tamho
tennessee association of mental health organizations

BEHAVIORAL HEALTH NEWS & EVENTS

Volume 4, Issue 2 Tennessee Association of Mental Health Organizations (TAMHO) **April 2016**

Message from the Executive Director

Ellyn Wilbur
Executive Director

If you have recently read a newspaper or listened to news reports, you have most likely heard about the opioid epidemic in this country. Unfortunately, the opioid epidemic is very present in TN and has had devastating results. The statistics are startling: 18 to 25 year olds in TN use prescription opioids at a 30% higher rate than the national average; in 2014 more than 1,000 babies born in TN were dependent on substances used by their mother while pregnant; deaths from drug overdoses in TN now outpace deaths by automobile accidents with more than 1,200 overdose deaths in 2014.

Governor Haslam and the members of the General Assembly passed various legislative acts to address this problem and the Governor's fiscal year 2017 budget proposes additional funding for recovery court funding. We applaud these steps but strongly believe that funding for addiction treatment must be part of the response to address this systemic issue that impacts all areas of our society.

Senator Doug Overbey and Representative Art Swann have filed a budget amendment, with strong support from other legislators, stakeholders and community leaders, to appropriate $30 million to the Tennessee Department of Mental Health and Substance Abuse Services to increase access to treatment for approximately 10,000 individuals in our state in need of services.

Please help support this effort by contacting your legislator and ask for their support for such vital funding. Feel free to contact us if you need more information.

VIEW THE WHITE PAPER ON PAGES 8-10 OF THIS NEWSLETTER

WATCH THE VIDEO, FIND YOUR LOCAL LEGISLATOR, OR DOWNLOAD THE WHITE PAPER AT

WWW.TAMHO.ORG/RECOVERY

Busy Season for Behavioral Health Advocates on Tennessee's Capitol Hill

TAMHO member agencies and members of the Coalition for Mental Health and Substance Abuse Services have had an active season of advocacy during this second session of the 109th General Assembly. TAMHO held its Advocacy Day on March 1 and its members were visible in large numbers at Capitol Hill. A huge thank you goes to all who advocated that the 1% TennCare provider rate reduction scheduled to take effect July 1st be restored. Governor Haslam restored this funding in his budget amendment released March 28th. (See page 9 for full details).

But there is still work to do! The Tennessee Coalition for Mental Health and Substance Abuse Services is a group of more than 30 organizations whose purpose is to ensure behavioral health services are accessible to all Tennesseans and these services are maintained at a funding level that assures quality care to those in need. On March 15th over 400 Coalition members convened on Legislative Plaza to advocate for improved access to needed services. The days agenda included distinguished guests and speakers on each of the major Coalition taking points, shown below. TAMHO's 2015 Dorothea Dix Professional Service award recipient, Hilde Phipps, spoke on the need for additional treatment resources for substance abuse. Advocates met with their legislators asking for their support for the following:

$30,000,000 for Addiction/Substance Abuse Treatment — Between 2011 and 2014, admissions to state-funded treatment facilities for heroin use increased 157%, yet in 2014**, only 4% of Tennesseans in need of addiction treatment actually received services**.

In each of the past two years (2014 and 2015), about 1000 babies were born in Tennessee dependent on drugs their mother used while pregnant. Lack of adequate resources to treat pregnant and post-partum women are of particular concern as Tennessee addresses the Neonatal Abstinence Syndrome (NAS) epidemic. It is estimated that 4,318 of Tennessee's pregnant women will need access to addiction treatment for opioid use each year.

INSIDE THIS ISSUE

$6,400,000 for Crisis Services

($400,000) Adult Crisis Stabilization Unit

The eight existing adult CSUs have been successful in responding to behavioral health crises that do not necessitate hospitalization. When clinically indicated, it is more economical to access services at a CSU than an inpatient hospital. For example, in TN, the average CSU daily cost is $360 per bed; while an inpatient daily cost is $1169 per bed. In FY15 there were 10,320 CSU admissions compared to 9,737 RMHI admissions, saving the state thousands of dollars.

TDMHSAS Region 5 (South Central TN) consists of 26 counties, mostly rural in nature, and spans a large geographical area. This region lacks a CSU that could serve individuals in crisis who do not need admission to a hospital. For South Central Middle Tennessee, the need for a CSU is more pronounced due to the small number of community hospitals where individuals can be assessed.

($6,000,000) Children and Youth Crisis Stabilization (CSU) and Respite Services

There are no CSUs in our state for children and youth. Based on the experience with adult CSUs, we know there would be a benefit from having access to a brief crisis stay which would also relieve some of the pressure on the limited number of inpatient psychiatric beds available for youth in our state.

For the past three years, the Children's Committee of TDMHSAS Planning and Policy Council has made children's CSUs their number one mental health priority.

$2,400,000 for Supported Employment Services (Individual Placement and Support)

Research shows that employment is a great contributor to recovery for people with mental illness or addictions issues. Approximately 2 out of 3 people with mental illness want to work, yet less than 15% are employed.

Individual Placement and Support, (IPS) is a supported employment service that helps people with mental illness obtain employment using a skill building curriculum developed by Dartmouth University. Research has shown that individuals who receive supported employment services save states money in community mental health treatment, number of psychiatric hospitalizations days used and emergency room usage.

Furthermore, a 10-year follow-up study of clients with severe mental illness and co-occurring substance abuse disorder found an average annual savings of over $16,000 per client in mental health treatment costs for steady workers, compared to clients who did not work.

Call To Action: The General Assembly is in its final weeks of session when the state budget will be negotiated. We need your advocacy now more than ever! Please contact your legislators and ask them to support:

House Amendment #157 and Senate Amendment #128 to appropriate $30 million dollars to TDMHSAS for substance abuse treatment. Go to www.tamho.org/recovery for more information.

House Amendment #217 and Senate Amendment #80 for $8.8 million dollars ($2,400,000 for Supported Employment (IPS) and $6,400,000 for crisis funding.

Strategic Initiative: Enhancing Tennessee's Co-Occurring System of Care Announcement of Statewide Initiation

Planning for the implementation of the Strategic Initiative began in late January. An Advisory Group was identified from the Tennessee Co-Occurring Disorders Collaborative (TNCODC) Steering Committee to guide the implementation.

An important component of the Initiative is implementing a state-wide Learning Community to support the Initiative. A Work Group has been formed to design and develop the COD Learning Community and they are in the early stages of discussion and planning.

Both, the Strategic Initiative Advisory Group and the Learning Community Work Group, have engaged the consultation of Kenneth Minkoff, MD, and ZiaPartners. Dr. Minkoff is well known for his work and expertise with systems change and has presented at the last two Co-Occurring Disorders Symposiums here in Tennessee. The groundwork initiated through these previous Symposiums serve as the foundation for the Strategic Initiative and Learning Community.

To announce this endeavor, the TDMHSAS Commissioner sent a letter on March 16 to agencies introducing and explaining the Strategic Initiative. More communications and discussions are being planned. [*content is provided on the next page*]

More details and communications will be forthcoming for the entire project. For immediate questions, you may contact Patrick Slay, TNCODC Project Manager, at pslay@tamho.org.

Patrick Slay
Project Manager
Tennessee Co-Occurring Disorders Collaborative (TNCODC)

STRATEGIC INITIATIVE ADVISORY GROUP

Mission Statement *— To enhance Tennessee's Co-Occurring Disorders System of Care by effecting organizational change by continuously improving program capability, ensuring sustained workforce development, and complementing the state's current investment in treatment and recovery for individuals with co-occurring disorders.*

Assistant Commissioner Rod Bragg, TDMHSAS

Assistance Commissioner Sejal West, TDMHSAS

Randy Jessee, TNCODC Steering Committee Chairman (Frontier Health)

Vickie Harden, TNCODC Strategic Initiative Co-author (Volunteer Behavioral Health)

Mary Linden Salter, TAADAS Executive Director

Charlotte Hoppers, TAADAS (Grace House)

Debbie Hillin, TAADAS (Buffalo Valley)

Ellyn Wilbur, TAMHO Executive Director

Vickie Boyd, TAMHO Chair of Addictions Committee (Carey Counseling Center)

Teresa Fuqua, TNCODC Grant Administrator

Patrick Slay, TNCODC Project Manager

COD LEARNING COMMUNITY WORK GROUP

COD Learning Community Work Group Purpose Statement: *Develop and implement a state-wide learning community to support universal co-occurring capability for programs and staff*

TAADAS

Barry Cooper (JACOA)

Mary Beth Heaney-Garate (Renewal House)

Charlotte Hoppers (Grace House)

Vicki Neal (Mending Hearts)

TAMHO

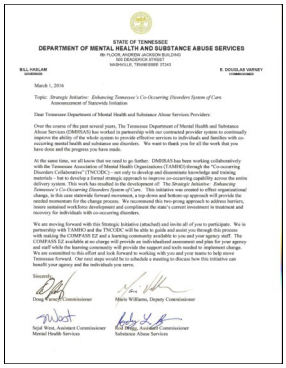
Vickie Harden (Volunteer Behavioral Health)

Tim Perry and Cicely Alvis (Frontier Health)

Nathan Zeiger (Ridgeview)

March 1,2016 | E. DOUGLAS VARNEY, COMMISSIONER

Topic: Strategic Initiative: Enhancing Tennessee's Co-Occurring Disorders System of Care Announcement of Statewide Initiation



STATE OF TENNESSEE
DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES
500 DEADERICK STREET
NASHVILLE, TENNESSEE 37243

BILL HASLAM, GOVERNOR — E. DOUGLAS VARNEY, COMMISSIONER

March 1, 2016

Topic: *Strategic Initiative: Enhancing Tennessee's Co-Occurring Disorders System of Care.* Announcement of Statewide Initiation

Dear Tennessee Department of Mental Health and Substance Abuse Services Providers:

Over the course of the past several years, The Tennessee Department of Mental Health and Substance Abuse Services (DMHSAS) has worked in partnership with our contracted provider system to continually improve the ability of the whole system to provide effective services to individuals and families with co-occurring mental health and substance use disorders. We want to thank you for all the work that you have done and the progress you have made.

At the same time, we all know that we need to go further. DMHSAS has been working collaboratively with the Tennessee Association of Mental Health Organizations (TAMHO) through the "Co-occurring Disorders Collaborative" (TNCODC) – not only to develop and disseminate knowledge and training materials - but to develop a formal strategic approach to improve co-occurring capability across the entire delivery system. This work has resulted in the development of: The Strategic Initiative: Enhancing Tennessee's Co-Occurring Disorders System of Care. This initiative was created to effect organizational change, in this case statewide forward movement, a top-down and bottom-up approach will provide the needed momentum for the change process. We recommend this two-prong approach to address barriers, insure sustained workforce development and compliment the state's current investment in treatment and recovery for individuals with co-occurring disorders.

We are moving forward with this Strategic Initiative (attached) and invite all of you to participate. We in partnership with TAMHO and the TNCODC will be able to guide and assist you through this process with making the COMPASS EZ and a learning community available to you and your agency staff. The COMPASS EZ available at no charge will provide an individualized assessment and plan for your agency and staff while the learning community will provide the support and tools needed to implement change. We are committed to this effort and look forward to working with you and your teams to help move Tennessee forward. Our next steps would be to schedule a meeting to discuss how this initiative can benefit your agency and the individuals you serve.

