

2012
Local Services Plan Guidelines
For Mental Hygiene Services

March 2011

Andrew M. Cuomo
Governor, New York State



Arlene González-Sánchez
Commissioner
*New York State Office of Alcoholism
and Substance Abuse Services*



Michael F. Hogan, PhD
Commissioner
*New York State
Office of Mental Health*



James F. Moran
Acting Commissioner
*New York State Office For People With
Developmental Disabilities*

***2012 Local Services Plan Guidelines
For Mental Hygiene Services***

**2012 Local Services Plan Guidelines
For Mental Hygiene Services**

TABLE OF CONTENTS

CHAPTER I: Introduction	1
A. Interagency Collaboration.....	1
B. Local Services Planning Process.....	3
CHAPTER II: Planning for Addiction Services	7
A. The OASAS Strategic Framework	7
B. Local Needs Assessment and Planning.....	8
C. How Local Plans Inform OASAS Priorities.....	12
CHAPTER III: Planning for Mental Health Services and Supports	14
A. Continuing the Momentum toward Effective Mental Health Planning	14
B. Context for Mental Health Planning and Priorities.....	14
C. Local Services Planning and Priorities.....	20
CHAPTER IV: Planning for Developmental Disability Services	22
A. Background	22
B. Guiding Principles	22
C. The Planning Process	25
CHAPTER V: County Plan Guidance and Forms	31
A. County Planning Activities Report.....	31
B. Outpatient Sub-County Service Plan Form (OASAS).....	37
C. Community Residence Multi-County Collaboration Agreement Form (OASAS)	38
D. County Mental Hygiene Priority Outcomes Form	40
E. Local Services Planning Assurance Form	45
F. Multiple Disabilities Consideration Form.....	46
G. Community Services Board Roster (New York City)	47
H. Community Services Board Roster (Counties Outside NYC)	48
I. Alcoholism and Substance Abuse Sub-Committee Roster (OASAS)	49
J. 2011 Mental Health Subcommittee Roster (OMH).....	50
K. 2011 Developmental Disabilities Subcommittee Roster (OPWDD)	51
L. DDSO Plan Approval Form (OPWDD).....	52
M. Outcomes Management Survey (OASAS).....	53
CHAPTER VI: Provider Plan Guidance and Forms (OASAS)	55
A. Outcomes Management Survey (all providers)	55
B. Health Coordinator Form (treatment programs)	57
C. Clinical Supervision and Qualifications Survey (treatment programs)	59
D. Domestic Violence Assessment and Referral Survey (treatment programs)	61
E. Older Adult Services Survey (selected treatment programs).....	62
F. Veterans/Military Services Survey (selected treatment programs)	65
G. Schedule C - Capital Funding Request Form (optional)	66

***2012 Local Services Plan Guidelines
For Mental Hygiene Services***

2012 Local Services Plan Guidelines For Mental Hygiene Services

CHAPTER I: INTRODUCTION

A. Interagency Collaboration

The 2012 local services planning process for mental hygiene services represents a partnership among the three New York State Department of Mental Hygiene agencies—the Office of Alcoholism and Substance Abuse Services (OASAS), the Office of Mental Health (OMH) and the Office for People With Developmental Disabilities (OPWDD). The partnership approach provides a platform for developing solutions to priority issues and a timetable that better aligns with State long-range planning and budgeting timelines.

Integrated planning rests upon a person- and family-centered philosophy designed for the provision of high-quality services and improved outcomes. The integrated planning approach reflects a continued commitment to the principles of collaboration and cooperation that were central to the “People First” Coordinated Care Listening Forums of 2007 and the work of the Inter-Office Coordinating Council (IOCC).

The Inter-Office Coordinating Council (IOCC)

Created in 1977 during the reorganization of the Department of Mental Hygiene, the Inter-Office Coordinating Council (IOCC) strives to ensure comprehensive planning and implementation of state policy for the prevention, care, treatment and rehabilitation of mental illness, developmental disabilities and addictions. The IOCC aims to eliminate gaps in services for individuals living with more than one disability.

