The STEP (Specialized Treatment Early in Psychosis) program in New Haven, Conn., offers care to individuals ages 16–35 who experience their first psychotic episode. The first randomized controlled trial of this clinical model found that it reduces hospitalizations and helps patients continue to work and go to school. The program can be adapted at community mental health centers nationally.

Analysis uncovers potential parity violations in Michigan HIEs.

Field awaits more details on HHS’s Medicare payment reform.

Rhode Island to improve mental health services statewide.

It might be difficult to find a more appropriate acronym out there for a mental health initiative than “H.U.G.S.,” short for the Health Under Guided Systems children’s screening effort administered by the Collier County, Fla., chapter of the National Alliance on Mental Illness (NAMI). At every step of the process from initial outreach to any possible service provision that a child might need, H.U.G.S. envelops children’s caregivers with one-on-one guidance in navigating the system.

“We believe that children have a right to early screening and early intervention, and that parents should have a choice in follow-up care,” NAMI Collier County CEO Kathryn Hunter told MHW.
STEP is modeled after similar first-episode services deemed successful in Denmark, the United Kingdom and Norway, said Srihari. Those FES models were adapted in this country by Yale researchers to determine whether they would result in similarly improved outcomes, he said.

Understanding first-episode services is about determining “what we already know to be effective treatment but putting them together in a package oriented toward the needs of young people and their families,” said Srihari. “We know medication treatment is effective,” he said, noting that family education, cognitive therapy and social skills are interventions that contribute to reducing relapse and rehospitalization for young people.

Srihari added, “When we found that family education, cognitive therapy and social skills are interventions that contribute to reducing relapse and rehospitalization for young people.

Srihari noted that other similar models of care have been implemented in California, North Carolina and Massachusetts (the Prevention and Recovery in Early Psychosis program). “What is novel about this program is that it is the first [to be tested] in a randomly controlled trial,” he said.

Study details
Researchers recruited participants from April 2006 to April 2012, and all assessments were concluded in May 2013 to allow for at least one year of follow-up for all enrollees. Recruitment efforts were limited to informing local hospitals, emergency departments and community clinics; making invited presentations to professional groups; and regularly visiting the largest regional private, nonprofit psychiatric hospital.

The randomized controlled trial enrolled 120 patients between the ages of 16 and 35 with first-episode psychosis within five years of illness onset and 12 weeks of antipsychotic exposure. Referrals were mostly from inpatient psychiatric units, and enrollees were randomly allocated to STEP or usual treatment.
The patient is assigned to a team that coordinates medication, counseling and social skills training, as well as education of family members. The team consisted of staff and trainees from psychiatry, psychology, social work and nursing.

The study found that three out of four in STEP care avoided hospitalization in the next year, compared to about half in the control group. STEP care resulted in fewer total hospitalizations (20 versus 39 with usual treatment) and a lower likelihood of hospitalization (14 of 60 [23 percent] patients versus 25 of 57 [44 percent] of those in usual treatment). Also, patients in STEP were more likely to be in school, have jobs or actively be seeking employment than those in usual systems of care.

“We believe that the STEP model is feasible to implement in similar community mental health centers across the country and, moreover, that will likely also be cost-effective,” said Srihari.

**Early identification**

Barbara Walsh, Ph.D., clinical coordinator for the STEP and PRIME Psychosis Prodrome Research Clinic at the Yale University School of Medicine, said that the coordinated care of providers and family in working with young people with early psychosis is paramount. “I think of it as a menu of services that are available to them,” Walsh told *MHW*. “We provide medication management, individual therapy, family therapy, and group and social support.”

Walsh added, “Just like a physical illness, the sooner you see and recognize the signs and symptoms, the better the short-term and long-term prognosis. I liken it to diabetes. The doctor recognizes the early warning signs, which is the metabolic syndrome. They treat you right then and there so that illness never progresses. We’re trying to do the same thing but without the [definitive] blood test.”