Sincerely,

Doug Varney, Commissioner — Marie Williams, Deputy Commissioner

Sejal West, Assistant Commissioner, Mental Health Services — Kal Dodge, Assistant Commissioner, Substance Abuse Services

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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

21 Council on Children's Mental Health (CCMH) | Nashville

22 ACES Summit | Nashville

25-29 TMHCA Wellness Recovery Action Plan (WRAP) II Facilitator Training | Chattanooga

28 Youth Transitions Advisory Council (YTAC) | Nashville

MAY

2 TMHCA Peer Counseling | Jackson

10 Celebrating Tennessee's IPS Community | Franklin

16-20 TMHCA Wellness Recovery Action Plan (WRAP) II Facilitator Training | Nashville

29 NAMI Tennessee Vision of Hope Award Gala | Nashville

JUNE

6-7 National Council for Behavioral Health Hill Day

6-10 TMHCA Wellness Recovery Action Plan (WRAP) II Facilitator Training | Jackson

23 Joint Meeting of the Council on Children's Mental Health (CCMH) & Youth Transitions Advisory Council (YTAC) | Nashville

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.

TAMHO MEMBER ORGANIZATION HAPPENINGS

Centerstone Creates Comic Book to Combat Bullying, Second in Series

Centerstone Prevention Services, part of one of the nation's largest not-for-profit behavioral health care providers, has created its second comic book for students who are dealing with important social issues. *Smokescreen: No Time for Bullies* is available now for distribution throughout Tennessee and Southwestern Kentucky and can also be read and reprinted for free online at WhoYouWant2Be.org/comic.

Written by Centerstone Senior Media Specialist Ian Skotte, with illustrations by Nashville artist Michael Cribbs, *Smokescreen: No Time for Bullies* teaches kids the importance of not acting on impulse when provoked by a bully. The 16-page, full-color comic introduces the character Smokescreen, a student attempting to master his skills at a school for superheroes. A fellow student, the Manipulator, and her henchman, Hippo, attempt to lure Smokescreen into retaliating against their bullying, which results in the hero being kicked out of school. Luckily for Smokescreen, he develops the ability to turn back time with the help of his superhero schooling. Unfortunately, in real life that can't happen.

"That is something we want to teach students," says Centerstone Program Coordinator Ashleigh Hall, a Certified Prevention Specialist. "Real life choices have a lasting effect on you and those around you."

By creating this comic, Centerstone aims to reach students and help them make the right choice when facing a bully – or even seeing a fellow student being bullied. There's even a special Q&A insert included to stimulate conversation among students about the educational information they just read.

Tabatha Floyd, team leader for Centerstone's Violence and Bullying Prevention services, points out that more often than not, bullying stops within 10 seconds of a bystander stepping in to help.

"There are scenes in this new comic book where bystanders comment about the degree of bullying taking place," Floyd said. "What we'd like to see is students stepping in and saying something – or telling a teacher or an adult about what's happening – rather than sitting back and watching the bullying unfold."

Prevention specialists at Centerstone will distribute *Smokescreen: No Time for Bullies* during presentations at schools where the organization is already present and will give copies to teachers at those locations. The comic will also be distributed at various school and community events, shared with counselors and promoted online via social media.

This isn't Centerstone's first go around in the comic world. *Spark and the Sext Message that Nearly Destroys Her* recently won a 2015 Davey Award from the Academy of Interactive and Visual Arts.

"My students really enjoy these comics," said Kristi Huffine, a school counselor at Ellis Middle School. "I really liked the insert. It gives us a way to discuss these topics after reading."

Through its Teen Pregnancy Prevention services, Centerstone has a presence in schools, community centers and juvenile detention facilities throughout Tennessee and Kentucky. Learn more, read the comics or make contact at WhoYouWant2Be.org. To learn about other Centerstone services, visit Centerstone.org.

The publication of *Smokescreen: No Time for Bullies* was made possible by a grant from the Department of Health and Human Services, Office of Adolescent Health, Grant Number **TP1AH000030**; its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Department of Health and Human Services.

Cherokee Health, UT Get Grants to Help Prevent Childhood Obesity

ARTICLE REPRINT | Knoxville New Sentinel | January 27, 2016 | Kristi L. Nelson | http://www.knoxnews.com/business/cherokee-heath-ut-get-grants-to-help-prevent-childhood-obesity-2a441018-8a56-52be-e053-0100007f1107-366758821.html

Nearly 40 percent of Knox County schoolchildren are overweight or obese — and among children 4-10 years old getting care at Cherokee Health Systems, that percentage is even higher.

But Cherokee and the University of Tennessee have a plan to change that: Each is receiving government funding to begin a two-year pilot program to prevent childhood obesity and Type 2 diabetes.

For Dr. Hollie Raynor, professor in public health nutrition, and her research team, it's a continuation of NIH-funded work begun in 2011 to study the effectiveness of trying to change the course of childhood obesity in the place the children receive primary health care.

For Cherokee, which will receive $108,000 in National Institutes of Health grant funds, it's an opportunity to work with Raynor and UT to provide resources and intervention to underserved East Tennessee families.

The Prevention Plus program will be tailored to fit the needs of Cherokee's patient families. Behavioral health consultants at Cherokee will conduct the program, which gives families individualized physical activity and diet recommendations; a scale; a wall-growth chart; a body mass index wheel and chart; intervention diaries; a six-month subscription to MyPlate nutrition newsletters; and other tools. Cherokee and UT will collaborate to design the program and track its results.

Families who receive care at Cherokee's Alcoa, Knox County Pediatrics, Maynardville, Seymour and Talbott clinics may be eligible to participate.

Dr. Parinda Khatri, chief clinical officer at Cherokee, one of the primary collaborators on the project, said half of the households with children receiving care at Cherokee are "food insecure" — they lack reliable, consistent access to enough affordable, nutritional food.

"This is a very prestigious award for Dr. Hollie Raynor and her team at the University of Tennessee, and we are ecstatic to be a part of it," Khatri said. "Together, we will be able to conduct research that leads to improved diabetes and obesity prevention and even improved treatment in routine health care settings."

Bowen Appointed Vice President of Integrated Care, Quality &Compliance

Frontier Health is pleased to announce the appointment of Diane Bowen, M.Ed., as Vice President of Integrated Care, Quality and Compliance.

Diane Bowen, MEd
Vice President of Integrated Care, Quality and Compliance
Frontier Health

With Frontier since 1990, Bowen was previously Director of Performance Improvement. She will continue to oversee Compliance, Risk Management, HIPPA, Performance Improvement, CARF Re-Accreditation, staff education, the implementation of quality initiatives and development.

"Among her many important duties, Diane has played an essential role in ensuring that Frontier Health is successful with initiatives such as Meaningful Use, Medicare's Physician Quality Reporting System and CARF reaccreditation," said Frontier President and CEO Teresa Kidd, Ph.D. "Healthcare delivery and payment reform is changing the nature of our business rapidly and we are moving toward an Integrated Care model to increase preventive care and chronic disease management resulting in improved outcomes, lower costs and higher quality care."

Bowen is very involved in the community. She helped a local United Way's implementation of quality and outcome measures for member agencies and the organization, helped facilitate Community Focus Groups to identify needs and service gaps. She is a national accreditation surveyor for the Commission on Accreditation of Rehabilitation Facilities (CARF); on the TAMHO Quality Committee; and the Mental Health

Tennessee Department of Mental Health and Substance Abuse Services

PLANNING & POLICY COUNCIL

June 14, 2016
August 16, 2016
December 13, 2016

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 | First 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

Corporations of American Quality Collaborative, which is an initiative to build quality improvement capacity, improve performance and promote transformational change in mental health service delivery.

Diane has presented, "Tennessee Outcome Measurement System," to the Mental Health Corporations of America; and has presented to state and local agencies on managed care, quality improvement, eating disorders, relapse prevention and co-occurring disorders. She has a master's degree in Counseling Psychology from East Tennessee State University, and a bachelor's degree in psychology from King College.

Frontier Health is the region's leading provider of behavioral health, mental health, substance abuse, co-occurring, intellectual and developmental disabilities, recovery and vocational rehabilitation services, and has been providing services since 1957. Its mission is to provide quality services that encourage people to achieve their full potential. For more information about Frontier Health's services, visit www.frontierhealth.org or call 423-467-3600.

Centerstone's Crisis Services Expands Suicide Prevention Efforts

Two grants totaling more than $5 million will increase suicide prevention efforts in Tennessee

Centerstone, one of the nation's largest not-for-profit providers of community-based behavioral health and addiction services, has expanded its Crisis Care Services in Tennessee with two new, statewide suicide prevention grants totaling more than $5 million.

Aiming to lower suicide deaths, reduce suicide attempts and promote long-term engagement in mental health services among youth and working-age adults, the combined initiative is funded by grants from the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Center for Mental Health Services (CMHS), awarded to the Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) in partnership with Centerstone, Centerstone Research Institute and Tennessee Suicide Prevention Network.

With these grant dollars, Centerstone has launched two enhanced follow-up tracks for Tennesseans at high risk of attempting suicide. SAMHSA data shows emergency room (ER) visits related to suicide attempts are increasing, while the number of ERs around the U.S. has decreased "at an alarming rate," according to *Journal of the American Medical Association.* The result often can be the discharge of suicide attempt survivors who haven't been connected appropriately to follow-up care due to ER overcrowding.

"Survivors of suicide attempts are at their highest risk following discharge, and up to 70 percent of survivors never attend their first follow-up counseling appointment," said Jennifer Armstrong, director of Crisis Care Services at Centerstone. "With our new enhanced services, we're increasing our reach, partnering with local hospitals and taking an in-depth approach to outreach and follow-up support that reduces relapse, suicidal ideation and suicide attempts. Our goal is to support our clients until we're confident they are safely supported beyond our care."

CONNECT is a five-year suicide prevention effort expected to serve at least 6,000 youth and young adults ages 10 to 24, and TARGET is a three-year grant program expected to serve over 3,500 working-age adults ages 25 to 64.

Facets of both plans being implemented by Centerstone's dedicated team of experts include face-to-face and telephone follow-up communication. A notable extra feature of TARGET is a technology package for enrollees that incorporates use of iPhones and Fitbits to encourage communication and to help track activities and health habits. Centerstone Research Institute is taking the lead on data collection and analysis for both grants with the goal of developing shareable best practices that will help save lives.

At pilot locations, early results of these new grant services are showing great success. To date, a higher number of clients have been linked to follow-up care, and no subsequent suicide attempts have been reported. The list of statewide partnerships, in various stages of program implementation, continues to grow as Centerstone conducts consultation with select emergency departments, inpatient psychiatric facilities and primary care physicians, assisting in standardizing suicide care, including referral of high risk patients to appropriate services.

Centerstone is widely known for its Crisis Call Center and pioneering suicide prevention efforts and has been recognized by major U.S. publications as well as The White House. Leaders at the organization have been instrumental in supporting the National Action Alliance's Zero Suicide in Health and Behavioral Health Care initiative, implementing effective suicide prevention protocols throughout Tennessee and championing the cause at events in Washington, D.C., Vancouver, Canada, and Oxford, England.

To access Centerstone's Crisis Care Services, call 800-681-7444. Experts are available 24 hours per day, 7 days per week.

For more information about Centerstone, please call 888-291-4357 or visit www.centerstone.org.

Cherokee Health Systems' Chief Clinical Officer Appointed to Bluecare Tennessee Advisory Panel

ARTICLE REPRINT | The Chattanoogan.com | February 22, 2016 | http://www.chattanoogan.com/2016/2/22/318548/Cherokee-Health-Systems-Chief-Clinical.aspx

Parinda Khatri, PhD
Chief Clinical Officer
Cherokee Health Systems

Dr. Parinda Khatri, chief clinical officer of Cherokee Health Systems, has been appointed to the BlueCare Clinical Advisory Panel on Population Health and Integrated Primary Care. The panel, which meets twice per year, consists of providers from across the state of Tennessee who use their knowledge to improve health outcomes and access to primary care services for the nearly 500,000 members of BlueCare Tennessee.

