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tennessee association of mental health organizations

BEHAVIORAL HEALTH NEWS & EVENTS

Volume 3, Issue 2 | Tennessee Association of Mental Health Organizations (TAMHO) | April 2015

Message from the Executive Director

Ellyn Wilbur
Executive Director

I have spent many years working in the community mental health system and have had the opportunity to see first-hand the tremendous positive impact case management services can have on an individual's path to recovery. It has been shown to be an effective service not just with people who have a mental illness or co-occurring disorders, but with many other populations with complex needs. All of us in the advocacy community were taken by surprise when we learned that there was a proposed TennCare reduction of $30 million dollars specifically targeted for adult level 2 case management, which is provided to more than 40,000 adults each year.

We have included in this newsletter information about case management services. After reading this, I hope you will have a better understanding of why advocates including families, consumers, social workers, protection and advocacy organizations, law enforcement, mayors, sheriffs, hospitals, medical, mental health, and other providers have been so vocal in their opposition to these proposed funding reductions.

We want to publically thank Governor Haslam and his administration for taking a second look at these proposed reductions. We believe that was the right thing to do and we are grateful that he took this step.

In the meantime, TAMHO will continue to strongly advocate against these reductions and hope you will join us in these efforts.

INSIDE THIS ISSUE

The Impact of Proposed Bureau of TennCare Cuts in Level 2 Case Management to Mental Health Service Recipients

A White Paper

Issue/Current Realities

The FY16 TennCare budget includes a $30 Million decrease, ($10 Million of which is state funds) in "Level 2" Adult Mental Health Case Management (L2MHCM), a recovery oriented service that links individuals with mental illness to necessary appointments, medications, housing and social supports. It is a TennCare benefit that is currently provided to individuals with disabilities based on medical necessity criteria. If these cuts are implemented, L2 MHCM would be restricted to a 90 day period following a discharge from the hospital or a crisis setting, with the possibility of an extension. While advocates and providers are keenly aware of the state's financial situation and the difficult task ahead in this 109th General Assembly Session, sound budget decisions must be made in consideration of moderate and long term perspectives, and in consideration of both intended and unintended consequence. TAMHO thanks Governor Haslam for taking a second look at the proposed redesign in L2 MHCM and looks forward to working with Finance and Administration, The Bureau of TennCare, and The Tennessee Department of Mental Health and Substance Abuse Services to come up with a collaborative, workable and sustainable plan for Level 2 Case Management Services.

Brief History of Case Management in Tennessee

Adult Mental Health Case Management was developed as a community-based response to deinstitutionalization. As psychiatric hospital beds were closed, there was a need to help connect individuals with mental illness to the services and supports they would need in order to live successfully in the community and progress in their recovery. It was a win-win solution. States saved money by closing expensive psychiatric hospital beds and those with mental illness realized a greater quality of life, accomplishing significant levels of recovery through the support of mental health case management. In fact, for many years, providers were required to offer case management services to every adult with Severe and Persistent Mental Illness.

If the client declined the service, there had to be written documentation indicating reason for refusal. This policy changed when providing case management became dependent on the client meeting medical necessity criteria. Centers for Medicare and Medicaid Services (CMS) ruled that case management services include a comprehensive assessment and care plan, referral to services, monitoring, and follow-up activities for an individual with

Severe and Persistent Mental Illness (SPMI). CMS also identified 12 guiding principles for the practice of case management and Tennessee has refined and further defined how those principles would be implemented state-wide. In Tennessee, "Adult mental health case management is a comprehensive service that aims to enhance treatment effectiveness and outcomes with the goal of maximizing recovery and resilience…" "Case management is defined as those services that are necessary to coordinate an optimum life style for the targeted consumers. As designed, it will help consumers access clinical and other services that prevent deterioration in their current mental status and promote their recovery toward independent living." Tennessee further defined that case management "service is not time-limited, as service recipients/families will work through case management at their own pace."[1] As a result of MHCM, Tennessee has permanently closed 590 state-funded inpatient beds. This saves Tennessee more than $86,000,000 per year.[2]

Who Receives L2 MHCM Services and How Do Case Managers Meet Their Needs?

Level 2 MHCM serves a complex population of Tennesseans. The overwhelming majority of individuals (more than 90%) receiving Level 2 MHCM are diagnosed with Severe and Persistent Mental Illness (SPMI). Moreover, many of these individuals present with complex medical conditions. When compared with the general population, there is a significantly higher incidence of co-morbid and co-occurring conditions such as asthma, congestive heart failure, diabetes, hypertension and substance use disorders. When such conditions are not treated in a coordinated way, these individuals die up to 25 years earlier than the general population and the cost associated with their care increases exponentially.[3] It is widely recognized that most individuals with SPMI can maintain a state of well-being, allowing them to live in their community and continue on their path of recovery within the service parameters of Level 2 MHCM. Level 2 MHCM has proven to contribute significantly to the overall recovery process and improved quality of life for the individuals served.

Case managers not only help individuals understand their chronic disease, but they also play a vital role in assuring that those with mental illness and substance use disorders receive medically necessary mental health ***and*** primary care services. Case managers are also responsible for monitoring client adherence to recommended medications, intervening in pre-crisis events and communicating with the rest of the interdisciplinary team responsible for the individual's overall care. Case managers are essential in assessing when a person's condition might be deteriorating and taking the necessary steps to avoid a potentially life-threatening event. Because of this holistic approach, case management services result in lower health care expenditures, improved access to essential services, reduced symptoms, improved social functioning, and reduced emergency department (ED) visits and incarcerations.[4]

Mental Health Case Management Efficacy

Case management is a widely accepted best practice for individuals with special needs. It has been adopted for use by The Tennessee Department of Children's Services (DCS), The Tennessee Department of Intellectual and Developmental Disabilities (DIDDS), the HIV/AIDs population, Veterans and The Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS). There have been many empirical studies over the years that have examined the efficacy of case management. In their Meta-level analysis, Ziguras & Stuart analyzed 44 of those studies to determine the effectiveness of case management. When they compared treatment that included case management services to treatment that did not include case management services, their analysis concluded that treatment that includes case management services was more effective than treatment without case management services in three distinct areas: (1) family satisfaction, (2) family burden, and (3) cost of care. More specifically, the research concluded:

- Participants receiving case management interventions had significantly greater improvement in their symptoms as compared to those receiving usual care;
- Participants receiving case management interventions used significantly fewer hospital days as compared with those receiving usual care;
- A significantly smaller proportion of those who received case management interventions were hospitalized as compared with those who received usual care;
- Participants receiving case management interventions had significantly lower dropout rates from mental health services as compared with those receiving usual care;

LEVEL 2 CASE MANAGEMENT is the GLUE that holds the delivery system together for individuals with severe and persistent mental illness.

- Participants receiving case management interventions had significantly greater improvement in social functioning as compared with those receiving usual care;
- Participants who received case management interventions resulted in significantly lower costs of care as compared with those who received usual care;
- Participants receiving case management interventions were significantly more satisfied with their care as compared with those receiving usual care;
- Families of participants who received case management interventions were significantly more satisfied with their care as compared with those whose family member received usual care; and
- Families of participants who received case management interventions reported significantly less burden of care as compared with those whose family member received usual care.[5]

In addition, Gensichen et al., 2009 found that patients randomly assigned to case management had lower depression scores and increased treatment adherence, compared to control patients (or those who did not have case management).[6]

In Tennessee, we know that case management has been effectively used to improve the health and well-being of those it serves. We also know that case management has saved the state millions in inpatient psychiatric costs as well as cost to other state departments and local governments.

The Healthcare Effectiveness Data and Information Set (**HEDIS**) is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. The managed care companies (MCCs) contracted to provide care for the State's TennCare enrollees are evaluated annually on their HEDIS scores. In addition, HEDIS scores are used for accreditation by The National Committee for Quality Assurance (NCQA) Accreditation, an accreditation that TennCare requires of the MCCs. In 2013, one MCC, Blue Care, engaged two community mental health centers (CMHCs) to pilot an initiative using case managers to help improve their HEDIS score by closing actionable gaps in care for those with severe and persistent mental illness. They focused on gaps in care around breast cancer screening, cervical cancer screening, adolescent well child screenings, diabetes care and asthma care—all traditional primary care issues, not psychiatric care issues. During the 2013 pilot, Blue Care found:

- Appointments of screening or services were successfully scheduled to address 79% of actionable gaps;
- The rate of kept appointments was 93%; and
- In a number of cases, practitioners confirmed that as a result of screenings, serious medical conditions were identified in time to successfully initiate treatment.[7]

Since this pilot, Blue Care has expanded their HEDIS gap initiative state-wide by engaging CMHCs to use case managers to assist in closing these gaps. Of the 9 providers who reported participating in this initiative 100% have helped the MCCs close gaps. As a result of this success, other MCCs have followed suit and have begun engaging CMHCs in assisting them with closing these healthcare gaps of this critical population of individuals with mental illness and co-morbid and co-occurring disorders.