The field, however, is getting much better at recognizing biosignals and can be the best biomarker alerts that face someone at risk of developing psychosis, she said. “I think between the PRIME and STEP [programs], we’re really changing the face of mental illness,” said Walsh.

**DMHAS commitment**

The program began with $250,000 in grant funding, Patricia Rehmer, commissioner of the Connecticut DMHAS and newly appointed president of the National Association of State Mental Health Program Directors, told *MHW*.

“The program has a large focus on family involvement,” added Rehmer. “Families become disengaged over time, which is why the STEP program focuses largely on family involvement. We provide family education; families get connected,” she said. “That’s an important step.”

**Social media campaign to promote early detection in young adults**

Professionals of an early intervention clinical model based in New Haven, Conn., for young people with early psychosis on January 22 launched a social marketing approach to empower caregivers and patients to seek care.

Mindmap addresses the challenge of early detection through a broad-based education effort that combines professional outreach with a social media and advertising campaign.

“In this campaign we’re interested in outreach to professionals in the area [who can] refer patients to our services quickly to engage them,” Vinod Srihari, M.D., associate professor of psychiatry and clinical director of STEP (Specialized Treatment Early in Psychosis) — an early intervention model for young people with psychosis. (See story, beginning on page 1 about new STEP research.)

STEP officials will work with primary care centers, police departments, the social welfare system, the judicial system and other stakeholder groups that work with young people. They will share resources and show young people how to contact the program for STEP consultation and clinical evaluation.

Srihari and his team at the Connecticut Mental Health Center, a community mental health center in New Haven jointly run by the Yale Department of Psychiatry and the Department of Mental Health and Addiction Services, coordinate STEP. The free program, available free to young people with psychosis, places an emphasis on returning them to educational or vocational pursuits.

Mindmap will run for three years, said Srihari, lead author of the STEP research. Eight New Haven–area towns will be involved with the campaign, he said. Social media programs like YouTube, Pinterest and Facebook will all be a part of the campaign, said Srihari. “We want young people to friend us,” Srihari said.

“We’re trying to reach young people, their parents and friends — anybody [in a position] to help — in any way that we can,” Barbara Walsh, Ph.D., clinical coordinator at the PRIME Clinic at the Yale University School of Medicine, told *MHW*.

Walsh added, “This whole campaign is about educating people and letting them know that help is available. Hopefully, people will admit they need help and come to us quickly.” The new initiative is supported by a grant from the National Institutes of Health (NIH).

For more information, visit www.mindmapct.org.

Continues on next page
Analysis uncovers potential parity violations in Michigan HIEs

Following an analysis of health insurance exchange plans to determine how the policies stack up against federal parity laws, the Mental Health Association in Michigan (MHAM) has found issues with the definition of “office visits” and challenges with behavioral health prescription coverage and is urging federal and state officials to be more vigilant about monitoring plans for parity compliance.

Michigan is one of the few states without a state parity law. Advocates say with the advent of the federal parity law and the Affordable Care Act (ACA), the state has entered new territory for small-group and individual policies as well as those offered through the ACA health insurance exchanges. Parity became effective in the state in January 2014.

The new report, "A 2014 Analysis of 88 Michigan Individual Health Insurance Policies for Compliance with Mental Health Parity," released mid-January, will be submitted to the Michigan Department of Community Health and the state Department of Insurance the week of February 2. Additionally, the report will be distributed to the national Mental Health America (MHA).

"What we found wasn’t very encouraging," Mark Reinstein, Ph.D., lead author of the report and former president and CEO of MHAM, told MHW. Reinstein retired from MHAM on January 15 and will remain on as a consultant.

Of the 88 individual policies examined in Michigan in 2014, 70 percent represented plans from the health insurance exchange marketplace and 30 percent were off-exchange, said Reinstein. Insurers in the analysis included Aetna, Blue Cross Blue Shield, Humana and United Healthcare.

"We wanted to do a two-pronged check of compliance in Michigan with federal parity law and policy," he said. "We decided part one would be what we did in ’14, checking out a bunch of individual coverage policies on- and off-exchange for what they claimed to offer. Part two will be in ’15 when we attempt to survey 1,500 consumers about their recent experiences with behavioral health insurance coverage."