BlueCare Tennessee explained that Dr. Khatri was appointed to this prestigious board because of her long-standing history of providing clinical care in the East Tennessee community and her commitment to continuous improvement of care for all of her patients, including those that are members of BlueCare Tennessee.

In her role at Cherokee Health Systems, Dr. Khatri provides oversight and guidance on clinical quality, program development and management, workforce development, clinical research, and clinical operations for blended primary care and behavioral health services. She also trains, consults, and presents extensively on integrated care in addition to leading Cherokee Health Systems' APA-accredited Psychology Internship Program.

For more information about Cherokee Health Systems, please call (865) 544-0406.

Vanderbilt Psychiatric Hospital Boss Leaving for Maryland Job

CEO had held position only since February

ARTICLE REPRINT | Nashville Post | April 5, 2016 | Geert De Lombaerde | http://www.nashvillepost.com/business/health-care/behavioral/article/20492873/vanderbilt-psychiatric-boss-leaving-for-maryland-job

Harsh Trevedi, MD
CEO
Vanderbilt Psychiatric Hospital

The newly appointed — and first — CEO of Vanderbilt Psychiatric Hospital will soon leave that post to lead a prominent Baltimore-based mental health and substance abuse system.

Harsh Trivedi, who came to Vanderbilt six years ago after working at Brown University and Bradley Hospital/Brown Medical School, has been named president and CEO of Sheppard Pratt Health System. Word of his appointment comes less than two months after the chief medical officer of Vanderbilt Behavioral Health was tapped to lead Vanderbilt Psychiatric Hospital and coordinate behavioral health services across the Vanderbilt University Medical Center complex.

Trivedi will begin his role at Sheppard Pratt on July 1, succeeding Steven Sharfstein, who has been its CEO for nearly 25 years. The system runs two psychiatric hospitals, 12 special education residential and day schools and a network of outpatient and telepsychiatry sites in Maryland. It also has not-for-profit affiliates and has partnered on various community housing, rehabilitation, crisis beds and case management programs as well as three research initiatives.

"Harsh is respected in the field both for his work in behavioral health as a psychiatrist associated with Harvard, Brown, and Vanderbilt universities, and as an administrator," said Sharfstein. "He is absolutely the right person for the job, and we're excited to see him bring new energy and vision to the health system."

Heather Combs Joins Centerstone as Vice President of payer Contracting and Strategy

Payer contracting veteran to strengthen organization's payer coordination and relationships

Heather Combs
Vice President of Payer Contracting and Strategy
Centerstone

Centerstone, one of the nation's largest not-for-profit providers of community-based behavioral healthcare, recently announced the addition of Heather Combs as vice president of payer contracting and strategy.

In her new role, Combs will be responsible for developing payer strategies, negotiating contracts, developing and managing client relations with the managed care industry, and overseeing emerging healthcare payer organizations. She will provide strategic leadership related to the development and management of payer contracts, optimizing Centerstone's revenue, margin, and growth in alignment with its care delivery strategy.

"We are excited to welcome Heather to our team and are confident that her background and expertise in healthcare will positively affect the way we work with others in our industry," said Debbie Cagle, chief marketing officer of Centerstone. "As the healthcare industry evolves and Centerstone grows, she will play a critical role in ensuring that we are able to provide quality care to as many people as possible."

Combs joins Centerstone with more than 16 years of experience working in the healthcare field in managed care contracting, account management and sales. She spent a decade working at national managed healthcare providers Cigna and

UnitedHealthcare. She also served as director of account management for MedSolutions' largest payer account, with responsibility for implementation, strategic planning and contract fulfillment.

Combs brings extensive experience in provider contracting with large, complex provider organizations as well as in healthcare analytics. Her contacting experience includes negotiating on behalf of ACOs, large hospital systems, physician groups, and ancillary providers.

Combs is a graduate of the University of Kentucky at Lexington, where she received her bachelor's in finance.

For more information about Centerstone, please visit www.centerstone.org.

Pathways to Mental Health

ARTICLE REPRINT | The Jackson Sun | March 29, 2016 | David Thomas| http://www.jacksonsun.com/story/news/2016/03/29/state-of-pathways-delivered-during-wth-board-meeting/82403824/

Pathways Behavioral Health Services became the focal point when the board of trustees at Jackson-Madison County General Hospital held its March meeting Tuesday.

Pathways is the result of the 1995 merger between Northwest Counseling and West Tennessee Behavioral centers that were formed as a result of the Community Mental Health Act of 1963.

"Pathways Behavioral Health Services is a vital part of the health care spectrum provided by West Tennessee Healthcare. We have 240 staff members who served over 9,900 clients last year in eight different locations," said Dr. Lisa Piercey, executive vice president, West Tennessee Healthcare. "Moving forward, we are focused on integrating behavioral health services with primary care to offer a more comprehensive approach to health and wellness in our community."

During her special report with Pam Henson, executive director of Pathways, Piercey said the breakdown consists of 9,900 patients — 54 percent female, 46 percent male.

Ages 12 and under make up 10 percent of the patients; ages 13 to 17 make up 10 percent; ages 18 to 29, 19 percent; ages 30 to 64, 56 percent; and for those age 64 and older, 5 percent.

There are two locations in Jackson, and one each in Dyersburg, Milan, Brownsville, Lexington, Union City, and Tiptonville in Lake County.

Pathways offers 24-hour programs; an inpatient psychiatric hospital; inpatient detoxification hospital; crisis respite; a crisis triage walk-in center, a mobile crisis unit and a 24-hour crisis line.

Outpatient services include outpatient counseling (mental health and substance abuse); medication management; intensive outpatient programs; employee assistance program; pharmacy (Jackson office only); group counseling; case management services and a psychosocial rehabilitation program (Union City only).

Housing is available at the Preston Street House and the Berry Street House, and peer support centers are located in Jackson at the Rainbow Center; Hope Center in Dyersburg; and the Comfort Center in Lexington.

The staff includes psychiatrists, nurse practitioners, counselors, case managers, crisis responders, grant staff, nurses, psychiatric technicians, certified peer support specialists, office staff and medical records staff.

Patient volumes average nine per day — 10 at the crisis stabilization unit. Mobile crisis has 3,800 evaluations yearly, outpatient services has 105,000 visits each year, and at peer support centers, there are 1,600 encounters per year.

TennCare handles 55 percent of the payor mix; self-pay and grants covers 22 percent; commercial insurance 12 percent; and Medicare, 11 percent.

Special grant programs include treatment and recovery for youth, and action items include gaps in identification and tracking, and continued recruitment of psychiatrists.

WATE and WBIR Recognized by Helen Ross McNabb Center on Behalf of TAMHO for Their Media Coverage Efforts in 2015

Emily Scheuneman, *Director of Community Relations,* Helen Ross McNabb Center

Hailey Holloway, *Reporter,* WATE

Emily Scheuneman, *Director of Community Relations,* Helen Ross McNabb Center

Martha Jennings, *News Director,* WBIR

Kara McFarland, *Director of Community Relations,* WBIR

Jeff Lee, *General Manager,* WBIR

STATEWIDE HAPPENINGS

Haslam Introduces Fiscal Year 2016-17 Budget Amendment

Legislation proposes additional investment for local transportation needs; student enrollment growth

Tennessee Gov. Bill Haslam today unveiled additions to the FY 2016-2017 budget that will be considered by the 109th General Assembly in the coming weeks.

The appropriations amendment to HB2629/SB2653 follows closely the governor's original budget proposal presented to the legislature on February 1, and it recognizes $60 million in savings from state departments that was returned to the General Fund.

"Earlier this year we presented a budget proposal that took advantage of the unique opportunity this state has because of a strengthening economy combined with the hard work and discipline of our departments and the conservative fiscal strategy employed by the General Assembly, our constitutional officers and this administration," Haslam said. "This amendment builds on our priorities by making thoughtful and strategic investments in services across state government."

In the amendment, the governor proposes adding $12 million to the $130 million originally presented to repay the state's Highway Fund. If the budget is approved as amended, $42 million of the total $142 million would go toward local governments' transportation needs as part of the state aid program.

Other notable funding priorities in the governor's budget amendment include:

- $18.2 million to restore a 1 percent provider rate reduction in TennCare;
- $9 million to fund additional K-12 student enrollment growth during the current year;
- $2.43 million for a 1 percent provider rate increase with the Department of Intellectual and Developmental Disabilities (DIDD);
- $2.07 million in additional funding for non-formula units in public higher education;
- $1.3 million to increase the work being done with adverse childhood experiences (ACE);
- $1.04 million to leverage Tennessee State University's land grant status;
- $1 million to support growth in the state's captive insurance program; and
- $147,400 for an additional position in the state's Office of Open Records Counsel.

The appropriations amendment is customarily introduced in the final weeks of the legislative session each year for consideration and approval by the General Assembly. The budget amendment is scheduled to be filed Thursday, April 7. Finance and Administration Commissioner Larry Martin begins presentations on the amendment to finance committees of the state Senate and House of Representatives Tuesday, March 29.

Tennessee Law That Punishes Mothers of Drug Dependent Babies to End

ARTICLE REPRINT | The Tennessean | March 23, 2016 | Joel Ebert | http://www.tennessean.com/story/news/politics/2016/03/22/tennessee-law-punishes-mothers-drug-dependent-babies-end/82141832/

A controversial law that criminalizes women who give birth to drug-dependent babies will sunset later this year after a bill in front of a House committee failed Tuesday.

The legislation, sponsored by Rep. Terri Lynn Weaver, R-Lancaster, failed to receive the necessary approval from the Criminal Justice subcommittee, as a result of a tie vote on the six-member committee.

Tennessee made national headlines in 2014 after lawmakers passed a law to make it the first state in the nation to penalize women who give birth to babies who test positive for narcotics.

Weaver's bill specifically sought to extend the law beyond its July 1 sunset date.

Rep. Mike Stewart said he worried the unintended consequences of the law have resulted in people being discouraged from seeking drug treatment. He said the law has even caused some women to seek an abortion.

Reiterating Stewart's point, Charles Harmuth, a doctor practicing addiction medicine in Coffee County, said, "I do feel that in my practice and also in the meetings that I attend, women do discuss having had abortions and also their fear of being prosecuted."

Noting that he has seen an increase in the number of therapeutic abortions since 2014, Harmuth said Weaver's bill would not give women the freedom and trust in the system to come out of the shadows and seek treatment.

"I beg of the committee to look at prevention and treatment as opposed to punitive actions and possible incarceration," he said.

Last week, one of the first women to be charged under the law told the committee that extra jail time would not help mothers get clean and it even discouraged mothers from getting prenatal care.

Rep. William Lamberth, R-Cottontown, questioned Harmuth, who cited state Department of Health totals to make his case against the law, before saying, "It's too early to be able to decide those numbers are caused by this bill."

Tony Clark, district attorney for the First Judicial District, who noted that East Tennessee leads the state in drug-dependent children, said when the bill was introduced two years ago the state had 865 drug-dependent babies born.

"We cannot let this bill die," he said, questioning the argument being made about women seeking abortions as a result of the law. Clark said he has had only one out of 30-plus women go to jail as a result of the law.

"And that was by her choice, because she refused treatment. The rest have gone through treatment," he said, explaining that the law is not intended to put women in jail but to get them to seek treatment.

Before the committee's vote, Rep. Micah Van Huss, R-Jonesborough, who had been critical of the law until it was amended on Tuesday, said he planned on supporting the measure.

The amendment made several changes to the bill, including a provision aimed at encouraging women to remain under prenatal care until the child is born.