Potential Impacts

- Case management services were implemented as a cost effective alternative to inpatient services in the TennCare program. Since that time, as a result of this service, 590 state funded inpatient beds have been permanently closed in Tennessee, at a cost savings of more than $86,000,000 per year.
  - Inpatient beds are now consistently full and there are often waiting lists.
  - Half of the adults being admitted to state hospitals are new to the system.
- There is grave concern that reduction of this service will result in increased hospitalizations, increased numbers of individuals being homeless, increased emergency room visits, unnecessary involvement with law enforcement and

The trusted voice for Tennessee's behavioral health system for more than half a century.

The Tennessee Association of Mental Health Organizations (TAMHO) is a statewide trade association representing Community Mental Health Centers and other non-profit corporations that provide behavioral health services. These organizations meet the needs of Tennessee citizens of all ages who have mental illness and/or an addiction disorder. The TAMHO member organizations have been the virtual cornerstone of the Tennessee community-based behavioral health system since the 1950s and continue today as the primary provider network for community based care in Tennessee.

TAMHO member organizations provide mental health and addictions services to 90,000 of Tennessee's most vulnerable citizens each month. Services provided by the TAMHO network include:

Prevention, Education and Wellness: Includes programs for the prevention of addictions, violence, and suicide; early intervention; mental health and drug courts, jail diversion and community re-entry initiatives.

Psychiatric Rehabilitation: Programs that include peer support, illness management and recovery services, supported employment, and supported housing.

Community Based Services: Services include mental health case management, Programs for Community Treatment (PACT), intensive in-home services, school based services, therapeutic foster care, and jail liaison services

Clinic Based Services: Services include psychiatric evaluation and medication management; monitoring of core health indicators; individual, couples and family psychotherapy; psychological assessment; specialized treatments for trauma and addiction disorders and co-occurring disorders; partial hospitalization; intensive outpatient services; and forensic services.

Residential Services: Includes residential treatment services, group homes, independent housing.

Inpatient Services: Includes hospital based mental health and addiction disorder treatment services.

Crisis Services: Includes clinic based walk-in services, hospital based emergency evaluation, mobile crisis services, crisis respite, and crisis stabilization services.

Important Dates and Events

April

March 30—April 1	Tennessee Conference on Social Welfare 102nd Anniversary Leadership & Networking Conference | *Marriott Cool Springs, Franklin | http://www.tcsw.org/state-conference-2015.php*
20-22	National Council for Behavioral Health Annual Conference | *Orlando, Florida | http://www.thenationalcouncil.org/events-and-training/conference/*
24	Tennessee Transition Summit — Medical Home Implementation Project | *Scarritt Bennett Center, Nashville | http://www.tennesseemedicalhome.com/tnaap/*

May

13	NAMI Tennessee Vision of Hope Award Gala | *Omni Hotel, Nashville | www.namitn.org*
25	TAMHO Office Closed in Observance of Memorial Day

June

TBA	2nd Annual Co-Occurring Disorders Symposium | *date and location forthcoming | www.tamho.org or www.tncodc.com*
18	Building Resilience — Awareness and Prevention of Suicide in Children | *Austin Peay State University | www.earlyconnectionstn.org*

Please visit the TAMHO website Calendar page at http://www.tamho.org for the most current listing of TAMHO meetings and events.

Contact the TAMHO Office to add your behavioral health association or advocacy group's statewide or national conference promotional information.

poor health outcomes.

- Hospitals, local governments and law enforcement, including Crisis Intervention Team (CIT), will bear the brunt of the impact if this change is implemented.
- Increase costs of local governments. The state's mental health system is ill equipped to help disabled adults with mental illness if case management is reduced. The burden will fall to the local community. The state's trend to limit services to this population only makes for a more difficult situation on the local level.
  - Increase cost for corrections/ill-advised incarceration
  - Increase homelessness
- Ultimately the unnecessary deaths of adults with mental illness.

Mental health case management services are essential to the recovery and stability of the nearly 50,000 vulnerable Tennesseans who receive this service annually. The restriction on this service to a 90 day post hospitalization or crisis event illustrates a misunderstanding of the impact of serious mental illness on the on-going recovery and stability of individuals who battle chronic and persistent depression, anxiety, bi-polar disorders, schizophrenia, and other mood and thought disorders. Recovery is possible and sustainable, provided the necessary supports and care coordination are available, not only after a hospitalization or crisis event, but on an as needed basis hopefully, to prevent these types of disruptive and expensive alternatives.

Within the next 18 to 24 months, Tennessee will be moving to a health home system that relies on prompt access to integrated services and coordination of care. The services provided by case managers today are consistent with the case management and care coordination functions that will be required in the state's patient-centered health home model once it is implemented. Case management will be essential to the success of behavioral health homes in the coming years. It is not prudent to dismantle the system today only to restructure it in the near future. Once the current infrastructure and workforce are eliminated, the cost of rebuilding will be exponential.

Solutions

- We strongly recommend that the proposed funding reduction ($10M of state funding) be restored in the TennCare budget and designated for the Level 2 Case Management Benefit.
- We strongly recommend that the proposed limitation regarding both the admission pathways and duration of L2 Case Management be eliminated from the TennCare budget.
- We propose that regular dialogue continue between TennCare, TDMHSAS, and the providers to address any concerns about utilization or case management activities.
- We propose that definitions and expectations be consistent across all three MCCs in order to reduce miscommunications and misunderstandings.

Conclusion

Having ready access to mental health treatment, available crisis services, physical health care and case management has been a life-saving formula for adults with severe mental illness and substance use disorders in our state. The evidence over time is undeniable. We urge you to include $10 million state dollars ($30 million total) in the TennCare budget during FY 16 for the Level 2 Case Management Services Benefit.

REFERENCES

[1] *TDMHSAS & Bureau of TennCare. (March 2012). Adult Mental Health Case Management.*

[2] *Calculation assumes $400/day x 365 days a year x 590 beds.*

[3] *National Association of State Mental Health Program Directors (NASMHPD). (October 2006). Morbidity and Mortality in People with Serious Mental Illness.*

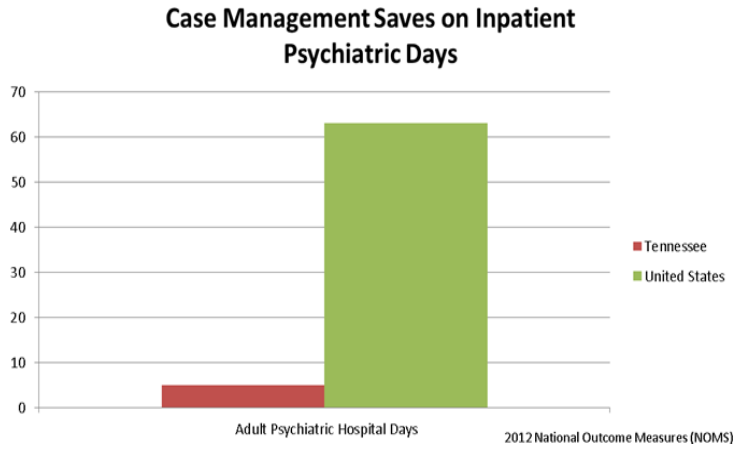
[4] *TDMHSAS, Bureau of TennCare (March 2012). Adult Mental Health Case Management.*

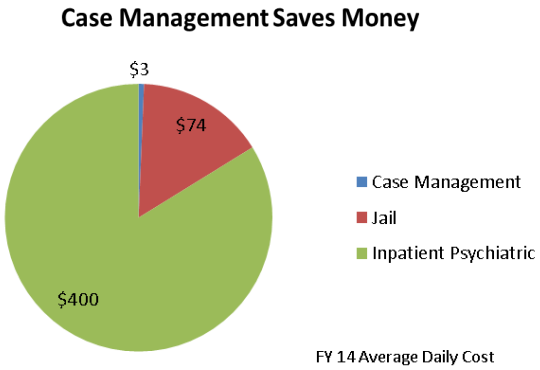
[5] *Ziguras, S.J. & Stuart, G.W. (2000). A meta-analysis of the effectiveness of mental health case management over 20 years. Psychiatric Services.*