Treatment access and parity compliance under the ACA have come under national scrutiny of late. Last December, MHA released its own report analyzing behavioral prescription drug and services coverage within the federal exchange plans. The newer behavioral health medications involved higher co-pays or the highest out-of-pocket costs for consumers (see MHW, Dec. 15, 2014).

Bottom Line...
Advocates in Michigan intend to have follow-up discussions with Department of Insurance and community mental health officials about key issues raised in the new report.

The Baltimore Sun this month reported that the Mental Health Association of Maryland released a study that found that not enough psychiatrists are available on plans sold on the state exchange. Additionally, a survey released by the Partnership to Fight Chronic Disease found that despite having insurance, people are still encountering obstacles to getting the right treatment when needed, the Sun reported.

Final BH ‘priorities’
Advocates were interested in focusing on six behavioral health areas highlighted by the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act final rules as “priorities”: (1) inpatient, in-network; (2) inpatient, out-of-network; (3) outpatient, in-network; (4) outpatient, out-of-network; (5) emergency care; and (6) prescription drugs. "Reviewing the parity rules was something we had to be sure that we did," Reinstein said.

"The issue of office visits became a confounding factor because the final federal parity rules say conditions for outpatient ‘office visits’ can be different from those for other outpatient services (i.e., they don’t have to be comparable), and we couldn’t find a formal definition in the rules of ‘office visit,” he said.

“We believe it likely that the categories of primary care and behavioral outpatient would both be office visits to the feds (and legally comparable), especially since the preamble to the rules offered both ‘physician
and psychological visits’ as examples of ‘office visits,” added Reinstein.

“Whether these differences represented technical violations of federal parity law and policy would be partly dependent on how the federal government defines ‘office visits,’ as federal parity rules state that such visits (undefined) are in effect a parity category unto themselves,” he said. “Either way, what we found represents a violation of at least the spirit of federal parity law and policy, if not legally technical noncompliance.”

He noted that in numerous instances, the plans that were analyzed had cost-sharing or other conditions that were disadvantageous to behavioral health in-network outpatient as compared to what was in place for in-network primary care. In 45 of 88 cases (51 percent), coverage for behavioral and primary was not equal, and in 24 of those instances (27 percent of all plans), enough information was available to conclude that the differences negatively targeted (were more disadvantageous for) behavioral health, he said.

“When at least 27 percent of plans cover behavioral health outpatient in a lesser manner than they do primary care outpatient, that represents for us too much noncompliance with federal parity law and policy in Michigan in 2014,” said Reinstein.

Prescriptions

The report concentrated on three mental health medications that did not have generic equivalents in 2014: Abilify (aripiprazole), Seroquel-XR (quetiapine fumarate) and Strattera (Adderall). The study found that Abilify required prior approval on four formularies, Seroquel-XR on six and Strattera on four. Step therapy (“fail-first” on other products) was required for Abilify by four insurers, for Seroquel-XR by three and for Strattera by four.

“We concluded there was no uniformity and no standardization [of these products],” Reinstein said. “How come some plans use fail-first for three products and some didn’t? This is what’s meant by lack of uniformity.”

Field awaits more details on HHS’s Medicare payment reform

U.S. Health and Human Services (HHS) officials announced new goals toward paying Medicare providers based on the quality, rather than the quantity, of care provided to patients, while noting that this is the first time in the history of the Medicare program that HHS has set explicit goals for alternative payment models and value-based payments.

HHS Secretary Sylvia M. Burwell, in a meeting January 26 with consumers, providers, insurers and business leaders, said that HHS has a goal of tying 30 percent of traditional fee-for-service Medicare payments to quality or value through alternative payment models, such as Accountable Care Organizations (ACOs) or bundled payment arrangements, by the end of 2018.

HHS also intends to tie 50 percent of payments to quality or value

‘When at least 27 percent of plans cover behavioral health outpatient in a lesser manner than they do primary care outpatient, that represents for us too much noncompliance with federal parity law and policy in Michigan in 2014.’