The commissioners continue to provide strong leadership and strengthen interagency planning through their collaboration with the Conference of Local Mental Hygiene Directors (CLMHD), the Department of Health and other relevant agencies. They do this by fostering the elimination of structural, financial and regulatory barriers to services for people with multiple disabilities. The [2010 IOCC Annual Report](#) is available on the OASAS Website. IOCC accomplishments during 2010 included:

- Approval of nine Community Services Directors in Franklin, Chenango, Lewis, Schenectady, Greene, Columbia, Essex, Tompkins, and Cortland counties.
- Enhancements to and maintenance of quality services for children/youth and their families.
- Continuing implementation of the Task Force on Co-Occurring Disorders recommendations to better integrate mental health and addictions treatment through the introduction of OMH and OASAS licensed/certified provider web-based training modules available through the [Focus on Integrated Treatment \(FIT\) Initiative](#) located on the Center for Practice Innovations website. Modules include inspiring personal recovery stories, clinical vignettes, interactive exercises, and expert panel presentations; tests of understanding and competence; a strong foundation in evidence-based integrated screening, assessment and treatment for co-occurring disorders; and more.
- Ongoing implementation of [wellness self-management](#), an evidence-based mental health approach that has been adapted to address mental health,

2012 Local Services Plan Guidelines For Mental Hygiene Services

substance use, and other addictions in an integrated way that supports recovery; pilot programs and evaluations indicate that 75 percent of participants report significant progress on self-identified goals and that the practice is sustainable.

- Introduction of the [New York State Clinical Records Initiative \(NYSCRI\)](#), a voluntary project aimed at standardizing and integrating clinical case records for select outpatient programs regulated by OMH and OASAS, helping to improve mental health and chemical dependency quality, regulatory compliance, and clinical documentation.
- Continuing reinforcement of OMH and OWPDD training and resource sharing to better prepare clinicians to address the needs of adults with mental health developmental disabilities.
- Ongoing support for the partnering between OMH and the Office of Children and Family Services (OCFS) to address the chronic need for community-based mental health alternatives in Brooklyn for children and their families and the intensive residential treatment in New York City for youth with mental health problems involved in the court system, with implementation to begin in 2011.
- New collaboration between OASAS and OCFS for developing program standards for the OCFS Division of Juvenile Justice and Opportunities for Youth (DJJOY) facilities to improve and fully integrate addiction prevention and treatment services for youth.
- Encouragement for the Interagency Fetal Alcohol Spectrum Disorders Workgroup (including agencies such as OCFS, OASAS, OWPDD) activities, to improve the quality and availability of services and resources.
- Strengthened alliances between the State Office for the Aging (SOFA), OMH, and other State and voluntary agencies to improve service delivery and planning for older adults and their families.
- Strengthened the utility of the Mental Hygiene Online County Planning System (CPS) and support for an integrated local services planning process.

Mental Hygiene Planning Committee

A standing committee of the IOCC, the Mental Hygiene Planning Committee formally represents a partnership among the three agencies, CLMHD, and local governmental units (LGUs) that promotes integrated local mental hygiene services planning. The Committee's mission is to enhance the partnership through the development of an efficient, integrated, uniform planning system that helps to identify and quantify current and emerging needs, support local management and coordination, foster the continued development of person-centered services; and ultimately inform State policy and budget decisions.

The Committee is co-chaired by William Phillips, OASAS Associate Commissioner for Outcome Management and System Information, and Scott LaVigne, Director of Community Services in Seneca County. Meeting regularly year round, the Committee aims to integrate local planning and to develop web-based planning tools and data resources that support and facilitate planning and needs assessment. Two subcommittees focus specifically on county data needs and on the dissemination of best practices for planning.

2012 Local Services Plan Guidelines For Mental Hygiene Services

B. Local Services Planning Process

State Mental Hygiene Law requires that OASAS, OMH and OPWDD guide and facilitate the process of local planning (§41.16(a)). It also requires each LGU to develop and annually submit to each mental hygiene agency a local services plan that establishes long-range goals and objectives consistent with statewide goals and objectives (§41.16(b)(1)). In addition, the law requires that State goals and objectives embody the partnership between the state and LGUs (§5.07(a)(1d)); each agency's statewide comprehensive five-year plan, therefore, should be formulated from the LGU comprehensive plans (§5.07(b)(1)).