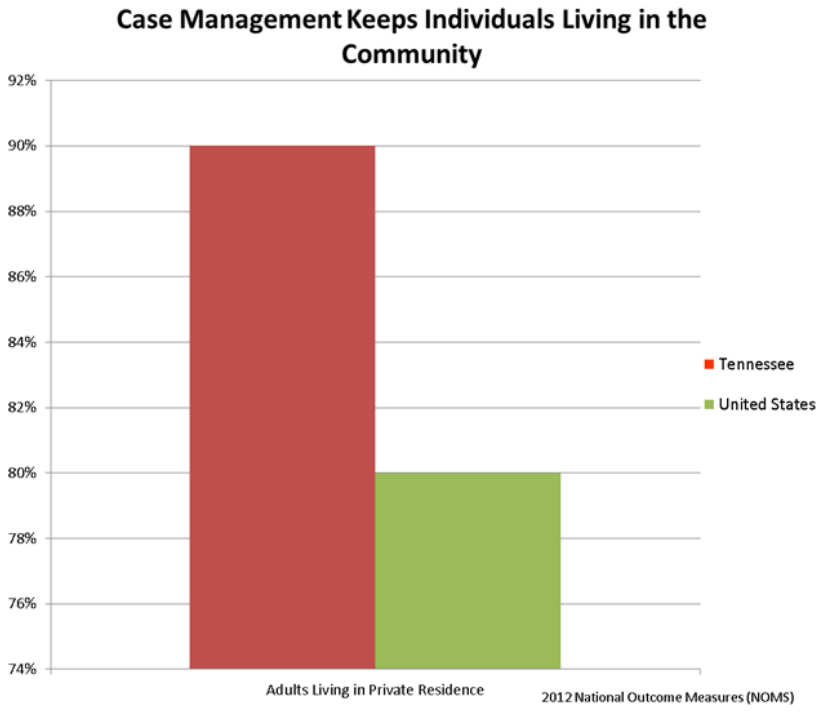
[6] *Gensichen, J., et al., (2009). Case management for depression by health care assistants in small primary care practices: A cluster randomized trail. Annals of Internal Medicine.*

[7] *Blue Care Tennessee Behavioral Health Provider Incentive Program.*

Benefits of Level 2 Case Management







Tennessee Department of Mental Health and Substance Abuse Services

PLANNING & POLICY COUNCIL

June 16, 2014
August 18, 2014
December 15, 2014

Meeting Times:
Approx. 10:00 a.m. to 2:30 p.m. CT.

Meeting location:
Conference Center
Middle TN Mental Health Institute
221 Stewarts Ferry Pike
Nashville, TN 37214

Direct questions/inquiries to **Avis Easley** at **(615) 253-6397** or by email at **Avis.Easley@tn.gov** or **Vickie Pillow** at **(615) 253-3785** or email at **Vickie.Pillow@tn.gov**

Meeting schedules and information are available online at **http://www.tn.gov/mental/recovery/meeting_sch.html**. Meetings are subject to change.

REGIONAL PLANNING & POLICY COUNCIL

Region I Second Tuesday/ quarterly
Harrison Christian Church, Johnson City, TN
10:00 AM-12:00 PM

Region II Wednesday quarterly
Helen Ross McNabb Center, 201 West Springdale Avenue, Knoxville, TN
11:30 AM-1:30 PM

Region III First Wednesday/quarterly
AIM Center, 472 W. MLK Blvd, Chattanooga, TN
10:00 AM - 12:00 PM

Region IV First Wednesday/ quarterly
Nashville CARES, 633 Thompson Lane, Nashville, TN
11:00 AM-1:00 PM

Region V Thursday/quarterly
Airport Executive Plaza -1321 Murfreesboro Pike, Suite 140, Nashville, TN
9:30 AM-11:30 AM

Region VI Second Tuesday/quarterly
Pathways, 238 Summar Drive, Jackson, TN
1:30 – 3:00 PM

Region VII Fourth Tuesday/quarterly
–Church Wellness Center, 1115 Union Avenue, Memphis, TN
11:00 AM-1:00 PM

kidcentral tn
KIDCENTRALTN.COM
To find resources for children in Tennessee, visit http://kidcentraltn.com/.

Dr. Teresa Kidd Provides Testimony to the Tennessee Senate Health and Welfare Committee

Teresa Kidd, Ph.D.
CEO
Frontier Health

Dr. Teresa Kidd, CEO of Frontier Health, provided testimony to the Senate Health and Welfare Committee on March 9, 2015 about proposed budget reductions for Level 2 Case Management.

Dr. Kidd introduced herself as an advocate for TennCare recipients who have severe and persistent mental illness and who stand to lose a service that she believes is essential to their recovery and stability. She indicated that currently 42,000 adults receive Level 2 Case Management and that more than 90% meet the definition of severely and persistently mentally ill.

She described case management as the cornerstone of the service system and what makes recovery possible. Services provided by case managers include linkage and referral to medical and psychiatric appointments, housing, education, employment, legal, financial or other resources that help to improve the individual's functioning and overall health. She explained that individuals with mental illness frequently have co-morbid health conditions such as asthma, diabetes and hypertension and if not connected to a health provider to address these conditions, they can die up to 25 years earlier than the general population.

Dr. Kidd indicated that 48 states fund case management because it is known to be a cost effective alternative to higher cost services.

She explained that the TennCare managed care companies are evaluated in part by meeting measures called HEDIS, Health Effectiveness Data Information Set. Achieving these outcomes depends on successfully connecting patients with assessments and follow-up services related to their health care needs. Because the case manager is so instrumental in this role, one of the managed care companies has initiated a system to rely on the case manager to help them improve their outcomes and it has been very successful.

In closing, Dr. Kidd noted that case management was a benefit provided as a way to promote recovery and help individuals remain in the community while also reducing the use of inpatient and other higher cost services. It has been so successful that close to 600 inpatient psychiatric beds have been closed since case management services began being provided in the TennCare program.

She encouraged the members of the Committee to fully restore the funding for this essential service.

Fast Facts

Fascinating facts and interesting information

Case Management Services
Fiscal Year 2014

- **53%** of TennCare Clients Served in Behavioral Health Care received Case Management Services.
- This represents only **8%** of the total Adult TennCare population.
- **92%** of those receiving case management are SPMI.
- Our analysis that followed the same cohort over time shows that there is nearly a **20%** decline every six months in the number of individuals receiving the service.
- **21%** of individuals with either a primary or secondary substance use disorder received Case Management Services.

SOURCES

Total TennCare Enrollees — *TennCare*

TennCare Enrollees Served by Behavioral Health — *TAMHO Data Warehouse*

TennCare Enrollees Who Received Case Management — *TAMHO Data Warehouse*

TAMHO ADVOCACY DAY | March 25, 2015 | Legislative Plaza | Nashville, Tennessee

LEVEL 2 CASE MANAGEMENT is the GLUE that holds the delivery system together for individuals with severe and persistent mental illness.

TAMHO opposes:

$30 Million decrease ($10 million state funds) in Level 2 Mental Health Case Management (MHCM)

- Level 2 MHCM is a community based, recovery oriented service that provides assessment and care planning, referral to services, monitoring and follow-up activities for a complex population of Tennesseans with mental illness and co-occurring disorders. More than 90% are diagnosed with Severe and Persistent Mental Inness (SPMI).
- Case management services were implemented as a cost effective alternative to inpatient services. As a result of this service, 590 state funded inpatient beds have been permanently closed in Tennessee, at a cost savings of more than $86,000,000 *per year*.
- Individuals who have severe mental illness also have higher rates of asthma, congestive heart failure, diabetes, hypertension and substance use disorders. When such conditions are not treated in a coordinated way, these individuals die up to 25 years earlier than the general population and the cost associated with their care increases exponentially.
- There is grave concern that reduction of this service will result in increased hospitalizations, increased numbers of individuals being homeless, increased emergency room visits, unnecessary involvement with law enforcement and poor health outcomes.
- We urge you to include $10 million state dollars ($30 million total) in the TennCare budget during FY 16 to cover the Level 2 Case Management Services Benefit and strongly recommend that the proposed limitation regarding both the admission pathways and duration of Level 2 case management be eliminated from the TennCare budget.

TAMHO supports:

- **SB1223 (Bell) / HB699 (Sexton) Telehealth**
  This bill specifies that a healthcare provider who delivers services through the use of telehealth must be held to the same standard of professional practice as with in-person encounters. This bill further specifies that the practice of telemedicine does not apply to out of state physicians, uncompensated consultations, transferring of medical information outside the state, or abortions and requires a physician who practices telemedicine to be licensed to practice within the state of Tennessee.
- TAMHO Supports Governor Haslam's budget proposal for FY2016 that continues funding for 45 Peer Support Centers and 10 Adolescent Treatment Centers.
- TAMHO Supports Governor Haslam's Insure Tennessee Plan and urges the General Assembly to keep it as a viable option. Approximately 200,000 people currently uninsured will have access to necessary treatment. Treatment works but people have to have access to it. Having insurance coverage that includes behavioral health services will help people have access to treatment earlier, which will improve their health status, help them manage their illness and have protection from a catastrophic health condition.