Mark Reinstein, Ph.D.

Recommendations

Among its recommendations, the report noted that:

• The federal government should take steps to see that more information about behavioral health coverage, including prescriptions, is provided in summative plan information available electronically for ACA exchanges. For off-exchange electronic summaries, private insurers should do the same.

• Federal parity rules must definitively and clearly define what is and isn’t an “office visit” since that is allowed by the federal government to be a parity outpatient category unto itself — not comparable to other outpatient services.

• The federal government and state insurance commissioners must be more vigilant about monitoring plans for parity compliance and assuring corrective action for instances of noncompliance. The federal government especially must redouble its efforts in this regard.

“I’d like to gain assurance in working with our state insurance commissioner that our annual review of small-group and individual policies on- and off-exchange have truly been vetted for parity,” said Reinstein. “I’m not saying that didn’t happen in 2014, but it certainly raises questions.”
Continued from previous page

by 2016 and 90 percent by 2018 through programs such as the Hospital Value Purchasing and the Hospital Readmissions Reduction Program.

To make these goals scalable beyond Medicare, Burwell also announced the creation of a Health Care Payment Learning and Action Network, according to a HHS release. Through the Learning and Action Network, HHS will work with private payers, employers, consumers, providers, states and state Medicaid programs, and other partners to expand alternative payment models into their programs.

HHS officials said they will intensify their work with states and private payers to support adoption of alternative payments models through their own aligned work, sometimes even exceeding the goals set for Medicare. The Network will hold its first meeting in March 2015, and more details will be announced in the near future.

The Affordable Care Act created a number of new payment models that move the needle even further toward rewarding quality, according to the release. These models include ACOs, primary care medical homes and new models of bundling payments for episodes of care. In these alternative payment models, health care providers are accountable for the quality and cost of the care they deliver to patients.

Providers have a financial incentive to coordinate care for their patients — who are therefore less likely to have duplicative or unnecessary X-rays, screenings and tests. An ACO, for example, is a group of doctors, hospitals and health care providers that work together to provide higher-quality coordinated care to their patients, while helping to slow health care cost growth. In addition, through the widespread use of health information technology, the health care data needed to track these efforts is now available, officials said.

Many health care providers today receive a payment for each individual service, such as a physician visit, surgery or blood test, and it does not matter whether these services help — or harm — the patient. In other words, providers are paid based on the volume of care, rather than the value of care provided to patients.

Officials said the January 26 announcement would continue the shift toward paying providers for what works — whether it is some-thing as complex as preventing or treating disease or something as straightforward as making sure a patient has time to ask questions.

Field keeping watch

“We’re watching for more information,” Diane M. Pedulla, JD, director of regulatory affairs for the American Psychological Association Practice Directorate, told MHW. “The HHS announcement was very broad.” A number of changes are being proposed involving ACOs, health plans and other programs, she said.

One of the areas the APA intends to watch closely will involve any changes that suggest quality improvement and how it might be linked to provider payments, she said.

Laurel Stine, director of congressional relations at the APA Practice Directorate, added, “Our psychologists are always concerned about decreasing reimbursements.” The APA will ensure the organization is in a good position to provide comment and responses to HHS’s proposal, she said.

This is the time of year when the new Congress has a lot going on. Congress continues to grapple with the Sustainable Growth Rate (SGR), a system it created that pegged the amount of money budgeted for Medicare payments to projected growth of the economy. Congress still has to determine whether or not to make it permanent or temporarily fix it like they’ve done 17 times already,” said Stine. “They’ve got a lot on their agenda.”

A spokesperson for the National Association of Social Workers told MHW that the organization still has not yet analyzed the Medicare payment reform policy.

Screening from page 1

and the National Council for Behavioral Health) honored the chapter with a 2014 Community Innovation Award in the early intervention category. Hunter believes that one characteristic of H.U.G.S. that stood out to judges involves its use of peers as system navigators for families. Several of the system navigators are “NAMI mommies” who have had experience with a child of their own receiving care in the mental health services system, she said.