Rep. Andrew Farmer, R-Sevierville, sided with the committee's two Democrats — Reps. Mike Stewart, D-Nashville, and Raumesh Akbari, D-Memphis — resulting in the bill's defeat.

Allison Glass, state director of Healthy and Free TN, praised the action.

"This would have extended a dangerous and harmful law that has jailed pregnant women and new mothers who have used drugs, instead of working to ensure that they have access to effective treatment options," she said. "Health and drug treatment professionals agree that treatment for addiction is critical, but they also agree that bills that focus on punitive measures in order to coerce people into getting treatment simply are not effective. In fact, this law has harmed the very people it was supposed to help."

Haslam Announces Departure of TennCare Director Darin Gordon

Gordon is the longest serving Director of TennCare in State history

Tennessee Gov. Bill Haslam today announced TennCare Director and Deputy Commissioner of Health Care Finance and Administration Darin Gordon will enter the private sector at the end of June, leaving a nationally respected legacy of stability and innovation for a program serving some of Tennessee's most vulnerable populations.

Started in 1994, TennCare is the state's Medicaid program, a $10.5 billion health care enterprise that provides services to nearly 1.5 million Tennesseans and has earned customer satisfaction ratings above 90 percent for the past seven years.

Having taken on his role in 2006, Gordon is not only the longest serving TennCare director in state history but also is currently the longest serving director in the country. During the 12 years prior to his appointment, the position changed hands 10 times.

Under Gordon's leadership TennCare has maintained the lowest cost trend in its history, made significant improvements in a substantial number of quality measures, and has been nationally recognized for innovations in managed care and payment and delivery system reform.

"Across the country states face the same challenge: a Medicaid program that takes up more and more of the state's budget, pulling money away from other service areas," Haslam said. "The impact of Darin's steady leadership extends well beyond TennCare. Darin has quite literally saved Tennessee taxpayers hundreds of millions of dollars by keeping the program's costs low, allowing Tennessee to invest in K-12 education and other critical service areas. He has managed to achieve that while still running a program with a 95 percent customer satisfaction rating.

"Darin brought much needed stability to the program, guiding it through difficult times, and all of Tennessee is indebted to his incredible service," Haslam added.

TennCare gained national recognition as a model of an innovative, well-run Medicaid managed care program during Gordon's tenure. His contributions extend beyond Tennessee, having been elected by his peers to serve as president of the National Association of Medicaid Directors.

"I will always be grateful to Gov. Haslam and former Gov. Bredesen for giving me the rewarding opportunity to serve the people of Tennessee in such a meaningful way as the director of TennCare," Gordon said. "It has been an absolute honor to be granted this once in a lifetime experience. During my public service, I have been incredibly fortunate to have worked with such an exceptional team of hard working and dedicated people. Through the efforts of so many, we have successfully transformed TennCare to one of the most highly regarded programs in the country."

Gordon started his career in state government as an intern for the Senate Finance Committee in 1996, and he has more than 18 years of experience in public health care finance and management. Prior to 2006, Gordon held key executive management positions within TennCare as the director of Managed Care Programs and chief financial officer.

He and his wife, Shawn, have three children: Matthew, Libby and Abby, and they attend Christ Church in Nashville.

Gordon's last day will be June 30 as he continues work on TennCare's waiver extension and aids in the transition to new leadership with the program.

Tennessee's Statewide Council on Homeless Reconvenes

Governor Bill Haslam, by Executive Order, is reconstituting the statewide council to focus on ending homelessness among Tennessee veterans, chronically homeless, families, and children

Tennessee Department of Mental Health and Substance Abuse Services' Commissioner E. Douglas Varney, by the authority of Governor Bill Haslam, is reconstituting the Governor's Interagency Council on Homelessness, with the aim of not just reducing but eliminating homelessness among veterans, the chronically

homeless, families, and children.

"When he was mayor of Knoxville, Bill Haslam realized the high cost and impact homelessness has on neighborhoods, communities, governments and entire cities and regions," said Commissioner Varney. "He saw the need and addressed it. Governor Haslam realized it takes a coordinated effort to bring about change, both in policy and how we perceive individuals who struggle with homelessness."

The Governor's Interagency Council on Homelessness will coordinate Tennessee's efforts, and identify, develop, and ensure sustained partnerships among supporting agencies, service providers, and those who advocate for people experiencing homelessness.

The Statewide Council on Homelessness will focus on addressing challenges in partnership with other local, state, and federal organizations. The council may include representatives deemed necessary by Commissioner Varney, including, but not limited to, representatives of the following:

- Department of Mental Health and Substance Abuse Services
- TennCare – Tennessee Healthcare Finance Administration
- Tennessee Department of Health
- Tennessee Department of Veterans Services
- Tennessee Housing Development Agency
- Shelby County Government
- Metro Nashville-Davidson County Government
- Persons who have experienced homelessness, in recovery from serious mental illness, substance use disorders, or co-occuring substance use and mental health issues
- (SSI) Supplemental Security Income and (SSDI) Social Security Disability Income Outreach, Access, and Recovery
- Community-based, CABHI service providers (Cooperative Agreement to Benefit Homeless Individuals)
- U.S. Substance Abuse & Mental Health Services Administration
- Governor's designee, to be selected by the Governor

"The challenges we face with homelessness in Tennessee affects us all," said Varney. "Our chronically homeless, veterans, families, and especially children deserve a coordinated statewide and community-based effort."

Strategic and time-sensitive goals have been established to address and solve homelessness among the three primary target populations in Tennessee with the objective to effectively ending homelessness among the most vulnerable citizens in Tennessee by 2020.

"If we do nothing, the end result is a very high price," said Varney. "Many homeless cost studies show that there is a savings to governments and communities that invest in providing the right blend of support and services to individuals who are experiencing homelessness and chronic homelessness."

As homelessness will never be completely eliminated in Tennessee, representatives of the reconstituted Statewide Council on Homelessness are confident, with established support services in place, no one will be homeless longer than 30 days.

"Securing housing, temporary supplemental income, Social Security benefits, employment, treatment for mental health and substance use, and other social services is a part of the plan and will result in cost savings," said Varney. "When you consider the alternative and expense of doing nothing, not to mention human suffering, this is a logical, economical and most of all a compassionate approach."

The council will make an annual progress report to the Governor at the end of each fiscal year and shall exist for as long as resources are available, as determined by Commissioner Varney in consultation with the Governor.

Anxiety and Chronic Depression TAG Members Recently Announced

The Tennessee Health Care Innovation Initiative has announced the Wave 5 Episodes of Care that include Anxiety and Chronic Depression. This TAG will meet during the months of March, April and May 2016 to design this episode, identify triggers for the episode, and determine what quality metrics should be used to evaluate quality care. TAMHO is pleased to have several member participants on the TAG.

Anxiety and Chronic Depression TAG Members

- **Jonathan Becker, DO,** Vanderbilt University Medical Center
- **Susan Bell, LCSW,** Alliance Healthcare Services
- **Mona Blanton Kitts, LCSW,** Helen Ross McNabb Center
- **Howard Burley,MD,** Department of Mental Health and Substance Abuse Services
- **David Cook, LPC-MHSH,** Professional Care Services of West TN
- **Rick Donlon, MD,** Resurrection Health
- **Michelle Fiscus, MD,** Cool Springs Pediatrics
- **Jill Forbess, MD,** Brentwood Pediatrics
- **TroyGilson, MD,** Volunteer Behavioral Health Care
- **Jami Ivey, LCSW,** Generations Mental Health Center
- **PushpendraJain, MD,** Cookeville Medical Clinic
- **Jennie Mahaffey, MD,** UT Erlanger Behavioral Health
- **Susan McGuire, MD,** Parkridge Valley
- **Kim Rush,LPC, MHSP,** The Guidance Center

Changes to HIPAA Privacy, Rule May Help Distinguish Mental Illness from Violence

Administration's changes to the HIPAA privacy rule reflect an effort to balance a number of competing interests – those who favor gun control, those who want to protect second amendment rights, those who provide diagnostic and treatment services to people with mental health concerns, and people who have mental illnesses.

It makes no changes to the HIPAA law or Brady Act, but it clarifies and limits the information that can be reported to the FBI's

National Instant Criminal Background Check System (NICS).

Since 1993, when the Brady Act was passed, (and really since 1968 when the Gun Control Act was passed) it has been illegal for the following to own or possess firearms: "individuals who have been involuntarily committed to a mental institution; found incompetent to stand trial or not guilty by reason of insanity; or otherwise have been determined by a court, board, commission, or other lawful authority to be a danger to themselves or others or to lack the mental capacity to contract or manage their own affairs, as a result of marked subnormal intelligence or mental illness, incompetency, condition, or disease." (45 CFR Part 164, 1/4/16)

The NICS was intended to include the names of all of those individuals who could not possess firearms legally. This presents no problem for judicial system reporters. They add the information to their state repository, which in turn is supposed to report it to the NICS.

However, in some states, the repository is housed in a HIPAA "covered entity," – a provider covered by the HIPAA law. And in some cases, a HIPAA-covered entity – not a court – makes the determination as to whether an individual meets the standard for inclusion in the registry and orders an involuntary commitment.

While HIPAA allows for the sharing of an individual's protected health information (PHI) without the individual's authorization for law enforcement purposes, it was not clear to these covered entities that they could report the names for inclusion in the NICS database without violating a patient's privacy.

Therefore, what the rule says is this: (1) a firearms control data center housed in a HIPAA-covered entity can share limited demographic information with the national registry; and (2) a HIPAA-covered entity that is participating in a judicial proceeding to determine that a person cannot lawfully have a firearm (such as ordering an involuntary commitment) can share limited demographic information with the registry.

The new provision does <u>not</u>:

- Allow for the addition sharing without authorization of diagnosis or treatment information of any kind, even for people who cannot legally possess firearms;
- Affect anyone who voluntarily seeks mental health services of any kind; i.e., even if they say they have an intent to harm themselves or others a provider cannot simply add their name to the registry – they must go through the judicial process and be found to meet one of the categories in the existing law;
- Allow for the additional sharing of information between or among covered entities or their business associates without authorization;
- Have any effect on HIPAA-covered entities that do not house the data repositories or make determinations regarding involuntary treatment or legal competency;
- Add anyone new to the list of people who are not legally able to possess firearms.

This change will affect a relatively small number of people (maybe in the hundreds, maybe in the thousands). So why does it matter?

It has already been determined that it is illegal for the individuals whose names will be added to the list to own or possess firearms. So this might prevent a tragic event without infringing on the rights of anyone who can possess firearms.

More importantly from the perspective of those of us who advocate daily on behalf of individuals with mental health conditions, this might also help to draw a greater distinction in the minds of the public between those who have mental illnesses and those who are violent. The following diagram will help to explain why:

People with violent tendencies and even people with serious mental illnesses are two distinctly different groups of people. In some instances, they overlap, but most often they do not. Those who think that a diagnosis of mental illness should be a reason to deny firearms possession are off-track.

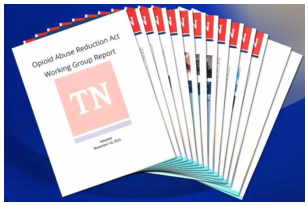
Millions of people have mental illnesses and not a violent thought or idea. Millions of other people have violent thoughts and not a mental illness.

The HIPAA change implicitly acknowledges this, and this is very important to those of us who are advocates.

It is our hope that people who embrace the change will do so not only for its carefully crafted limitations on the sharing of additional information and because it will add to the national registry some more people for whom it is already illegal to possess firearms, but also because its helps to clarify the distinctions we must continually make between those who have mental illnesses and those who have violent tendencies.