2015 MEDIA COVERAGE

PROPOSED LEVEL 2 CASE MANAGEMENT FUNDING CUTS

LEVEL 2 CASE MANAGEMENT is the GLUE that holds the delivery system together for individuals with severe and persistent mental illness.

February 16, 2015
Restore money for case management of mental illness, *Knoxville News Sentinel*

February 21, 2015
Proposed Mental Health Cuts Baffle Area Officials, *Johnson City Press*

February 25, 2015
Cuts Could Affect Hundreds of Locals, *the Lauderdale Voice, Ripley*

February 26, 2015
Avoid TennCare Cut, *Commercial Appeal, Memphis*

February 26, 2015
Cutting Mental Health Funding will Cost Taxpayers More, *Tennessean*

February 26, 2015
Local Mental Health Programs Brace for Big Cuts, *Local24 News, Memphis*

March 2, 2015
Governor's Budget cut threatens you, many in local community dealing with severe mental illness, *www.vbhs.org*

March 5, 2015
TennCare to present mental health reforms to legislature, *Tennessean*

March 6, 2015
TennCare puts Mentally Ill at Risk, *Tennessean*

March 9, 2015
State Budget Cuts could affect mental health aid, *WBIR TV, Knoxville*

March 9, 2015
Governor Haslam Considering Cutting Funds for mental health, *WATE TV, Knoxville*

March 12, 2015
TennCare Mental Health Care Cuts, *WBIR TV, Knoxville*

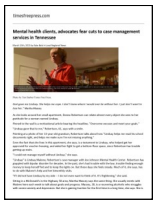
March 15, 2015
Mental health clients, advocates fear cuts to case management services in Tennessee, *Times Free Press*

March 18, 2015
TennCare Cuts, *WZTV, Fox 17, Nashville*

March 19, 2015
Tenn. Mental Health Patients Brace for Possible Cuts, *I-Team, www.LocalMemphis.com.*

March 22, 2015
Inside Tennessee, *WBIR TV, Knoxville*








Tennessee Co-Occurring Disorders Collaborative (TNCODC) to Receive National Recognition

National Council for Behavioral Health to honor individuals and organizations during NCBH Awards of Excellence Ceremony on April 21 in Orlando

The National Council for Behavioral Health is pleased to recognize the **Tennessee Co-Occurring Disorders Collaborative (TNCODC)** as one of 18 individuals and organizations for their outstanding contributions to people recovering from mental illnesses and addictions. The honorees will be celebrated on April 21st at the National Council Conference in Orlando, FL.

"The Awards of Excellence honorees are our heroes, they have turned private pain into public passion, focused on people's gifts and abilities, not their disabilities, and blended business sense and common sense into community-based solutions, said Linda Rosenberg, National Council President and CEO.

The National Council Awards of Excellence feature three categories. The **Impact Awards** honoring the innovative efforts of individuals and organizations staff, boards, volunteers, consumers, families and partners who change the lives of children, adults and families living with mental illnesses and addictions. The **Inspiring Hope Awards** honoring the contributions of individuals living with mental illnesses and addictions, as well as those treating and supporting them inspiring others and improving lives. The **Advocacy Leadership Awards** honoring individuals and organizations that have led legislative or regulatory advocacy efforts to expand access to services for people living with mental illnesses and addictions.

An independent panel selected the honorees from a large pool of very worthwhile applicants. Grants of $10,000 supported by Eli Lilly and Company, Sunovion Pharmaceuticals, Inc., myStrength, Negley Associates, Relias Learning, Qualifacts, Inc., the Maryland Department of Health and Mental Hygiene and the Missouri Department of Mental Health are made to a nonprofit organization of the honoree choosing.

TNCODC STEERING COMMITTEE

CHAIRMAN: Randy Jessee, Ph.D., Senior Vice President Specialty Services, Frontier Health, Gray

GRANT ADMINISTRATOR: Teresa Fuqua, Director of Member Services, TAMHO

MEMBER ORGANIZATIONS:

NAMI Tennessee | *CO-FOUNDING ORGANIZATION OF TNCODC*

Tennessee Association of Mental Health Organizations (TAMHO) | *CO-FOUNDING ORGANIZATION OF TNCODC*

Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS)

Tennessee Association of Alcohol, Drug & Other Addiction Services (TAADAS)

Tennessee Voices for Children (TVC)

Tennessee Coalition for Mental Health and Substance Abuse Services (TCMHSAS)

Tennessee Association of Alcohol and Drug Abuse Counselors (TAADAC)

Mental Health America of Middle Tennessee (MHAMT)

Tennessee Mental Health Consumers' Association (TMHCA)

U.S. Department of Veteran's Affairs

Tennessee Suicide Prevention Network (TSPN)

Tennessee Association of Drug Court Professionals (TADCP)

PUBLIC EDUCATION

Tennessee Co-Occurring Disorders Collaborative (TNCODC), made up of 12 statewide behavioral health organizations, brings education and awareness of the impact of co-occurring disorders to individuals, families, and communities. Their unique statewide approach is the only one of its kind in the United States.

— NATIONAL COUNCIL FOR BEHAVIORAL HEALTH

WWW.TNCODC.COM

ADDRESS 42 Rutledge Street
Nashville, TN 37210

PHONE 615-244-2220
TOLL FREE IN TN 800-568-2642
FAX 615-254-8331

The TNCODC is managed by the Tennessee Association of Mental Health Organizations and is funded by a grant from the State of Tennessee, Department of Mental Health and Substance Abuse Services (TDMHSAS). No person in the United States shall on the basis of race, color or national origin, be excluded from participation in, be denied benefits of, or be subjected to discrimination under any program or activity receiving Federal funding assistance. Civil Rights Act of 1964.

STATEWIDE HAPPENINGS

Cambron Promoted to BlueCare Tennessee President and CEO

Amber Cambron
President and CEO
BlueCare Tennessee

Amber Cambron has been named president and CEO of BlueCare Tennessee, the Medicaid managed care subsidiary of BlueCross BlueShield of Tennessee.

Ms. Cambron succeeds Scott Pierce, who has been appointed senior vice president for government programs, and assumes strategic leadership of all BlueCross' participation in government programs. Currently that participation includes Medicaid managed care and Medicare Advantage products.

"Amber is uniquely well prepared to lead BlueCare Tennessee," Mr. Pierce said. "She has been a leader in the company since it was founded 20 years ago, and knows its operations and opportunities as well as any chief executive could."

Ms. Cambron joined BlueCare Tennessee in 1993 as a claims supervisor and has steadily taken on more responsibility, including serving as chief operating officer for three years prior to her current promotion.

BlueCare Tennessee serves nearly a half million members as a managed care contractor with the state's TennCare program. BlueCare has been a TennCare contractor since the program began and last year was awarded a new contract to continue that relationship.

Implementation of a Statewide Surveillance System for Neonatal Abstinence Syndrome — Tennessee, 2013 | CDC

ARTICLE REPRINT | Children's Safety Network (CSN) | http://www.childrenssafetynetwork.org/spotlight/implementation-statewide-surveillance-system-neonatal-abstinence-syndrome-%E2%80%94-tennessee-2013 | Posted on February 17, 2015

Over the last decade, rates of opioid pain reliever prescribing grew substantially in the United States, affecting many segments of the population, including pregnant women. Nationally, Tennessee ranks second in the rate of prescriptions written for opioid pain relievers, with 1.4 per person in 2012. The rising prevalence of opioid pain reliever use and misuse in Tennessee led to an increase in adverse outcomes in the state, including neonatal abstinence syndrome (NAS). NAS is a withdrawal syndrome experienced by infants shortly after birth. The syndrome most commonly occurs after antenatal exposure to opioids, although other medications have also been implicated. From 2000 to 2009, the incidence rate of NAS in Tennessee increased from 0.7 to 5.1 per 1,000 births, exceeding the national average, which increased from 1.2 to 3.4 per 1,000 births. NAS is associated with numerous morbidities for the infant, including low birth weight, poor feeding, and respiratory problems. Previous population-based analyses of NAS relied on hospital discharge data, which typically become available for analysis only after substantial delay. In Tennessee, the rising incidence of NAS and its associated public health burden created an urgent need for timelier incidence figures to drive policy and prevention efforts. Beginning January 1, 2013, the Tennessee Department of Health (TDH) made NAS reporting mandatory. A total of 921 cases were reported in 2013 (among 79,954 births), with the most cases clustered in eastern Tennessee; 63% of cases occurred to mothers who were reported to be using at least one substance prescribed by a health care provider (e.g., opioid pain relievers or maintenance medications for opioid dependency), and 33% of cases occurred among women using illicit or diverted substances (e.g., heroin or medications prescribed for someone else). The first year's surveillance results highlight the need for primary prevention activities focused on reducing dependence/addiction among women of childbearing age and preventing unintended pregnancy among female opioid users.

