plans focus on efforts to facilitate high quality integrated behavioral health projects from the PPS's.

DCS's actively coordinate with state Mental Hygiene agencies to ensure local mental hygiene services are developed and implemented in a responsible cost effective way. Each LGU is required by statute (see attached) to develop a Local Services Plan, which defines behavioral health service priorities, identifies local needs and service gaps, and provides a framework for managing available state and local resources with the identified priorities for each of the disability areas. Through the Mental Hygiene Planning Committee, Directors of Community Service, state and local planners and state agency representatives from OMH, OASAS and OPWDD work together to develop and share data to improve the efficiency and effectiveness of the local planning process.

3. As the state fosters partnerships to transform the health care delivery system, we are pleased that the state is supporting our call for the creation of Regional Planning Consortiums (RPC's) to guide policy, problem solve on regional issues and monitor local systems to improve care and foster recovery for clients, integrate care and stabilize through care management and system oversight. The effect of managed behavioral healthcare and system transformations on consumers and other local services in which they are involved including social services, criminal justice systems are extremely important to local government. Analyzing regional-data from multiple sources, RPCs will monitor the impact of change-initiatives within a region and will develop stakeholder-informed strategic plans for improving outcomes. RPCs will guide policy, and will detect and address unintended-consequences that may emerge for consumers and families, the healthcare system, and for other local services (i.e. social services, criminal

justice, schools etc.), all to better ensure these transformation efforts fully achieve their goals. We see RPCs as a way of maintaining an effective, ongoing informed planning process that ensures that the voices of consumers, family members, payers and policy makers across systems contribute to shaping the services and the delivery system.

Thank you Commissioners Sullivan and González-Sánchez for providing this opportunity to share our thoughts and ideas on the system transformation and ways we can together build an integrated system of care that facilitates recovery and encourages resiliency. We appreciate the opportunity to provide comments regarding the Mental Hygiene Statewide Comprehensive Plans and we look forward to continuing our collaborative efforts to improve the planning process to better serve the residents of New York State.

Sections of NYS Mental Hygiene Law Article 41

Title E - GENERAL PROVISIONS
Article 41 - (41.01 - 41.57) LOCAL SERVICES

41.10 - State conference of local mental hygiene directors.
§ 41.10 State conference of local mental hygiene directors.
(a) There is hereby created the New York state conference of local mental hygiene directors, hereinafter referred to as the conference.
(b) The conference shall be composed of all the directors of community services as defined in this chapter.
(c) The conference shall meet twice a year, or when called by the chairman, provided ten days' notice is given.
(d) The conference shall elect bi-annually, from among its members, a chairman, vice-chairman, secretary and treasurer who shall serve for two-year terms. An executive committee composed of, but not limited to, the above named officials shall be responsible for the convening of meetings, recording and distribution of minutes, and other administrative functions.
(e) The conference shall have the power to adopt, amend or repeal by-laws relating to its business and the conduct of its affairs.
(f) The conference shall have the following powers:

1. To review and comment upon rules or regulations proposed by any of the offices of the department for the operation of local service plans and programs. Comments on rules or regulations approved by the conference shall be given to the appropriate commissioner or commissioners for review and consideration; and
2. To propose rules or regulations governing the operation of the local services programs, and to forward such proposed rules or regulations to the appropriate commissioner or commissioners for review and consideration.

(g) The chairman of the conference may appoint, for the purpose of advising the commissioners, such other committees of the conference as he may from time to time deem necessary.

§ 41.05 Local governmental unit

(a) To be eligible for state aid pursuant to this chapter, a local government shall establish a local governmental unit, which shall be an identifiable entity within the local government.
(b) Each local governmental unit shall have a community services board for services to individuals with mental illness, developmental disabilities and those suffering from alcoholism and substance abuse which shall have separate subcommittees for mental health, developmental disabilities, and alcoholism, except that, at the discretion of the local government, a subcommittee for alcoholism and substance abuse may be substituted for a subcommittee for alcoholism.
(c) Each local governmental unit shall have a director who shall be its chief executive officer. Charter governments may vest policy-making functions in the director or they may vest all or some of such functions in the board. In all other cases, the policy-making functions shall vest in the board.

(d) Applications to the state for aid pursuant to this chapter shall be made by the respective local govermental units, except that an application for capital costs may be made by a voluntary agency in accordance with the provisions of this article.
(e) Each local governmental unit shall direct and administer a local comprehensive planning process for its geographic area, consistent with established statewide goals and objectives. All providers of services and department facilities shall participate in and provide information for this planning process. The department shall provide technical assistance as may be requested by such local governmental units, within available resources.

§ 41.07 Provision of services by the local governmental unit

(a) Local governmental units may provide local services and facilities directly or may contract for the provision of those services by other units of local or state government, by voluntary agencies, or by professionally qualified individuals.
(b) Subject to the approval of the commissioners of the offices having jurisdiction over the services, local governments may arrange for the provision of services eligible for state aid outside their territorial jurisdictions or the state.

§ 41.09 Director

(a) Charter governments may provide for appointment and removal of directors in a manner authorized by such governments. In all other local governments, the board shall appoint and remove the director. Salaries and allowable expenses shall be set by the appointing authority.
(b) Each director shall be a psychiatrist or other professional person who meets standards set by the commissioner for the position. If the director is not a physician, he shall not have the power to conduct examinations authorized to be conducted by an examining physician or by a director of community services pursuant to this chapter but he shall designate an examining physician who shall be empowered to conduct such examinations on behalf of such director. A director need not reside in the area to be served. The director shall be a full-time employee except in cases where the commissioner has expressly waived the requirement.
(c) Local governments may provide joint local services and facilities through agreements, made pursuant to law, which may provide either that one local government provide and supervise these services for other local governments or that a joint board or a joint local department be established to administer these services for the populations of all contracting local governments.