Tennessee Opioid Abuse Reduction Group Recommends More State Action

ARTICLE REPRINT | WJHL News Channel 11 | January 18, 2016 | Nate Morabio | http://wjhl.com/2016/01/18/tennessee-opioid-abuse-reduction-group-recommends-more-state-action/



Tennessee's Opioid Abuse Reduction Act working group thinks Tennessee should do more to fight its painkiller epidemic and reduce the number of overdose deaths.

Lawmakers created the group last year. The state recently released a 265-page report, which includes four recommendations.

"I think we've made great progress, but it's such a huge thing," Frontier Health Senior Vice President Dr. Randall Jessee, a member of the working group, said. "It has such impact and power. There's so many people involved in it that we still have a drop in the bucket."

As we reported in November, 580 people in Northeast Tennessee died from 2009 to 2014 from drug overdoses; most of those people from pain pills.

Dr. Jessee says Tennessee has made strides in tackling the problem, but he says a lack of funding to properly treat patients is holding the state back.

"Limited dollars, that's handcuffing us more than anything else," he said. "I think we have more information, we have more ability to take knowledge and use it than ever before. What I'd like to see is funding for long-term treatment. We have the ability to treat people, but it's short-term."

According to Dr. Jessee, most patients who need long-term help are uninsured. He says the proper residential treatment costs anywhere from $200 to $300 a day and can last up to a year.

"I'm talking about full behavioral health addiction treatment that deals with the person," he said. "Extended intense treatment is necessary to deal with these individuals. You need a really structured process with the person. They need to learn how to live all over again."

Among other things, the group as a whole is recommending lawmakers extend the law behind Tennessee's controlled substance monitoring database. The law, which requires healthcare workers to review a person's substance abuse history before prescribing certain drugs, is set to expire in June.

Sen. Steve Dickerson, (R-Nashville), was one of the lawmakers who helped create the working group. The state senator, who is a pain management doctor, continues to push for more access to tamper proof medications; pain pills that are more expensive, but are made to prevent drug abuse. He says those medications don't allow abusers to crush their pills and snort them or take them in other ways. Instead, they have to take them the proper way.

He says that could be a short-term solution. Long-term, he says a lot of it comes down to money.

"In Tennessee we do not have enough mental health professionals to help with this group of patients," he said by phone Monday. "Additional funding and focus on that is one of the cornerstones."

Dr. Jessee says the state also needs to do more to educate doctors and the public. He referenced a report by National Safety Council Medical Advisor Dr. Donald Teater, who met with the working group. According to Dr. Jessee, the answer doesn't always have to be prescribe first.

"The information out there now is you can take two ibuprofen and deal with your pain much better than taking opioids," he said.

Dr. Jessee says opioids are still considered effective for cancer and end-of-life situations.

CLICK HERE TO READ: Opioid Abuse Reduction Act Working Group Report (.pdf) [https://mgtvwjhl.files.wordpress.com/2016/01/opioid-abuse-reduction-act-working-group-report.pdf]

Tennessee Transforms Response to Children in Crisis

Record number of face-to-face crisis assessments in 2015 for children and youth

When a child or young person is experiencing a mental health crisis, response time by a trained youth crisis specialist is of the essence. This rapid response is helping to ensure more Tennessee children and youth in crisis situations receive a face-to-face assessment from a trained professional as soon as possible.

For the Tennessee Department of Mental Health and Substance Abuse Services, that goal translated into a new focus and realignment of the state's system of care for children and youth experiencing a mental health crisis.

In 2015, crisis services specialists conducted 10,422 face-to-face assessments of children and youth in crisis, the most ever in the department's history. That compares to 8,753 in 2014, representing a 19% increase in these vital assessments. And of the more than 10,000 assessments completed in 2015, an impressive 92% (or 9,483) occurred within the first two hours of a crisis event.

Children & Youth Crisis Assessments in Tennessee
2015 - 10,442 face-to-face mental health assessments
2014 - 8,753 face-to-face mental health assessments

"The quicker children and youth crisis responders can engage and assess a mental health emergency, the more likely intervention will reduce the trauma and long-term impact of a child's experience," said E. Douglas Varney, Commissioner of the Tennessee Department of Mental health and Substance Abuse Services. "In these situations, time is absolutely of the essence. When it comes to a young person or child suffering abuse, neglect, or mental

health crisis we all have the responsibility to act fast and with the utmost compassion."

As a result of this enhanced and more time-sensitive focus, whenever possible first responders are going directly to where a child is first identified to be in crisis. In most cases it is a healthcare worker, doctor, or nurse in an emergency room or hospital who identifies a mental health situation and knows to alert the nearest mental health professional.

Top 4 Tennessee Youth Crisis Assessment Locations

53% hospitals and emergency rooms

19% home or residence, 15% school, 4% jail

A key development in 2014 that helped lead to more timely youth crisis assessments in 2015 is the engagement and recruitment of more mental health crisis providers in Tennessee who are qualified to offer services to children and youth.

In 2014, children and youth crisis response was handled by only one provider for the entire state. In 2015, mental health providers from Frontier Health, Helen Ross McNabb, and Mental Health Cooperative were included, with each securing a designated service area in the state based on a competitive bidding process.

Tennessee's Children & Youth 2015 Crisis Provider Network

Frontier Health (Tri-Cities, Northeast TN)

Helen Ross McNabb (Knoxville, Knox County Region)

Mental Health Co-op (Nashville, Davidson County)

Youth Villages (Memphis, West and Central TN)

"This re-alignment of providers and resources, going from one single provider to a total of four, has resulted in a powerful and positive impact on children in crisis," said Commissioner Varney. "We're seeing significantly more children, and the level of service they receive has improved, leading to less trauma and better outcomes. By all accounts, having more providers in our statewide network is benefiting our children who are most at risk."

Of the total number of children and youth who had a face-to-face mental health assessment in 2014 and 2015, the vast majority, 69% were referred to a community mental health provider for treatment, and the remaining 31% were admitted to a psychiatric facility.

If you, or someone you care for, are experiencing a mental health emergency, call now. Help is available 24 hours a day, 7 days a week. Phone: 855-CRISIS-1 or 855-274-7471.

For more information, visit www.tn.gov/behavioral-health.

Employment and Community First

ARTICLE REPRINT | TennCare Advocates Newsletter | January/February, 2016

Employment and Community First CHOICES is a new approach to provide critical services and supports in a coordinated and cost-effective manner for individuals with intellectual and developmental disabilities that focuses on promoting integrated employment and community living as the first and preferred outcome.

Employment and Community First will target individuals with intellectual disabilities on the current waiting list for Home and Community Based Services as well as people with other kinds of developmental disabilities not currently eligible for these programs. The goal is to serve approximately 1,700 people in the first year. Implementation of this new program is slated to begin July 1, 2016.

More information about Employment and Community First is available online at http://tn.gov/assets/entities/tenncare/attachments/Amendment27ECFCHOICES.pdf.

Legislation Aims to Increase Patient Access to Lifesaving Opioid Antagonists

ARTICLE REPRINT | The Chattanoogan.com | February 19, 2016 | Author/Reporter | http://www.chattanoogan.com/2016/2/19/318351/Legislation-Aims-To-Increase-Patient.aspx

Legislation that would expand patient access to lifesaving opioid antagonists used to combat opioid overdose is headed to the Senate floor for final consideration after receiving approval in the Senate Health and Welfare Committee this week. Senate Bill 2403, sponsored by Senator Doug Overbey, would require the Tennessee Department of Health to draft a Collaborative Pharmacy Practice Agreement where standards and parameters are to be outlined for the dispensing of the medication by pharmacists.

An antagonist is a drug that blocks opioids by attaching to the opioid receptors without activating them. Opioid overdoses can be accidental from a legitimately obtained prescribed medication or as a result of the abuse of prescription opioids or heroin, and can result in death if not treated promptly.

“Prescription drug overdoses and especially overdoses of opioid pain killers continue to be a very serious problem in Tennessee,” said Senator Overbey. “This bill expands patient access to this lifesaving medication and promotes continued collaboration between pharmacists and other healthcare providers to help ensure effective strategies for the prevention and treatment of opioid overdose.”

According to the Centers for Disease Control and Prevention, 44 people die as a result of prescription opioid overdose every day in the United States. Among people 25 to 64 years old, drug overdose caused more deaths than motor vehicles crashes. The prevalence of opioid drug overdose has become such a problem that the High Intensity Drug Trafficking Area Program, which covers Blount County, has provided aid for law enforcement access to naloxone and narcan, two of the most commonly used antagonists.

Under the bill, a pharmacist must complete an opioid antagonist training program approved by the Department of Health related to opioid antagonist therapy within the previous two years to

dispense the medication. It also establishes immunity from disciplinary or adverse administrative actions, as well as immunity from civil liability, if dispensed pursuant to a valid statewide collaborative pharmacy practice agreement.

"Opioid antagonists are life-saving drugs, and the ultimate goal is not to have to use them, but rather to educate people so that prescription opioids are not misused or, in the case of those who are addicted, to get them into treatment to stop an overdose before it happens," said Senator Overbey. "This is just one of a multifaceted approach to confronting this growing problem in our state."

At least 24 other states either have enacted legislation or introduced a bill to give pharmacists some level of authority to dispense opioid antagonists at their discretion.

Tennessee Makes Strides in Saving Lives

Suicides down 7% as legislators consider suicide prevention training laws

In any given day, three people in Tennessee die by suicide. As of 2014, suicide is the third-leading cause of death for young people (ages 10-19) in Tennessee, with one person in this age group lost to suicide every week. We lose one person between the ages of 10-24 every four days, and every day we lose at least one person over the age of 45—midlife and older adults are actually at higher risk.

The latest edition of the *Status of Suicide in Tennessee* report, published annually by TSPN, addresses the problem of suicide in our state. It also highlights major innovations within the Network's outreach and awareness efforts during the past year.

In 2014, the latest year for which state-specific figures are available, both the raw number of suicide deaths and the rate per 100,000 had backed away from the all-time high noted the previous year. There were 945 recorded suicide deaths, at a rate of 14.4 per 100,000 people, down from 15.7 suicide deaths per 100,000 and 1,017 deaths reported.

However, suicide rates remain elevated among people in midlife, especially white males. Tennesseans aged 45-64 are over three times more likely to die by suicide than those aged 10-19--typically the age group that attracts most of the attention when it comes to suicide prevention efforts. Non-Hispanic whites made up 79% of Tennessee's population in 2014 but accounted for 94% of all reported suicide deaths in the state that year (747 out of 945).

Over the course of the lifespan, white males in Tennessee experience suicide rates several times higher than any other race-sex subgroup, and this distinction is especially pronounced in midlife and old age. Attention is also given to the nature of non-fatal versus fatal attempts and common suicide methods—almost two-thirds of all suicides in Tennessee involve a firearm.

"While the recent decline in suicide rates is encouraging, we at TSPN realize that even one death by

suicide is too many," explains TSPN Executive Director Scott Ridgway in the Executive Summary. "With the publication of this report, TSPN rededicates itself to the cause of preventing suicide and saving lives in Tennessee."

This year's *Status of Suicide in Tennessee* report includes several new and redeveloped sections. One new addition highlights the economic cost of suicide, not just in terms of deaths but also non-fatal

injuries. In 2014 alone, the total charges for inpatient hospitalization and emergency-department visits associated with suicide attempts in Tennessee amounted to $135.7 million. The section on methods of suicide death includes an update on TSPN's work in the area of lethal means reduction, by way of its Gun Safety Project and new brochures on suicide-proofing private residences. The new report also includes data on regional variations in suicide rates and attempts.