Gap analysis

Another noteworthy aspect of H.U.G.S. is that the circumstances of its initial rollout did not occur exactly according to the original plan.

The idea grew out of results of a gap analysis, conducted under the auspices of the Naples Children & Education Foundation (NCEF), to identify deficiencies in children’s services in the county. “It showed that mental health was an area that we were not addressing as a community,” said Hunter. Foundation
trustees would follow up by meeting with parents of children struggling with mental health issues, who would explain the challenges they were experiencing in trying to negotiate the system.

NCEF and NAMI Collier County would set out to apply for a Robert Wood Johnson Foundation grant to initiate a screening project, but Florida’s extremely low national ranking in mental health funding and services would contribute to stalling that effort. Essentially, a program such as H.U.G.S. was being seen at the outset as innovative by Florida’s standards, but not so much for the rest of the country, Hunter said.

However, NCEF decided the need in the community warranted its support of the initiative itself, and it continues to be the sole funder of H.U.G.S., Hunter said. The foundation provides $350,000 a year for the program, according to data from NAMI Collier County’s application materials for the national award. A major contributor to NCEF’s overall mission of improving the lives of underprivileged and at-risk children is proceeds from the annual Naples Winter Wine Festival.

**Early progress**

H.U.G.S.’s first target population was children of migrant worker families in the community of Immokalee, and NAMI Collier County believed that it would have to offer some kind of incentive to get parents to agree to have their children screened. Working from an RV parked at the location of the community’s largest primary care provider, leaders found instead that families were eager to participate, and were comfortable interacting with the program’s culturally sensitive and Spanish-speaking staff.

Screening efforts have since expanded across the county, taking place at a variety of child-serving programs. Among the targeted groups, all children in Head Start are now screened for mental health concerns, Hunter said. Overall, children from ages 3 months to 18 years receive screenings, at a rate of 1,200 screenings a year.

Hunter said that while screening on a national basis tends to identify about 20 percent of screened children as warranting follow-up, the percentage in Collier County has been around 24 percent. The program uses the Ages & Stages Questionnaire to screen younger children and the Pediatric Symptom Checklist for older age groups. “There was a lot of discussion of that,” Hunter said of the process of identifying desired screening tools. As for the selections, “The education system likes it. The providers like it,” she said.

**‘We believe that children have a right to early screening and early intervention, and that parents should have a choice in follow-up care.’**

Kathryn Hunter

Parents whose children would appear to benefit from follow-up are allowed to choose a care navigator (NAMI purposely avoids the term “case manager”) as well as the person who will provide a formal assessment, in terms of whether that person is male or female and what his/her professional credential is.

Around 98 percent of parents whose children are determined in initial screening to meet the threshold for follow-up will agree to pursue additional help, Hunter said. Care navigators maintain a side-by-side role with parents throughout. For example, they execute warm handoffs to service providers, and they attend school meetings with parents whose children have an Individualized Education Program (IEP), she said.

H.U.G.S. is part of a broader local children’s mental health initiative called Beautiful Minds. This effort integrates primary care and mental health entities in order to lower the prevalence of serious mental illness by increasing access to care for children with behavioral health needs.

**Evaluating results**

NAMI Collier County has implemented a database that has captured the past four years of data on who is being screened, where children are being referred for follow-up, and the degree to which parents are refusing follow-up services in this voluntary program. Hunter said H.U.G.S. soon will be looking at variables such as wait times for follow-up services.

In essence, she believes this initiative would have national potential for widespread implementation. “There is not a huge cost involved, and it can save hundreds of thousands of dollars,” she said.

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**State News**

Rhode Island to improve mental health services statewide

Rhode Island Gov. Gina Raimondo said she has already started conversations with the future head of the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) about the creation of a statewide plan to improve the long-troubled public mental health system, the Providence Journal reported January 24. Advocates say there are critical issues that cannot await the outcome of comprehensive study and planning. Among those, Susan Jacobsen, head of the Mental Health Association of Rhode Island, said, “It’s time to bring the executive branch into the conversation.”