Prior to the establishment of the Mental Hygiene Planning Committee four years ago, each agency conducted its own local planning process, followed its own timetable, and established its own planning requirements for the LGUs. At the county level, planning for each disability was frequently conducted independent of the other disabilities. Collaboration was all but absent from this process. Today, counties enjoy a more integrated mental hygiene local planning process that is guided by the state and carried out at the county level. More attention is focused on enabling LGUs to address cross-system issues that impact people with co-occurring disorders and improve the quality of services and supports. In the four years since the committee was formed, the local planning process has resulted in more efficient and effective planning focused on problems and needs that impact all three disability systems. Major milestones include:

- Establishing an annual planning calendar that aligns local services planning with state planning and budgeting processes;
- Developing comprehensive local services plan guidelines and planning forms to facilitate a more integrated local planning process;
- Integrating the plan guidelines and planning forms into the OASAS online County Planning System (CPS) and providing greater access to all completed plans for the three state mental hygiene agencies and all counties; and
- Incorporating extensive county planning resources in CPS and promoting effective local planning practices that facilitate a more data informed and results focused local planning and needs assessment effort.

Many of the improvements to the local planning process, plan guidelines, and CPS resulted from input provided by counties and OASAS service providers through surveys, meetings, and other means of communication throughout the year. Moving forward, the Mental Hygiene Planning Committee will continue to seek input and to act on recommendations that will further improve planning and result in improved outcomes for individuals and families served.

In preparation for this year's planning cycle, the Mental Hygiene Planning Committee used this feedback to continue to refine CPS, thereby allowing it to be the most up-to-date, valuable, and user friendly planning tool available. The committee has also focused significant attention on adding new and updated data resources in CPS. Most recently, OASAS Detailed Medicaid Profiles, OMH Medicaid Reports, and OMH County Profiles were added to the growing inventory of available data resources.

2012 Local Services Plan Guidelines For Mental Hygiene Services

OASAS will continue to use CPS as a means to survey counties and providers on important issues in support of ongoing planning initiatives. In the most recently completed planning cycle, 99 percent of all county planning forms and 96 percent of all OASAS provider planning forms were completed. In addition to planning surveys conducted in the spring when the local plan guidelines are released, mid-cycle planning surveys may also be conducted in the fall. This approach establishes a more predictable timetable for conducting planning surveys that will be least burdensome on counties and providers and allow available OASAS resources to be utilized in the most efficient manner.

The Online County Planning System (CPS)

CPS was developed and piloted in 2004 by OASAS to enable nine counties and their service providers to complete and submit required annual local planning forms electronically. Based on feedback obtained through the pilot, CPS was redesigned and implemented statewide the following year. CPS quickly became a state-of-the-art platform from which counties could access significant and timely data resources for conducting their needs assessment and planning activities, complete required planning forms, and submit their entire plan to OASAS via the Internet. A number of other tools were developed over the years that help counties to manage their agency's presence in CPS, including the ability to communicate directly with their addiction service providers and manage the completion and certification of all required planning forms.

In 2007, OMH utilized CPS on a pilot basis giving counties the opportunity to electronically submit their mental health priorities to OMH. After the success of that pilot, the OMH local planning requirements were fully integrated into CPS in 2008. At that time, OMRDD (now OPWDD) also fully integrated its local planning requirements into CPS, creating the first ever fully integrated mental hygiene local services planning process in New York State. Counties now had the ability to submit a single fully integrated mental hygiene local services plan to all three state agencies at once.

Today, there are more than 2,200 individuals with a CPS user account in one or more of eighteen separate user roles. Each role provides the user with specific entitlements depending on their organization and the features and resources they need to access or use. While the system was designed primarily for county and OASAS provider use, it has expanded significantly over the years. Additional roles have been added for anyone not employed by the three state agencies, the county mental hygiene agencies, or OASAS provider agencies.

There are approximately 150 CPS users registered in the role of "Guest Viewer" or "Researcher" which provides read-only access to all completed county plans and most of the planning resources currently housed in CPS. A CPS account may be requested by completing the online registration form at <http://cps.oasas.state.ny.us/cps/>. When establishing an account in CPS, each user must specify a role in the system. The following table describes the major roles and the entitlements offered by each.