TSPN is currently supporting two bills related to suicide prevention currently being considered by the Tennessee General Assembly. Tennessee HB 2071/ SB 1992 would mandate the require all employees of each LEA to attend annual in-service training sessions in suicide prevention and require each LEA to develop a suicide prevention policy. Meanwhile, Tennessee HB 2317/ SB 2372 would build two hours of suicide prevention training into the licensure requirements for mental health professionals in Tennessee. More information about both of these bills is available on the website of the Tennessee General Assembly (www.capitol.tn.gov).

The *Status of Suicide in Tennessee* report has been published annually since 2012. The latest edition, along with past versions, is available online via the TSPN website (www.tspn.org/sost).

TTY line: 1-800-799-4TTY (4889)

For non-emergency information on suicide prevention, contact the

Tennessee Suicide Prevention Network at (615) 297-1077 or tspn@tspn.org.

CMS Finalizes Mental Health and Substance Use Disorder Parity Rule for Medicaid and CHIP

Final rule strengthens access to mental health and substance use disorder benefits for low-income Americans

ARTICLE REPRINT | Center for Medicaid Services (CMS) | March 29, 2016 | www.go.cms.gov/media

Medicaid Fact Sheet

On September 26, 1996, Congress enacted the Mental Health Parity Act of 1996 (MHPA), which required parity in aggregate lifetime and annual dollar limits for mental health benefits and medical/surgical benefits. The Balanced Budget Act of 1997 (BBA) generally applied certain aspects of MHPA to Medicaid Managed Care Organizations and CHIP benefits. The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) is a federal law that generally prevents group health plans and health insurance issuers that provide mental health or substance use disorder benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical benefits. The changes made by MHPAEA consist of new standards, including parity for coverage of substance use disorder benefits, as well as amendments to the existing mental health parity provisions enacted in MHPA.

MHPAEA originally applied to group health plans and group health insurance coverage and was amended by the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the "Affordable Care Act"),"), to also apply to individual health insurance coverage. Additionally, the Affordable Care Act requires non-grandfathered individual and small group plans (including those in the state and federal Marketplace) to provide coverage of mental health and substance use disorder services as one of ten essential health benefit categories and those benefits must meet parity requirements and are required benefits in Medicaid alternative benefit packages. In addition, the Children's Health Insurance Program Reauthorization Act of 2009 (Pub. L. 111-3) (CHIPRA) requires that CHIP plans that provide both medical and surgical benefits and MH/SUD benefits comply with the parity provisions of MHPAEA, in the same manner as a group health plan.

In this final rule, CMS applies certain provisions of the MHPAEA to requirements for Medicaid managed care organizations, Medicaid alternative benefit plans, and the Children's Health Insurance Program (CHIP). The rule is designed to align as much as possible with the approach taken in the final MHPAEA regulation to create consistency between the commercial and Medicaid markets. This helps to prevent inequity between beneficiaries who have mental health or substance use disorder conditions in the commercial market (including the state and federal Marketplace) and Medicaid and CHIP, and helps to promote greater consistency for these beneficiaries.

The final rule requires that all beneficiaries who receive services through managed care organizations, alternative benefit plans, or CHIP be provided access to mental health and substance use disorder benefits that comply with parity standards, regardless of whether these services are provided through the managed care organization or another service delivery system. States are required to include contract provisions requiring compliance with parity standards in all applicable contracts for these Medicaid managed care arrangements that provide services to enrollees in managed care organizations, including prepaid inpatient health plans or prepaid ambulatory health plans.

In contrast to the proposed rule, this final rule also extends parity protections to apply to long term care services for mental health and substance use disorders in the same manner that they are applied to other services.

Key Provisions for Medicaid Managed Care Organizations

Under the final rule, states that have contracts with managed care organizations are required to meet the parity requirements regarding financial and treatment limitations consistent with the regulation applicable to private insurers. States will include the cost of providing additional services or removing treatment limitations in their capitation rate methodology for affected managed care plans. By allowing changes to the managed care rate setting process, the rule also provides each state with flexibility to enable Medicaid managed care organizations to fully comply with the rule by including additional costs necessary to include extra services or remove treatment limits without changing the state's non-alternative benefit plans and state plan. In addition, the final rule requires managed care entities to make available upon request to beneficiaries and contracting providers the criteria for medical necessity determinations with respect to mental health and substance use disorder benefits. The rule also directs managed care plans to make available to the enrollee the reason for any denial of reimbursement or payment for services with respect to mental health and substance use disorder benefits.

Key Provisions for Medicaid Alternative Benefit Plans

Under the final rule, states with Medicaid alternative benefit plans are required to provide mental health and substance use disorders benefits in compliance with parity standards, regardless of the delivery system. In addition, the final rule requires the managed care plan (or in some instances the state) to make available upon request to beneficiaries and contracting providers the criteria for medical necessity determinations with respect to mental health and substance use disorder benefits. The rule directs the managed care plan or the state to make available to the enrollee the reason for any denial of reimbursement or payment for services with respect to mental health and substance use disorder benefits.

Key Provisions for CHIP Program

Under the final rule, separate CHIP programs, regardless of delivery system (including fee-for-service and managed care), are subject to parity standards. CHIP state plans that provide full coverage of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services will be deemed in compliance with the parity requirements. In CHIP plans that do not provide the full EPSDT coverage, the final rule applies parity standards in the same manner as the law applies those

standards to health insurance issuers and group health plans. In addition, the final rule requires the state or the managed care entity to make available upon request to beneficiaries and contracting providers the criteria for medical necessity determinations with respect to mental health and substance use disorder benefits. The rule directs the state or managed care entity to make available to the enrollee the reason for any denial of reimbursement or payment for services with respect to mental health and substance use disorder benefits.

This final rule is on display at https://www.federalregister.gov/public-inspection and will be posted on https://www.federalregister.gov/.

FREQUENTLY ASKED QUESTIONS:

Q1. How does the final rule impact Medicaid and the Children's Health Insurance Program?

A1. Under this final rule, CMS applies certain mental health and substance use disorder parity provisions of the Mental Health Parity and Addiction Equity Act (MHPAEA) to the coverage provided to the enrollees of Medicaid managed care organizations (MCOs), Medicaid alternative benefit plans (ABPs), and Children's Health Insurance Program (CHIP) to ensure that financial requirements (such as copays and coinsurance) and treatment limitations (such as visit limits) on mental health and substance use disorder benefits generally are no more restrictive than the requirements and limitations that apply to medical and surgical benefits in these programs.

Q2. Why are the regulations needed?

A2. CMS believes a regulation specific to MHPAEA's application to Medicaid and CHIP is important because the final rules applying MHPAEA to the commercial market do not currently apply to Medicaid and CHIP. The statutory provisions applying specific MHPAEA provisions to Medicaid managed care organizations, Medicaid alternative benefit plans, and CHIP are stated generally and do not include significant detailed provisions. In the absence of a Medicaid or CHIP-specific regulation, states and plans may not have the necessary guidance to implement the parity requirements for these programs in a uniform manner. CMS believes that adopting these regulations for Medicaid and CHIP will implement existing statutory provisions but also better align regulation of Medicaid and CHIP with commercial product regulation.

Q3. How does the final rule impact Medicaid and CHIP beneficiaries?

A3. Medicaid beneficiaries enrolled in Medicaid managed care organizations or receiving benefits through Medicaid alternative benefit plans will benefit from the final rule. This includes beneficiaries who receive medical and surgical benefits through a managed care organization, but whose mental health and substance use disorder benefit are provided through fee-for-service. Similarly all CHIP beneficiaries, regardless of delivery system, will benefit from the protections in the final rule. Coverage for Medicaid benefits for beneficiaries that are not enrolled in an MCO and receive non-ABP state plan benefits offered under a fee-for-service basis is not subject to these parity standards.

Q4. How does the final rule apply to long term care services for mental health and substance use disorders?

A4. Although the proposed rule did not apply to long term care services, the final rule applies parity protections to long term care services for mental health and substance use disorders

in the same manner that these protections apply to other services for these conditions. This approach will improve the quality of care for beneficiaries with mental health and substance abuse disorders by requiring that states and plans apply MHPAEA-compliant treatment limitations consistently across all mental health and substance use disorder services rather than only a subset of services. This approach will also improve simplicity and transparency for beneficiaries and ease of administration of the regulation. Because few states that offer long term care services for mental health and substance use disorders apply quantitative treatment limits to these services, we believe that the financial impact of this policy will be minimal in most states.

Q5. Does the final rule allow for cost exemption for Medicaid managed care organizations?

A5. In contrast to the MHPAEA regulations for the commercial market, the final rule does not include an increased cost exemption for Medicaid managed care organizations, prepaid inpatient health plans or prepaid ambulatory health plans. Instead, this rule allows states to include the cost of providing services beyond what is specified in the state plan into the actuarially sound rate methodology, so long as services beyond what is specified in the state plan are necessary to comply with mental health and substance use disorder parity requirements. This may include adding services or removing or aligning treatment limitations in managed care benefits. Given that the actuarially sound payment methodology will take into account the costs of compliance with parity requirements, Medicaid rather than the plan will bear the costs of these changes. Therefore, CMS does not believe that Medicaid managed care entities will incur any net increase in costs as a result of this final rule. This is different from the circumstances of the commercial market and removes the rationale for an increased cost exemption for Medicaid managed care organizations, prepaid inpatient health plans and prepaid ambulatory health plans.

Q6. What options do states have if their plans do not meet the requirements under the final rule?

A6. States have two options if they find that the benefit package provided to enrollees of Medicaid managed care organizations does not meet the requirements of these final rules:

• Change their state plan so that the service package in the state plan complies with these final rules; or

• Add benefits, or remove or align any relevant treatment limitations or treatment limitations in the benefit package provided to enrollees of the Medicaid managed care organizations without making any change to the service in the non-ABP state plan as a whole.

If a state chooses the second option, in order to ensure that the Medicaid managed care organizations, prepaid inpatient health plans or prepaid ambulatory health plans receive appropriate funding for the delivery of those services, the payment provisions at 42 CFR §438.6 have been revised to allow the state to include those additional services when developing actuarially sound rates.

Q7. What is a state's responsibility under the final rule?

A7. This final regulation requires the state to determine whether the overall delivery system complies with the provisions of this final rule, including when some MH/SUD services are not included in the MCO benefit package. In states where the Medicaid managed care organization has sole responsibility for offering medical/surgical and mental health/substance use disorder services, the Medicaid managed care organization is responsible for undertaking the parity analysis and informing the state what changes are needed to the Medicaid managed care organization contract to comply with the provisions of this final rule.

In states where some or all mental health and substance use disorder services for enrollees of Medicaid managed care organizations are provided through some combination of Medicaid managed care organizations, prepaid inpatient health plans or prepaid ambulatory health plans, the state has the responsibility for undertaking the parity analysis across these delivery systems and determining if the benefits and any financial requirements or treatment limitations are consistent with this final rule. In addition, states must make available documentation of compliance with these final regulations to the general public within 18 months of the publication date of this rule.

For CHIPs, the state is responsible for ensuring parity regardless of the delivery system, and is responsible for making the corresponding changes in the state plan.

Q8. How will CMS ensure compliance with this rule?

A8. States have the responsibility of administering the state plan in compliance with federal law, so states are required to provide an assurance of compliance with parity requirements when submitting ABP or CHIP state plans. This rule requires the state Medicaid agency to include contract provisions requiring compliance with parity requirements in all applicable contracts with managed care organizations, prepaid inpatient health plans or prepaid ambulatory health plans. These provisions must ensure that all of the Medicaid managed care organizations, prepaid inpatient health plans or prepaid ambulatory health plans included in the delivery system work together to ensure any MCO enrollee in a state is provided access to a set of benefits that meets the requirements of this rule regardless of the mental health and substance use disorder benefits being provided by the Medicaid managed care organization.