Continues on next page
Madison, Wisconsin police dept.
adds mental health officers

Madison, Wisconsin Police Chief Mike Koval is dedicating officers to help address mental health incidents. Koval cited a stabbing incident involving a man with mental health issues on the east side in June 2014 that resulted in three deaths as a catalyst for the focus on mental health in the force. Channel3000.com reported on January 26 that Koval said there is a concern about removing officers from patrol services as calls for service are increasing, but that more has to be done about the need for mental health services. Eighteen officers in the department have voluntarily taken on mental health cases and helped assist officers with mental health cases. Koval is hoping to get more officers involved in those efforts.

Ohio advocates push for maintaining Medicaid expansion

A coalition of behavioral health groups say an extension of Medicaid has benefited low-income Ohioans with mental health disorders and addictions, and lawmakers should continue it, the Idaho Statesman reported January 27. The Coalition of Health Communities shared what it viewed as success stories from the Medicaid expansion, citing cases in which residents otherwise would not have had coverage to help pay for their addictions or mental health disorders. In 2013, Gov. John Kasich expanded Medicaid eligibility to cover more people, as allowed under the Affordable Care Act. The governor needs legislative approval to continue to fund it after June. Kasich is expected to seek continued support for the expansion. He will unveil his budget proposal February 2.

Continued from previous page

tion of Rhode Island, describes as urgent are homelessness, police training and the incarceration of people with mental illness who do not belong behind bars.

Data reveals suicide rates climbing in Iowa

More than 400 people committed suicide in Iowa in 2013, a 17 percent increase from the previous year, said Iowa Department of Public Health officials. There were 445 such deaths statewide in 2013, the most since 1989, according to data released by the department, The Des Moines Register reported January 28. The suicide rate was 14.4 per 100,000 people, up from 12.8 in 2012. Organizations did not cite a reason for the increase; however, advocates said the criteria for hospitalization and a lack of other mental health services leave some people more susceptible.

Iowa’s suicide rate is greater than those of neighboring Illinois and Wisconsin. Clete Gartner, a National Alliance on Mental Illness-Dubuque member, said the rules on who can be hospitalized for mental health crises leave some without necessary support. “If they’re not admitted in the hospital, basically they’re back on the street with no place to go,” he said. “If you don’t have a family member or a friend to help you in this crisis situation, you’re in a bad position.”

In case you haven’t heard...

Teens are more likely to smoke, drink and use marijuana — and to do so at an earlier age — if their mothers were depressed when the kids were in grade school, a new study says. These same teens are also more likely to engage in violence and other delinquent behaviors, according to the study, published online December 22 in Pediatrics. Researchers tracked more than 2,900 pairs of Canadian mothers and their children from 1994, when the children were between ages 2 and 5, until the children were ages 16 to 17. However, the study doesn’t prove that maternal depression led to the risky behaviors.

Coming up...

The American Group Psychotherapy Association annual conference will be held February 26–28 in San Francisco, Calif. For more information, visit www.agpa.org/home/continuing-ed-meetings-events-training/annual-meeting.

The International Association of Eating Disorders Professionals Foundation is holding its annual symposium March 19–22 in Phoenix, Ariz. For complete information and to register, visit www.iaedp.com.

The 28th Annual Research & Policy Conference on Child, Adolescent, and Young Adult Behavioral Health will be held March 22–25 in Tampa, Fla. For details and conference registration, visit http://cmhampaconference.com.


Names in the News

CMS Administrator Marilyn Tavenner to resign

Centers for Medicare & Medicaid Services (CMS) Administrator Marilyn Tavenner announced on January 16 that she will be leaving her post in February. According to the National Council for Behavioral Health’s release on January 22, Tavenner did not give a reason for her departure, but in an e-mail to CMS staff listed a series of agency accomplishments under her tenure, including slowing the growth of health care costs, now at a historically low rate.