Access the full study from the CDC

New Veterans' Housing Opens in Knoxville

ARTICLE REPRINT | TDMHSAS UPDATE | Volume 17, No. 2 | Winter/Spring 2015

The Helen Ross McNabb Foundation held a ribbon cutting ceremony for eight new units constructed on Coster Road in Knoxville.

Cutting the ribbon is Randy Boyd, Radio Systems Corporation, now serving as Commissioner of Economic and Community Development for the State of Tennessee. He stands alongside CEO/President Jerry Vagnier, Helen Ross McNabb Center

The new units are called Cedar Crossing and are part of a project started by Helen Ross, who has raised $1.83 million to develop and sustain housing facilities that serve homeless veterans with mental illnesses and/or behavioral health disabilities. In addition to the construction of Cedar Crossing, 15 units on Washington Pike have been renovated to serve the veteran population.

National studies indicate that one in every five people who are homeless also served in the military. Veterans of the wars in Iraq and Afghanistan are going from serving their country to life on the streets much faster than the generation of veterans who served in Vietnam.

The Helen Ross McNabb Center understands that veterans who are either homeless or at-risk of becoming homeless need access to integrated services to ensure the best possible outcomes for recovery and resilience. Supportive housing can be the first step in addressing complex factors like mental illness, addiction, and job

loss that compound a homeless veteran's ability to be healthy and successful.

In order to qualify for housing, prospective residents are homeless on intake and are likely to have little to no income.The Helen Ross McNabb Center collaborates with the Veterans Administration through the use of Veterans Affairs Supportive Housing (Y.A.S.H.) vouchers for placement at both locations.

Rick Duncan is Named the First Recipient the TDMHSAS Crisis Services Outstanding Employee

ARTICLE REPRINT | TDMHSAS UPDATE | Volume 17, No. 2 | Winter/Spring 2015 | by Leslie Judson

The Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) recently initiated the TDMHSAS Crisis Services Outstanding Employee award with the initial award being bestowed upon Rick Duncan, Crisis Clinician, Ridgeview Psychiatric Hospital and Center, Inc. in Oak Ridge.


Rick Duncan, Outstanding Employee

"We appreciate the dedication, commitment, and compassion demonstrated by professionals who are working in the crisis services system," said Melissa Sparks, Director of Crisis and Suicide Prevention Services. "For individuals experiencing a particularly difficult time, the interaction one has with the professional responding to them in crisis can make all the difference in the world. If the int4eraction goes well, it can aid the road to recovery for that individual but if it does not go well, the person in crisis may never be incentivized to seek mental health services again. Crisis services staff must be willing to work all hours of the day and night, travel through all types of weather, and have a mountain of patience as they attempt to negotiate care with insurance carriers and/or family members."

> "Unless you've walked in the shoes of someone in crisis, it's impossible to know exactly what they're feeling, but you can show empathy and listen."
>
> Rick Duncan

Anyone working in Crisis Services in the state of Tennessee can nominate someone for this honor. Rick was nominated as an Outstanding Employee by his colleague, David Morgan.

"Rick is a diligent worker with a positive attitude and always maintains a sense of humor even in difficult situations," Morgan said. "He works the weekend overnight shift which tends to be the busiest shift. Rick has actually seen up to eight face-to-face evaluations in a single shift which is a record for Ridgeview Mobile Crisis."

Mobile Crisis Team Coordinator Julie Upham said she is proud of the quality work accomplished by the 13-member staff. "We area small, close-knit group," Upham said. "Rick has worked a really tough, busy weekend night shift schedule for years and years. It is a relief to know there is a steady, dependable, and seasoned clinician working those shifts. When he takes a vacation, the covering clinician can bank on hearing, 'Where's Rick?' from ERs, jail staff, and other referring agencies. Rick lets very little stop him. He is valued by his co-workers throughout Ridgeview for his experience and his work ethic."

Rick, 56, is happy to be providing services in Oak Ridge where he grew up. He works 40 hours a week, manning the overnight shifts on Fridays, Saturdays, and Sundays. He also has a second job as a case manager with the Department of Intellectual and Developmental Disabilities.


Rick Duncan hard at work

About his role at Ridgeview, Rick says: "I assess adults who are experiencing a crisis in their lives. These assessments are completed in area hospitals and jails. My goal is to find suitable services for these individuals which can range from follow-up with a current provider, hospitalization, or assistance with entering the mental health system for the first time."

Rick spends a lot of time at work helping others but he also makes himself a priority too. "If we don't take care of ourselves, we are at tisk for burnout, which would affect how we approach our clients. First and foremost is that I try never to take my work home with me. I also spend a lot of time with my three kids and granddaughter and relaxing with my girlfriend."

Rick got a new perspective on life and self-care following a serious health scare in 2013. "I was diagnosed with a grapefruit-sized, non-malignant tumor. I was actually at Methodist Medical Center in Oak Ridge assessing a client when I passed out.

I had no symptoms whatsoever. I game myself three months to live when I was first informed. Luckily, I was given a second chance when they diagnosed it as a Meningioma. Ten days after my diagnosis, I was at Vanderbilt Hospital undergoing brain surgery for six hours." Rick was back at work 2 months after surgery.

"My experience showed me how quickly life could end. It changed me in ways that only I and others that have been there can understand. I no longer take life for granted and appreciate the little things in life that had become mundane. It changed my personality to a large extent. The little things don't really seem to bother me anymore."

Crisis Services in Tennessee
From 2011-2013:

116,891	Crisis Calls (adults)
11,388	Crisis Calls (youth)
54,333	Face-to-face Assessments (adults)
7,046	Face-to-face Assessments (youth)
9,469	Admissions to Crisis Stabilization Units

Each year, 40,000+ Tennesseans are provided suicide prevention education

Tennessee Statewide Toll-Free Crisis Line: 1-855-CRISIS-1
*Confidential help 24 hours a day, 7 days a week

NATIONAL HAPPENINGS

From RX to Heroin | Medicine Abuse Project

ARTICLE REPRINT | Children's Safety Network (CSN) | http://www.childrenssafetynetwork.org/news/rx-heroin-medicine-abuse-project | Posted on February 17, 2015

If you've seen the news lately, you may have noticed that heroin is back in a big way.

Communities across the country – regardless of geographic location or economic status – are experiencing an alarming uptick in deaths related to heroin overdose. So why is this happening? Why are so many teens becoming addicted to heroin in this day and age, when it seems nearly everyone knows the dangers of this drug?

It's beginning with something you might have at home right now. Nearly half of young people who inject heroin start by abusing prescription drugs.

To help you understand how the transition happens and what you should be aware of to keep your family and community safe, the Medicine Abuse Project have developed an interactive infographic. Follow the journey of a teen; hear stories from families who have been down this road; and find the tools you need to take action – whether you're a parent, health care provider, educator or community member.

U.S. Painkiller Abuse 'Epidemic' may be Declining, Study Says | Health Day

ARTICLE REPRINT | Children's Safety Network (CSN) | http://www.childrenssafetynetwork.org/news/us-painkiller-abuse-epidemic-may-be-declining-study-says-health-day | Posted on January 10, 2015

The U.S. "epidemic" of prescription-painkiller abuse may be starting to reverse course, a new study suggests.

Experts said the findings, published in the *New England Journal of Medicine*, are welcome news. The decline suggests that recent laws and prescribing guidelines aimed at preventing painkiller abuse are working to some degree.

But researchers also found a disturbing trend: Heroin abuse and overdoses are on the rise, and that may be one reason prescription-drug abuse is down.

"Some people are switching from painkillers to heroin," said Dr. Adam Bisaga, an addiction psychiatrist at the New York State Psychiatric Institute in New York City.