Q9. How long do states have to comply with the final rule?

A9. Under the final rule, states have up to 18 months after the date of the publication of the final rule to comply with the finalized provisions. This timeframe allows states sufficient time to take any actions needed to comply with the final rule, which may include budget requests to add new services or additional service units, contract changes to their Medicaid managed care organizations, prepaid inpatient health plans and prepaid ambulatory health plans contracts, and obtaining approval from CMS to make changes to their non-ABP state plan for services delivered through fee-for-service (if they so choose).

Q10. Where can I find additional information on the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act?

A10. Additional information can be found at:

http://webapps.dol.gov/FederalRegister/PdfDisplay.aspx?DocId=27169

http://www.dol.gov/ebsa/faqs/faq-aca17.html

http://www.dol.gov/ebsa/faqs/faq-mhpaea2.html

http://www.dol.gov/ebsa/faqs/faq-mhpaeaimplementation.html

Q11. Where can I find additional information on the final rule?

A11. Additional information can be found on Medicaid.gov at:

https://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/mental-health-services.htm

Mobile Resources To Support Behavioral Health

Download Free Apps From SAMHSA

This New Year, resolve to promote positive behavioral health in your community. SAMHSA has resources that can help address some of the toughest mental health and substance use challenges, including suicide prevention, bullying prevention, behavioral health following a disaster, and underage drinking prevention.

Suicide Safe helps health care providers integrate suicide prevention strategies into their practice and address suicide risk among their patients.

KnowBullying provides information and guidance on ways to prevent bullying and build resilience in children. A great tool for parents and educators, KnowBullying is meant for kids ages 3 to 18.

SAMHSA Disaster App provides responders with access to critical resources—like Psychological First Aid and Responder Self-Care—and SAMHSA's Behavioral Health Treatment Services Locator to help responders provide support to survivors after a disaster.

Talk. They Hear You is an interactive game that can help parents and caregivers prepare for one of the more important conversations they may ever have with children—underage drinking.

NATIONAL HAPPENINGS

Second Annual State of the Union in Mental Health and Addiction

Moderated by National Council President and CEO, Linda Rosenberg

ARTICLE REPRINT | National Council for Behavioral Health — BHIVE—Behavioral Health Hive | March 1, 2016

On February 23, National Council President and CEO Linda Rosenberg moderated the second annual State of the Union in Mental Health and Addiction. This national policy and media event – hosted by the Kennedy Forum and the Satcher Health Leadership Institute – brought together thought leaders, policymakers and stakeholders to highlight the most promising solutions in the behavioral health field. Linda is pictured above with Patrick Conway, Patrick Kennedy and his wife Amy, former Surgeon General Dr. David Satcher, and Dr. Montgomery Rice, President of Morehouse's School of Medicine and others.

It is imperative that behavioral health advocates not only speak up, but act on behalf of their interests. This June, at the National Council's **Hill Day 2016**, we will do just that. Hundreds of behavioral health providers, administrators, board members and consumers will come to Washington, D.C. June 6-7 to take their message to Capitol Hill as a part of the biggest behavioral health advocacy event of the year. **Register for free today**.

"The best place [for a patient] to get their physical health care is the place where they are getting psychiatric care. They want the same things we do — they want convenience," —**Linda Rosenberg**, President and CEO of the National Council for Behavioral Health in a ***CNN article*** highlighting the effectiveness of integrating primary and behavioral health care.

One of the biggest challenges facing those who work in behavioral health is determining which treatment or therapy will work best for which patient. **MoodNetwork**, an online research network for people with depression and bipolar disorder, wants to fix that with large-scale, comparative effectiveness studies. If only 10 patients from every National Council member joined this study, we would have 25,000 new members, and we would be well on our way to transforming how we treat mood disorders. **Click here to join.**

CDC's New Opioid Guidelines, HHS National Pain Strategy, Recognizing Addiction Medicine and more in this Focus on Addiction

CLICK or PASTE this link to view all information [http://echo4.bluehornet.com/hostedemail/email.htm?CID=33852895007&ch=4B306EB5A9DC0EB79C0D4402FEEEAEFF&h=538c574061fe898261a9bb3b024c2ba2&ei=7Cdb49CNt***]***

ARTICLE REPRINT | Focus on Addiction—Prevention, Treatment and Recovery | March 22, 2016 | Becky Vaughn, Vice President of Addictions, National Council for Behavioral Health

Last week, the Centers for Disease Control and Prevention (CDC) released new guidelines for doctors on responsibly prescribing painkillers such as Oxycontin and Vicodin – bringing important attention to the opioid crisis gripping our nation.

The CDC's reason for issuing these guidelines is clear - almost 29,000 people fatally overdosed on prescription opiates or heroin in 2014 – and addiction continues to be a growing problem in communities across the United States.

The CDC has created numerous resources, including a series of fact sheets and graphics for prescribers and others to understand the guidelines.Yet, the guidelines are, at this point, only voluntary. If we really expect to curb the rise in abuse, addictions, and overdose deaths, payers (Medicaid, Medicare and private insurers) will need to mandate these guidelines as part of their rules for reimbursing doctors.

We believe real change will come when payers are on board to mandate these guidelines – what do you think?

Senator Alexander Leads Charge Against Mental Health 'Crisis'

ARTICLE REPRINT | The Commercial Appeal | March 20, 2016 | Michael Collins | http://www.commercialappeal.com/news/government/sen-alexander-leads-charge-against-mental-health-crisis-2e54b46c-0c2c-76dd-e053-0100007f91e2-372637531.html | *Michael Collins is the Washington correspondent for The Commercial Appeal. He writes about the Tennessee congressional delegation and monitors the federal government for any policies or issues that might be of interest to Tennesseans.*

Dennis Freeman has felt for a long time that the best way to help someone with a physical illness and mental health problems is to treat the body and the mind together.
"For a long time, we've separated those two, and it hasn't worked out very well," said Freeman, chief executive officer of the

Knoxville-based Cherokee Health Systems.
Freeman is encouraged by what he sees in Congress, where lawmakers are looking not only to improve and expand mental health services but also to make them more readily available to patients as part of their primary health care.
"It doesn't matter where you live, access to behavioral health is a challenge," Freeman said. "Blending behavioral and primary health together is going to really address that.''
In the next few weeks, the U.S. Senate will vote on comprehensive legislation to deal with what U.S. Sen. Lamar Alexander and a bipartisan group of lawmakers are calling the nation's mental health "crisis."
The legislation, known as the Mental Health Reform Act of 2016, would increase access to mental health care for women, children, veterans, the homeless and others and calls for improved training for those who provide those services.
It requires federal agencies and programs involved in mental health policy to incorporate the most up-to-date approaches, such as integrated care, in treating mental illness. It also seeks to improve coordination between federal agencies and departments that provide mental health services and help states provide better care by updating block grant programs.
Leading the push for mental health reform are Alexander, the Tennessee Republican who is chairman of the Senate committee that oversees health care policy, and the committee's top Democrat, U.S. Sen. Patty Murray of Washington.
It's not the first time the two lawmakers have teamed up on comprehensive legislation. Last summer, they successfully pushed through Congress major legislation that reworked the No Child Left Behind school-reform law that had been in effect for 13 years.
Their latest effort takes aim at a problem that impacts a large segment of society.
One in five adults reportedly had a mental health condition over the past year, according to the Substance Abuse and Mental Health Services Administration, but 60 percent of them went untreated. Only half of adolescents receive treatment for their condition, often causing them to drop out of school and putting them at risk of substance abuse disorders, incarceration, homelessness and even suicide.
"This bill will help address this crisis by ensuring our federal programs and policies incorporate proven, scientific approaches to improve care for patients," Alexander said. "States like Tennessee and local governments are on the forefront in treating mental illness and substance abuse, and this legislation will support their efforts so people can get the help they need."
The legislation, if enacted, would represent progress in the delivery of mental health services, said Freeman, whose company operates primary care, behavioral health clinics and other facilities in 13 counties.
"In many, many ways, this is a step forward," he said, adding that it's especially gratifying to see large bipartisan support for the bill given that Congress is so often divided along party lines.
Shelby County Mayor Mark Luttrell, who in January launched a special court to provide adjudication for people with mental illness and direct them toward mental health services, also lauded the approach outlined in the bill.
"I think it really pulls the study of metal health out of dark corners and puts it out on the main street, as far as resources to deal more effectively with it," he said. "It takes away the stigma (of mental illness). The more sunshine we can bring to this problem, the less stigmatized it becomes."
Luttrell said he is glad to see the bill promoting the use of evidence-based practices, such as early intervention programs for individuals with serious mental illness.
"As we can collect that data, we can get that data out," he said. "It helps educate the public to really watch for symptoms.
"I've often said the best doctor is the doctor within us. As we self-evaluate, as we look at ourselves and our particular habits, it's the individual that can be the very first one that recognizes (symptoms). When we talk about evidence-based, we're talking about really educating the public on what to look for and how to react to those symptoms when they are identified."
The federal legislation is in line with similar efforts underway in Tennessee to expand mental health services, said Houston Smelcer of the Helen Ross McNabb Center, which is based in Knoxville and offers mental health, substance abuse and social services in 20 counties.
The state is looking to allocate millions of dollars for alcohol and rehabilitation services for people who are uninsured or underinsured.
TennCare, the state's version of Medicaid, also is launching a new program to deliver both primary care and behavioral health services to more than 50,000 TennCare enrollees across the state. The program is expected to go live Oct. 1.
"You're seeing that mirrored at the federal level now as well," said Smelcer, the Helen Ross McNabb Center's vice president of development and government relations. "I think that's a very good thing."

Schizophrenias Strongest Known Genetic Risk Deconstructed

Suspect gene may trigger runaway synaptic pruning during adolescence — NIH funded study

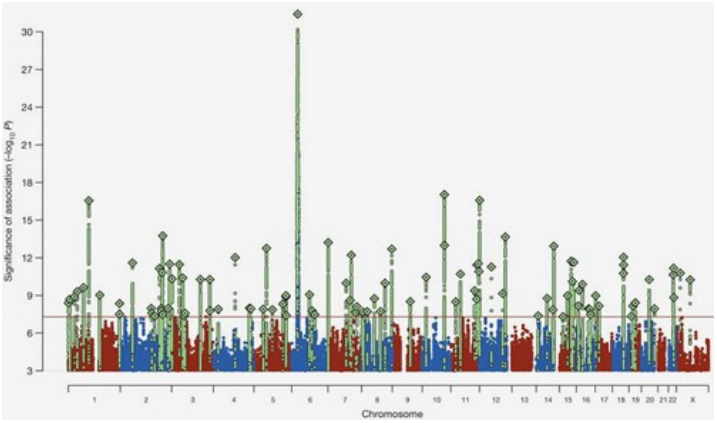
ARTICLE REPRINT | National Institute of Mental Health | January 27, 2016 | http://www.nimh.nih.gov/news/science-news/2016/schizophrenias-strongest-known-genetic-risk-deconstructed.shtml

Versions of a gene linked to schizophrenia may trigger runaway pruning of the teenage brain's still-maturing communications infrastructure, NIH-funded researchers have discovered. People with the illness show fewer such connections between neurons, or synapses. The gene switched on more in people with the suspect versions, who faced a higher risk of developing the disorder, characterized by hallucinations, delusions and impaired thinking and emotions.

"Normally, pruning gets rid of excess connections we no longer need, streamlining our brain for optimal performance, but too

much pruning can impair mental function," explained Thomas Lehner, Ph.D., director of the Office of Genomics Research Coordination of the NIH's National Institute of Mental Health (NIMH), which co-funded the study along with the Stanley Center for Psychiatric Research at the Broad Institute and other NIH components. "It could help explain schizophrenia's delayed age-of-onset of symptoms in late adolescence/early adulthood and shrinkage of the brain's working tissue. Interventions that put the brakes on this pruning process-gone-awry could prove transformative."