While the dip in painkiller abuse is good news, more "global efforts" -- including better access to addiction treatment -- are needed, said Bisaga, who was not involved in the study…

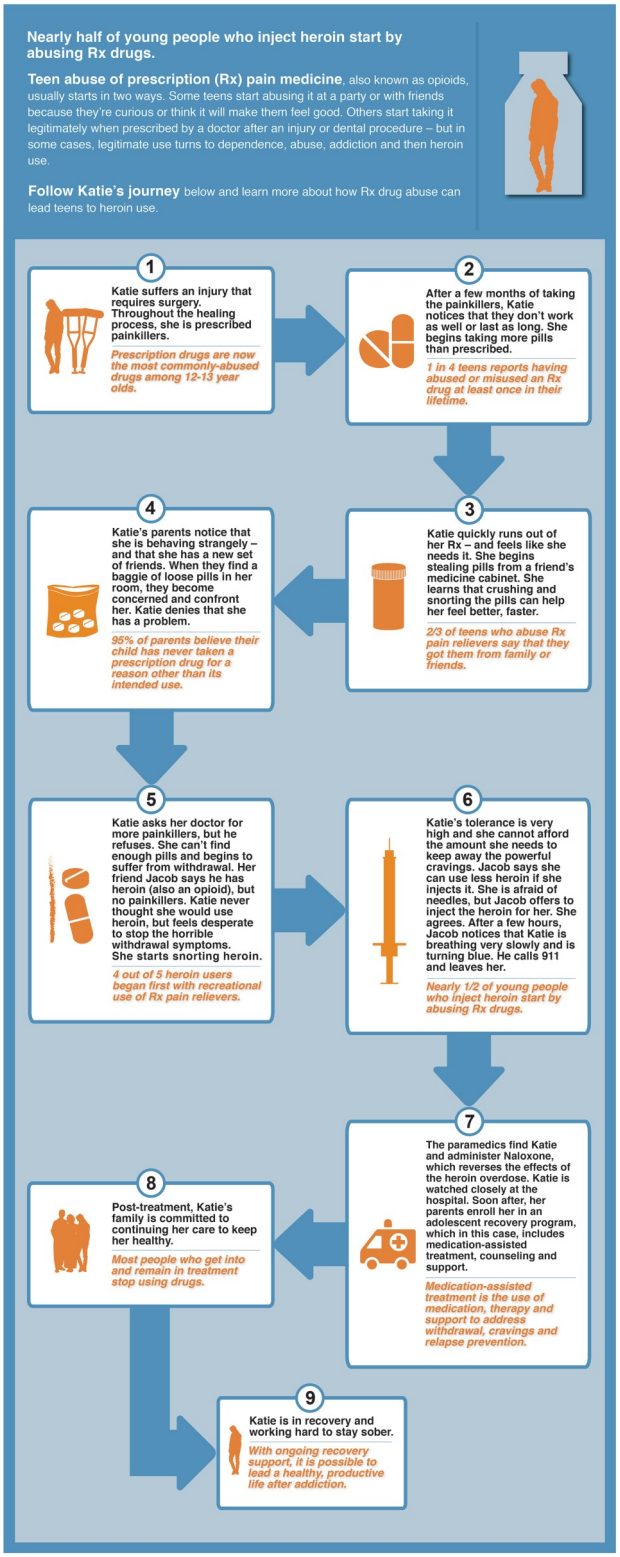
U.S. sales of narcotic painkillers rose 300 percent between 1999 and 2008, according to the U.S. Centers for Disease Control and Prevention.

The increase had good intentions behind it, noted Dr. Richard Dart, the lead researcher on the new study. Unfortunately, he said, it was accompanied by a sharp rise in painkiller abuse and "diversion" -- meaning the drugs increasingly got into the hands of people with no legitimate medical need.

What's more, deaths from prescription-drug overdoses (mostly painkillers) tripled. In 2010, the CDC says, more than 12 million Americans abused a prescription narcotic, and more than 16,000 died of an overdose -- in what the agency termed an epidemic.

Read the full article from Health Day

From Rx to Heroin



Michael Botticelli Unanimously Confirmed as New Director of National Drug Control Policy

A Statement by National Council CEO Linda Rosenberg

The U.S. Senate unanimously confirmed Michael Botticelli as the Director of the Office of National Drug Policy (ONDCP) in a 92-0 vote. Director Botticelli brings more than two decades of experience and leadership in supporting people struggling with addiction, their families and their communities.

Dominating American headlines, the recent spike in opioid and heroin addictions and deaths makes the tasks of prevention, treatment and intervention critical in communities in every corner of our country. The National Council strongly supported Botticelli's confirmation. His vision and passion prepared him for the principal task of successfully implementing the National Drug Control Strategy.

Director Botticelli had dedicated his life and career to combating addictions and ensuring access to treatment for those in need. As Director of the Bureau of Substance Abuse Services at the Massachusetts Department of Public Health, he expanded the range of innovative and nationally recognized prevention, intervention, treatment and recovery services. The range of innovative programs he helped create include expanded treatment systems for adolescents, early intervention and treatment programs in primary healthcare settings, jail diversion programs, re-entry services for those leaving correctional facilities and overdose prevention programs.

Director Botticelli has long asserted the notion that people can and do recover from addictions, going on to lead successful lives. We congratulate him on his confirmation, applaud him for his commitment and look forward to continuing to work with him in his role leading our nation's efforts to reduce the impact of drugs and drug addictions.

Comprehensive Addiction and Recovery Act Reintroduced in Both House, Senate

ARTICLE REPRINT | National Council for Behavioral Health | CAPITOL CONNECTOR — Policy Into Practice | http://www.thenationalcouncil.org/capitol-connector/2015/02/comprehensive-addiction-recovery-act-reintroduced-house-senate/ | Posted on February 19, 2015 | by Michael Petruzzelli, Policy Associate, NCBH

Last week, members in both chambers of Congress reintroduced legislation aimed at combatting the opioid epidemic. The Comprehensive Addiction and Recovery Act invests much needed funding in prevention, evidence-based treatment and recovery supports to help Americans struggling with addiction to heroin or narcotic painkillers.

This legislation, authored by Senators Rob Portman (R-OH) and Sheldon Whitehouse (D-RI), provides desperately needed funds to support community-based addiction treatment. It fosters the use of alternatives to incarceration for offenders in need of treatment. And it expands prevention and educational efforts—particularly aimed at teens, aging populations and parents and other caretakers—to prevent the abuse of heroin and other opioids and to promote treatment and recovery.

"To help Americans struggling with drug addiction, we must get beyond a top-down, one-size-fits-all approach," said Senator Portman. "We need a comprehensive strategy that starts from the bottom up. This legislation builds on proven methods to enable law enforcement to respond to this heroin epidemic and supports long-term recovery by connecting prevention and education efforts with treatment programs."

"As Co-Chair of the Congressional Addiction, Treatment and Recovery Caucus, I understand the damage substance abuse inflicts upon the nation. In my state of Ohio, fatal drug overdoses have been the leading cause of accidental death since 2007. Heroin and opiate addiction is destroying lives, disrupting families and destabilizing communities – it is imperative that we begin to stem this tide. The

provisions in this legislation are proven to work and I call on Congress to act now and pass this important legislation," said Congressman Tim Ryan (D-OH) who introduced a companion bill in the House with Congressman Jim Sensenbrenner (R-WI).

In the House, Representatives Ryan and Sensenbrenner were joined by Tom Marino (R-PA), Bobby Scott (D-VA), David Joyce (R-OH), Tammy Duckworth (D-IL) and Steve Chabot (R-OH) as original cosponsors of the Comprehensive Addiction and Recovery Act. In the Senate, Amy Klobuchar (D-MN), Kelly Ayotte (R-NH), Chris Coons (D-DE) and Mark Kirk (R-IL) joined as original cosponsors. We commend these legislative champions for their attention to the important issue of substance use prevention and treatment, and pledge to work closely with them to advance this bill to passage.

National Council Sends Finalized CCBHC Comments to SAMHSA

ARTICLE REPRINT | National Council for Behavioral Health | CAPITOL CONNECTOR — Policy Into Practice | http://www.thenationalcouncil.org/capitol-connector/2015/02/comprehensive-addiction-recovery-act-reintroduced-house-senate/ | Posted on February 19, 2015 | by Michael Petruzzelli, Policy Associate, NCBH

The National Council submitted finalized comments earlier this week to the Substance Abuse and Mental Health Services Administration (SAMHSA) on draft certification criteria for Certified Community Behavioral Health Clinics (CCBHCs). SAMHSA extended the deadline for comments on the draft criteria for CCBHCs, the comprehensive mental health and substance use treatment providers authorized by legislation based on the Excellence in Mental Health Act. Thank you to all advocates who submitted comments before Wednesday's deadline.

The National Council articulated a long list of concerns with the draft criteria, most notably:

- **The criteria are overly prescriptive, creating a disincentive for state participation.** While the National Council has long championed the creation of national standards for community behavioral health services, that must be balanced with the reality that CCBHCs are currently authorized only as a two year demonstration program.
- **The service requirements are laid out in absence of a discussion of the Prospective Payment System, or cognizant of limitations in State Medicaid Plans.** Payment by Medicaid for CCBHC services is limited to what is already allowable in a state's Medicaid program. Despite this limitation, the criteria include many services and activities that are not commonly covered in Medicaid programs (e.g., outreach and engagement).
- **The criteria hews too closely to services required for partial hospitalization services**, and does not leave room for a level of care for people with mild-to-moderate behavioral health conditions.
- **Directly approving accreditation by a national body or allowing states to deem would address many of the quality issues raised by SAMHSA through its draft criteria.** Many of the statutory requirements for CCBHCs are already addressed through accreditation systems.
- **The quality measures included are too extensive, often lack specificity, and are exceptionally labor intensive.** The criteria include a list of 30 required measures and more than 60 optional measures, many which would require individual chart reviews and pulling of information from personnel records.

Many other leaders in the field echoed similar concerns and we are hopeful SAMHSA will revamp the criteria to allow for greater state participation. SAMHSA has expressed the goal of releasing finalized certification criteria in May, along with guidelines to states for developing the payment methodology and the RFA for state planning grants. $25 million will be made available to states to engage in planning to determine whether and how CCBHCs fit into their larger system reform. Stay tuned for more news and information regarding the implementation of the Excellence in Mental Health Act.

To access the full finalized comments, please CLICK HERE or visit: http://www.thenationalcouncil.org/wp-content/uploads/2015/02/CCBHC-Draft-Criteria-Comments-National-Council-for-Behavioral-Health-2-18-15.pdf.

Bipartisan Group Introduces Veteran's Treatment Courts Legislation in the House

ARTICLE REPRINT | National Council for Behavioral Health | CAPITOL CONNECTOR — Policy Into Practice | http://www.thenationalcouncil.org/capitol-connector/2015/02/comprehensive-addiction-recovery-act-reintroduced-house-senate/ | Posted on February 19, 2015 | by Michael Petruzzelli, Policy Associate, NCBH

Bipartisan legislation introduced in the House would authorize veterans' treatment courts, helping veterans living with addiction and other mental health conditions receive specialized care when accused of certain nonviolent crimes. The Service member Assistance for Lawful Understanding, Treatment and Education (SALUTE) Act would give the Justice Department important guidance on veterans' treatment courts funding and will help make sure these programs are being implemented effectively.

"One in five veterans returning from Iraq and Afghanistan will experience a stress-related mental illness, and many others will fall victim to drug and alcohol abuse," said Congressman Patrick Meehan (R-PA). "We owe it to these veterans to ensure they get the care and treatment they earned for serving our nation. And we can help nonviolent offenders struggling with addiction or other crises avoid becoming entrapped in the criminal justice system, keeping them from getting the care they need."

Representative Meehan was joined by eight of his colleagues in supporting this legislation. He was joined by Reps. Mike Fitzpatrick (R-PA), Ryan Costello (R-PA), Chaka Fattah (D-PA), Larry Buschon (R-IN), John Carney (D-DE), Paul Tonko (D-NY), Barbara Comstock (R-VA) and Grace Napolitano (D-CA).

House Holds Hearing on ICD-10 Transition: Green Light for 2015

ARTICLE REPRINT | National Council for Behavioral Health | CAPITOL CONNECTOR — Policy Into Practice | http://www.thenationalcouncil.org/capitol-connector/2015/02/comprehensive-addiction-recovery-act-reintroduced-house-senate/ | Posted on February 19, 2015 | by Nancy Htay, Policy Intern, NCBH

Last week, the House of Representatives' Energy and Commerce Committee held a hearing on implementation of ICD-10 and readiness to transition to the new code set for October 1, 2015. The general sentiment? Green light.

Panel witnesses included practitioners, advocacy groups and vendors, the majority of whom were in favor of starting ICD-10 by the proposed date of October 1, 2015. No lawmaker advocated a delay.

While provider and payer readiness were cited as concerns, previous delays have caused counterproductive activity and high costs for providers.

Are you ready? Or ready to be ready? For resources to support your organization during this transition, explore the National Council's Coding Behavioral Health Services page, or directly visit CMS' ICD-10 transition resources.

Tobacco Cessation

ARTICLE REPRINT | National Council for Behavioral Health | http://www.thenationalcouncil.org/topics/tobacco-cessation/

People with mental illnesses and addictions can die decades earlier than the general population — and smoking is a major contributor.

- About 50% of people with mental illnesses and addictions smoke, compared to 23% of the general population.
- People with mental illnesses and addictions smoke half of all cigarettes produced, and are only half as likely as other smokers to quit.
- Smoking-related illnesses cause half of all deaths among people with behavioral health disorders.
- 30-35% of the behavioral healthcare workforce smokes (versus only 1.7% of primary care physicians)

What Can You Do to Decrease or Prevent Tobacco Use Among People with Mental Illnesses and Addictions?

- Access the resources available through the CDC National Behavioral Health Network for Tobacco & Cancer Control operated by the National Council for Behavioral Health.
- Read our issue of eSolutions on Smoking Cessation, which discusses facts about smoking and shares useful resources.
- Download DIMENSIONS: Tobacco Free Toolkit for Healthcare Provider, which contains information and step-by-step instructions on tobacco cessation education, client engagement, assessing readiness to quit, and treatment information.
- Read Linda Rosenberg's letter to the field, A Shared Struggle with Tobacco Addiction, and learn about the National Council's commitment to supporting tobacco control and prevention efforts.
- Bookmark BeTobaccoFree for some of the best information on the health effects of tobacco, quitting smoking, and more.
- Subscribe to the CDC's Tobacco Free Press for valuable tobacco-related news and resources.
- Order or download the CDCs free brochures and posters.
- Download Tobacco Cessation for Persons with Mental Illnesses: A Toolkit for Mental Health Providers to for information on how to help those you serve quit smoking.
- Learn not to create a smoke-free setting in Tobacco-Free Living in Psychiatric Settings: A Best-Practices Toolkit Promoting Wellness and Recovery.
- Learn the right billing codes for tobacco cessation in the American Society of Family Physicians' reimbursement code chart.
- Learn about CenterLink, giving a voice for LGBT community centers in national grassroots organizing, coalition building and social activism.

Trauma Informed Care

ARTICLE REPRINT | National Council for Behavioral Health | http://www.thenationalcouncil.org/topics/trauma-informed-care/

Trauma is a near universal experience of individuals with behavioral health problems. According to the U.S. Department of Health and Human Services Office on Women's Health, 55% – 99% of women in substance use treatment and 85% – 95% of women in the public mental health system report a history of trauma, with the abuse most commonly having occurred in childhood. The Adverse Childhood Experiences study conducted by the Centers for Disease Control and Prevention and Kaiser Permanente, is one of the largest investigations ever conducted to assess associations between childhood maltreatment and later-life health and wellbeing. Almost two-thirds of the study participants reported at least one adverse childhood experience of physical or sexual abuse, neglect, or family dysfunction, and more than one of five reported three or more such experiences.

An individual's experience of trauma impacts every area of human functioning — physical, mental, behavioral, social, spiritual. The ACE Study revealed that the economic costs of untreated trauma-related alcohol and drug abuse alone were estimated at $161 billion in 2000. The human costs are incalculable.

Trauma is shrouded in secrecy and denial and is often ignored. But when we don't ask about trauma in behavioral healthcare, harm is done or abuse is unintentionally recreated by the use of forced medication, seclusion, or restraints.

The good news is that trauma is treatable — there are many evidence-based models and promising practices designed for specific populations, types of trauma, and behavioral health manifestations.

CORRECTION . . .

Behavioral Health News & Events
Volume 3, Issue 1 | January 2015 | Page 17

TAMHO Member Agencies Participating in the Reducing Adolescent Substance Abuse Initiative (RASAI) Meet in Nashville

Technical assistance provided by National Council representatives

Carey Counseling Center, a participating agency in the Reducing Adolescent Substance Abuse Initiative (RASAI), was omitted in the listing of participants with representatives at the November 13th meeting in Nashville.

The four TAMHO member organizations participating in the Reducing Adolescent Substance Abuse Initiative (RASAI) gathered in Nashville on November 13 for a day of technical assistance and networking.

Participants included representatives from:

- National Council for Behavioral Health
- Health Management Associates
- TennCare
- TDMHSAS
- Alliance Health Services
- Carey Counseling Center
- Frontier Health,
- Helen Ross McNabb Center, and,
- Tennessee Association of Mental Health Organizations (TAMHO).

This two-and-a-half year project is designed to help providers systematically implement a screening, brief intervention, and referral to treatment (SBIRT) protocol to address substance use among adolescents ages 15–22 who receive services for an emotional disturbance or a psychiatric disorder. The project is supported by the Conrad N. Hilton Foundation.