The gene, called C4 (complement component 4), sits in by far the tallest tower on schizophrenia's genomic "skyline" (see graph below) of more than 100 chromosomal sites harboring known genetic risk for the disorder. Affecting about 1 percent of the population, schizophrenia is known to be as much as 90 percent heritable, yet discovering how specific genes work to confer risk has proven elusive, until now.



The site in Chromosome 6 harboring the gene C4 towers far above other risk-associated areas on schizophrenia's genomic "skyline," marking its strongest known genetic influence. The new study is the first to explain how specific gene versions work biologically to confer schizophrenia risk.

A team of scientists led by Steve McCarroll, Ph.D. , of the Broad Institute and Harvard Medical School, Boston, leveraged the statistical power conferred by analyzing the genomes of 65,000 people, 700 postmortem brains, and the precision of mouse genetic engineering to discover the secrets of schizophrenia's strongest known genetic risk. C4's role represents the most compelling evidence, to date, linking specific gene versions to a biological process that could cause at least some cases of the illness.

"Since schizophrenia was first described over a century ago, its underlying biology has been a black box, in part because it has been virtually impossible to model the disorder in cells or animals," said McCarroll. "The human genome is providing a powerful new way in to this disease. Understanding these genetic effects on risk is a way of prying open that block box, peering inside and starting to see actual biological mechanisms."

McCarroll's team, including Harvard colleagues Beth Stevens, Ph.D. , Michael Carroll, Ph.D. , and Aswin Sekar , report on their findings online Jan. 27, 2016 in the journal Nature.

A swath of chromosome 6 encompassing several genes known to be involved in immune function emerged as the strongest signal associated with schizophrenia risk in genome-wide analyses by the NIMH-funded Psychiatric Genomics Consortium over the past several years. Yet conventional genetics failed to turn up any specific gene versions there linked to schizophrenia.

To discover how the immune-related site confers risk for the mental disorder, McCarroll's team mounted a search for "cryptic genetic influences" that might generate "unconventional signals." C4, a gene with known roles in immunity, emerged as a prime suspect because it is unusually variable across individuals. It is not unusual for people to have different numbers of copies of the gene and distinct DNA sequences that result in the gene working differently.

The researchers dug deeply into the complexities of how such structural variation relates to the gene's level of expression and how that, in turn, might relate to schizophrenia. They discovered structurally distinct versions that affect expression of two main forms of the gene in the brain. The more a version resulted in expression of one of the forms, called C4A, the more it was associated with schizophrenia. The more a person had the suspect versions, the more C4 switched on and the higher their risk of developing schizophrenia. Moreover, in the human brain, the C4 protein turned out to be most prevalent in the cellular machinery that supports connections between neurons.

Adapting mouse molecular genetics techniques for studying synaptic pruning and C4's role in immune function, the researchers also discovered a previously unknown role for C4 in brain development. During critical periods of postnatal brain maturation, C4 tags a synapse for pruning by depositing a sister protein in it called C3. Again, the more C4 got switched on, the more synapses got eliminated.

In humans, such streamlining/pruning occurs as the brain develops to full maturity in the late teens/early adulthood – conspicuously corresponding to the age-of-onset of schizophrenia symptoms.

Future treatments designed to suppress excessive levels of pruning by counteracting runaway C4 in at risk individuals might nip in the bud a process that could otherwise develop into psychotic illness, suggest the researchers. And thanks to the head start gained in understanding the role of such complement proteins in immune function, such agents are already in development, they note.

"This study marks a crucial turning point in the fight against mental illness. It changes the game," added acting NIMH director Bruce Cuthbert, Ph.D. "Thanks to this genetic breakthrough, we can finally see the potential for clinical tests, early detection, new treatments and even prevention."

Source: Psychiatric Genomics Consortium
Grants: MH10564, MH077139, HG006855, GM007753

Reference:

Sekar A, Biala AR, de Rivera H, Davis A, Hammond TR, Kamitaki N, Tooley K Presumey J Baum M, Van Doren V, Genovese G, Rose SA, Handsaker RE, Schizophrenia Working Group of the Psychiatric Genomics Consortium, Daly MJ, Carroll MC, Stevens B, McCarroll SA. Schizophrenia risk from complex variation of complement component 4. Nature. Jan 27, 2016. DOI: 10.1038/nature16549.

About the National Institute of Mental Health (NIMH): The mission of the NIMH is to transform the understanding and treatment of mental illnesses through basic and clinical research, paving the way for prevention, recovery and cure. For more information, visit the NIMH website.

NHGRI is one of the 27 institutes and centers at the National Institutes of Health, which is an agency of the Department of Health and Human Services. The NHGRI Division of Extramural Research supports grants for research and for training and career development at sites nationwide. Additional information about NHGRI can be found at www.genome.gov .

NIGMS is a part of NIH that supports basic research to increase our understanding of life processes and lay the foundation for advances in disease diagnosis, treatment and prevention. For more information on the Institute's research and training programs, see http://www.nigms.nih.gov .

About the National Institutes of Health (NIH): NIH, the nation's medical research agency, includes 27 Institutes and Centers and is a component of the U.S. Department of Health and Human Services. NIH is the primary federal agency conducting and supporting basic, clinical, and translational medical research, and is investigating the causes, treatments, and cures for both common and rare diseases. For more information about NIH and its programs, visit the NIH website .

You can also hear an interview on this topic here: http://hereandnow.wbur.org/2016/01/27/schizophrenia-gene

AG Clears 10 More Behavioral Health Providers of Fraud

ARTICLE REPRINT | Albuquerque Journal | February 8, 2016 | Deborah Baker, Journal Staff Writer

Attorney General Hector Balderas has cleared 10 more behavioral health providers of fraud following an investigation.

They were among 15 referred to the AG in 2013 by the Human Services Department, which said there was overbilling, mismanagment and possible fraud. The nonprofits provided services to the mentally ill and addicted.

Two of the 15 had been cleared earlier by the AG.

“While we did find some regulatory violations, there did not appear to be a pattern of fraud for any of the ten completed investigations,” Balderas said in a letter delivered to members of the Legislature this morning.

The providers cleared of fraud are: Border Area Mental Health Services, Partners in Wellness, Youth Development Inc., Southern New Mexico Human Development, Hogares, Families and Youth Inc., Counseling Associates, Southwest Counseling Center, Presbyterian Medical Services, and Valencia Counseling Services.

Balderas said there are still two investigations ongoing, involving TeamBuilders and Pathways.

His office had earlier cleared The Counseling Center of Alamogordo, Easter Seals El Mirador, and Service Organization for Youth.

February 2016 was a Good Month for People with Addictive Disorders

ARTICLE REPRINT | Focus on Addiction—Prevention, Treatment and Recovery | February 23, 2016 | Linda Rosenburg, President & CEO, National Council for Behavioral Health | http://www.thenationalcouncil.org/lindas-corner-office/2016/02/far-good-addictions-get-due/

February 2016 has been a good month. A good month for advocates, organizations that provide treatment and services, and most importantly, a good month for people with addictive disorders. Our struggles and the struggles of people in recovery are producing results.

The White House asked for an additional $1.1 billion to fight opioid addiction. The Senate Judiciary Committee approved the Comprehensive Addictions and Recovery Act and the full Senate and the House are expected to do the same. And The New York Times published a two part series on addictions. What these all have in common is a shift from treating addiction as an acute disorder to an understanding that this often chronic condition requires more than an inpatient stay. Addictions require an array of longer-term, sometimes even lifetime, community treatments and supports.

> “As advocates for mental health and addiction treatment, we can't fix the unfairness in our economy and the loss of connection to family and friends that create social problems like addiction and crime. But we can understand better how - and whom - these trends affect most, and adjust our treatment and prevention strategies accordingly.” – ***Linda Rosenberg, president and CEO of the National Council and Joe Parks, M.D., Medical Director of the National Council*** *in their piece on Huffington Post Healthy Living.*

READ MORE @ http://www.thenationalcouncil.org/lindas-corner-office/2016/02/far-good-addictions-get-due/


NATIONAL COUNCIL
FOR BEHAVIORAL HEALTH
Save the Date
Hill Day
June 6-7, 2016 | Washington, DC


TAMHO 2016 Annual Conference
tamho
Marriott
FRANKLIN
COOL SPRINGS
December 13-14, 2016
Marriott Cool Springs Hotel
Franklin, Tennessee

CELEBRATING TENNESSEE'S IPS COMMUNITY

A STATEWIDE CONFERENCE CELEBRATING INDIVIDUAL PLACEMENT AND SUPPORT (IPS) COMMUNITY SUCCESSES

The eight principles of IPS . . .

- Competitive and Integrated Employment
- Mental Health Treatment Integration
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- Client Preferences Driven
- Benefits Planning and Counseling
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- Systematic Job Development
- Time-Unlimited Supports

Embassy Suites Hotel
Nashville—South/Cool Springs
Franklin, Tennessee

May 10, 2016

Volunteers are needed to spread the message . . .

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

ACCESS
Staying informed will be helpful when services are necessary.

RECOVERY
is real!

. . . into local communities throughout Tennessee.

May we count on you to help carry the message into your community?

Your voice of experience and expertise with co-occurring disorders can bring awareness to their impact on individuals, families, and communities. TNCODC has created brief, intermediate, and advanced level presentations for use in local communities.

Volunteering to spread the word is simple:

1. Consider the needs within your communities and develop a list of local outreach opportunities.
2. Visit http://www.tncodc.com/resources/education-and-presentations or contact TNCODC.
3. Submit your request for a SPEAKERS TOOLKIT that contains a slide deck, speaker guide, handouts, and evaluation materials.
4. Make arrangements and promote your event.
5. Conduct the event.
6. Provide your evaluation and feedback to TNCODC.
7. Celebrate your success in partnering with TNCODC and bringing about education and awareness.

HOPE ACCESS RECOVERY
Tennessee Co-Occurring Disorders Collaborative

42 Rutledge Street • Nashville, TN 37210-2043

(615) 244-2220, ext. 14
Toll free in TN. (800) 568-2642
Fax (615) 254-8331

This project is funded under an agreement with the State of Tennessee. The Tennessee Association of Mental Health Organizations (TAMHO) serves as the grant administrator for this project.

Education and Awareness Audiences . . .

- Families
- Individuals with Lived Experience
- Clinicians and Behavioral Health Professionals
- Local, State, and Legislative Governing Bodies
- Criminal Justice System
- Judicial System
- Business/Workforce
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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.

The Behavioral Health News & Events is a newsletter publication produced by the Tennessee Association of Mental Health Organizations (TAMHO) that is edited and published quarterly by TAMHO. It is distributed electronically to behavioral health professionals, advocates, members of the Tennessee General Assembly and representatives of various State Departments of Government, as well as key stakeholders in the provision of behavioral health products and services procured by behavioral health agencies, and numerous individuals in local communities and throughout the state and nation who have an interest in the advancement of behavioral health in Tennessee.

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ADDRESS 42 Rutledge Street
Nashville, TN 37210

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

We're on the web!
www.tamho.org

Executive Director | Ellyn Wilbur | ewilbur@tamho.org
Director of Policy and Advocacy | Alysia Williams | awilliams@tamho.org
Director of Member Services | Teresa Fuqua | tfuqua@tamho.org
Director of Administrative Services | Laura B. Jean | ljean@tamho.org
Project Manager—TNCODC | Patrick Slay | pslay@tamho.org