TAMHO MEMBER ORGANIZATION HAPPENINGS

Interpretation Minimizes Barriers for Deaf or Hard of Hearing

ARTICLE REPRINT | Impressions in Behavioral Health Care — *a Frontier Health Publication* | Volume XVIII Issue 3 | Fall/Winter 2014

The only thing a deaf person may not be able to do is hear. Just like you, the 28 million people who are Deaf of Hard of Hearing have similar hopes and dreams but often face unnecessary obstacles that narrow their choices. Existing technologies to eliminate barriers are slowly being embraced.

The overarching goal of Communication Center for Deaf and Hard of Hearing is as a channel of communication so Dear or Hard of Hearing can access daily life. CCDHH provides interpreting services, sign language classes, public awareness and advocacy for people who are Deaf or Hard of Hearing, verbal and non-verbal children (like those affected by autism), and the community.

It's like this. You may not understand when someone speaks Spanish but that doesn't mean his or her thoughts should be ignored. Language barriers are universal and should be minimized through interpretation. Understanding a fw words is not a meaningful conversation.

Not understanding how someone who is Deaf or Hard of Hearing communicates can be a barrier. They may gain attention by touching you, tapping a table or stomping the floor. Some hearing consider the interruption rude but it's no different from someone making a sound for attention. The struggle can be difficult for someone who is deaf and able to speak. Just because they speak does not mean they read lips or understand you.

It's sad when people ignore someone or walk away then they discover someone is unable to hear. It's frustrating when a clinician leaves without communicating a diagnosis or life-saving measures or someone is arrested because a law enforcement officer only hears one side of a dispute.

When captioning or interpretation is needed, CCDHH provides interpretation as a contractual service. CCDHH also teaches beginning, intermediate and advanced classes in American Sign Language. CCDHH is funded through the Division of Rehabilitative Serivces and the Tennessee Council for the Deaf, Deaf-Blind and Hard of Hearing.

Carey Counseling Participates in a Trial Study

Adherence to Medication in Early Psychosis: Long-Acting Injectable Antipsychotics or Community Medication Practice

Although waiting on IRB approval, Carey Counseling Center is moving forward as a participating agency in a trial study of adherence to medication in early psychosis. Their involvement evolved in response to their participation in an OnTrackTN grant involving clients. Clients involved in the research study will have full psychiatric assessments and diagnostic testing by national experts which will allow for a more focused diagnosis whether the diagnosis meets criteria or not (Schizophrenia only).

This investigator initiated trial is being conducted by Dr. John Kane of North Shore LIJ Health System. This large simple trial will be recognized as a "proof of concept" study. The principle being tested is that LAIs can be acceptable to patients early in the course of schizophrenia and lead to better outcomes. A couple of the study's critical design elements are the use of cluster randomization (sites, rather than clients are randomized, so all patients at any one site are offered the same course of treatment) and an LAI that is administered monthly rather than biweekly. A total of 40 sites throughout the U.S. will be select with many community mental health centers in addition to some university sites with community outreach, already enlisted to participate in the trial. The hope is that each site will recruit 0.5-1 FEP patients (0 -12 months lifetime exposure to antipsychotics) and 0.5-1 recent onset patients (1-5 yrs) per month (for a total of 10-15 patient sites). The first 8 sites ought to be IRB approved by the beginning of next year with the remaining 32 sites planning to train at the end of January for a February start.

Tennessee's Same Day Access Learning Collaborative Produces Positive Results

Seven CMHAs in Tennessee participated in a Same Day Access learning collaborative with David and Scott Lloyd and had very positive results. Once same day / next day appointments became routinely available at several sites, the TennCare transportation vendors' requirement of a 5 day notice period became a significant barrier. When we explained this to our Medicaid (TennCare) division, they changed the definition of "urgent appointment" to include any outpatient mental health appointment so that the notice period to get a transportation pick up would be hours instead of days. We saw that as a real win – win!

One of the learning collaborative participants, Carey Counseling Center, provided their feedback:

Carey Counseling Center participated in a same day access (SDA) learning collaborative in 2012 sponsored by the National Council that linked CMHC's with MTM services as consultants. CAREY was ready as an agency to make the changes to our system that would allow us to take full advantage of MTM's expertise. We were assigned to Scott Lloyd and we could not be happier that we took advantage of this system altering process. We are a rural CMHC in North West TN approx. 200 employees and 3000+ clients with 6 outpatient sites. The majority of the population we serve has TNCARE (TN Medicaid) so the staff needed to complete intakes (assessments for admission into the system) is non-licensed maters level counselors. We do have licensed staff to see clients that have Medicare or commercial insurance. MTM was very attentive to how our system differs slightly from others primarily because we are very fortunate to have telemed capabilities that allow us to do intakes and psych evals remotely. We successfully complete intakes daily with a small team of intake counselors face to face and thru telemed. The data that MTM has accumulated nationally allowed us to get buy in from staff on the front end of this project which allowed for a smoother transition (MTM has data that show a very high success

rate in helping agencies implement SDA). We had a relatively smooth transition from clients waiting 2 weeks for an intake, half would not show, then a month wait for a med appointment where approximately half would show up to 100% show rate for SDA daily at all of our sites to a 90%+ show rate for psychiatric evaluations. We are so happy with the way this process has changed our system that we have just contracted with MTM to further change are system to include Just in Time scheduling (med staff scheduling). We have also taken advantage of their expertise through training on the DLA 20, collaborative documentation and centralized scheduling. Scott and all of the staff at MTM have always been available for consultation throughout the process and just when we thought we were the only ones that may have a "glitch" with the process they could give us several examples of how other agencies have worked through those "glitches", and quickly led us in the right direction. Again we are very satisfied with the services that MTM have offered.

Council Fellows Announces 2015 Classes

List includes Harsh Trivedi, MD: Executive Director & CMO, Vanderbilt Behavioral Health

Last month, the Nashville Health Care Council and former U.S. Senate Majority Leader Bill Frist, MD, announced the latest class of the Nashville Health Care Council Fellows. For 2015, 36 senior healthcare leaders were selected for the renowned program, which is focused on influencing and transforming the nation's healthcare system.

"The 2015 Fellows include some of the industry's best and brightest leaders with experience and industry focus spanning all sectors of healthcare," said Frist, who co-directs the initiative with Larry Van Horn, PhD, a leading expert in healthcare management and economics and professor at Vanderbilt's Owen Graduate School of Management. "These individuals have a challenging task ahead, and I look forward to the meaningful discussion and debate on our nation's healthcare that will come from our rigorous curriculum," Frist continued.

Now in its third year, Council Fellows engages industry leaders in clearly defining healthcare's greatest challenges and exploring innovative business strategies to navigate the difficult issues facing the American healthcare system.

Council Fellows is presented in partnership with BlueCross BlueShield of Tennessee, Community Health Systems, HCA, Healthways, LifePoint Hospitals and Vanderbilt University Owen Graduate School of Management.

For more information on the program or Class of 2015, visit healthcarecouncilfellows.com.

Professional Care Services of West TN Awarded USDA Distance and Telemedicine Grant

Professional Care Services of West TN has been awarded a 2014 Distance Learning and Telemedicine grant of $109,245 to improve, upgrade, and expand telemedicine technology in six rural counties of West Tennessee.

Ten fixed site locations will be interconnected with access to live, real-time physician and licensed staff assessment, treatment, and consultation, while crisis staff and case managers will be equipped for more clients to be seen in their natural environment with immediate connectivity to other team members as needed.

tamho
tennessee association of mental health organizations

TNCODC.COM

HOPE ACCESS RECOVERY
Tennessee Co-Occurring Disorders Collaborative
WWW.TNCODC.COM

Hope
As long as there is life, there is hope.

ACCESS
Staying informed will be helpful when services are necessary.

RECOVERY
is real!

- Keep up with current co-occurring disorder events/ trends
- Access the latest perspectives related to the impact of co-occurring disorders on: 1) families, 2) communities; 3) local and state level policy and legislative matters, 4) judicial and criminal justice systems; and, 5) business and workforce
- Order educational and awareness materials
- Sign up with TNCODC to stay current on co-occurring disorder updates
- Request educational presentations
- Download a TNCODC link banner to place on your agency or organization website and so much more!

The TNCODC is funded by a grant from the State of Tennessee, Department of Mental Health and Substance Abuse Services (TDMHSAS). No person in the United States shall on the basis of race, color or national origin, be excluded from participation in, be denied benefits of, or be subjected to discrimination under any program or activity receiving Federal funding assistance. Civil Rights Act of 1964.

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