**2012 Local Services Plan Guidelines
For Mental Hygiene Services**

CPS Role	CPS Entitlements
Administrator	This role is appropriate for individuals responsible for managing their organization's presence in CPS. They have the ability to approve and delete staff and viewer accounts within their organization and can use the broadcast email feature and other system management features. LGU and provider administrators can also complete and submit required planning forms. All administrator accounts are approved by OASAS.
Staff	This role is appropriate for individuals in LGU and provider organizations that need to complete planning forms but do not need to perform system management functions. Completed forms can be submitted to the administrator for the organization for approval. State agency staff roles have read-only access to the entire system. A special role was created for DDSO staff that allows them to approve the OPWDD components of a county's plan.
Viewer	This role is appropriate for LGU and provider employees who only need read-only access to the system. They cannot complete planning forms nor perform any system management functions. Guest viewers and researchers have read-only access to completed plans and most available data resources.
All Roles	All user roles can view and print forms, run select reports, and access most county planning data resources.

The Mental Hygiene Planning Committee continues to be the primary input source for recommending CPS enhancements, developing planning data resources, and providing communication and technical assistance on planning related matters. A significant component of this effort is the feedback received through the annual CPS User Survey and input received from users throughout the year. CPS continues to be supported by all three mental hygiene agencies, is administered by the OASAS Bureau of State and Local Planning, and is maintained by the OASAS Bureau of Information Technology. All technical assistance questions related to CPS should be directed to the planning bureau at ogasplanning@ogas.state.ny.us or at 518-485-2410.

Local Services Planning Timeline

The following timeline highlights the critical points in the local services planning process. The timeline outlines a planning cycle that provides continuity in planning expectations from year to year.

2012 Local Services Planning Process Timeline	
Ongoing planning and needs assessment conducted by counties	Year round
Local Services Plan (LSP) Guidelines published; CPS updates available	March 1
LSP and CPS training for County and Field Office staff	March/April (TBD)
Due date for completed OASAS provider planning forms in CPS	May 1
Due date for completed LGU Plans in CPS	June 1
State summary analyses of county and provider plans completed	September 1
OASAS, OMH, OPWDD Statewide Comprehensive Plans released	October 1
Fall surveys distributed through CPS, if necessary	October 15
IOCC Annual Report released	December 31
OASAS, OMH, OWPDD Interim Reports released	February 15

2012 Local Services Plan Guidelines For Mental Hygiene Services

Informing Statewide Comprehensive Planning and Budgeting

Local services plans are central to state long-range planning and budgeting. As noted previously, Mental Hygiene Law requires that the OASAS, OMH and OPWDD formulate statewide comprehensive five-year plans in part from local comprehensive plans developed by LGUs. An important achievement of the integrated planning process is that planners at the state and local levels are now able to identify planning priorities that cut across the three disability areas. During the last planning cycle, nearly 47 percent of priorities cut across two or more disability areas, up from 37 percent two years earlier. This suggests that the new integrated mental hygiene planning process and CPS are serving as catalysts for more coordinated and focused planning across multiple systems of care.

The integrated planning process is also proving its value by helping to identify best practices and ultimately informing long-range planning and budgeting priorities. This past year, counties were asked to identify practices they considered innovative, that had been effective in making progress in priority areas, or that could be of benefit to colleagues in other counties. The goal was to identify service and system approaches that were showing promise at the local level so that they can be considered, modified as needed, and implemented as appropriate in other counties. By leveraging local innovation and creativity, and supporting information sharing across counties, a goal of strengthening the system as whole may be realized. A summary analysis of the innovative practices reported in the 2011 planning cycle, [*Innovative Practices in Mental Hygiene Services Planning and Management*](#), was prepared by the CLMHD and is available on their website.

The local services planning process and the priorities identified in county plans, particularly the cross-system priorities and promising practices, inform each State agency's policy, programming and budgeting decisions in a way that is more timely and comprehensive than previously possible. Taken as a whole, systematic processes and tools that lead to efficiencies and effective care continue to play a crucial role in difficult fiscal times. They help to identify resources that can be directed toward areas of high priority and contribute to improved service delivery and outcomes.

To help ensure that policies support people with mental illness, developmental disabilities and/or addictions and their families and are planned, developed and implemented comprehensively, OASAS, OMH, and OPWDD will continue to look to the local services plans as a primary source of input.

2012 Local Services Plan Guidelines For Mental Hygiene Services

CHAPTER II: PLANNING FOR ADDICTION SERVICES

A. The OASAS Strategic Framework

This chapter provides a strategic framework that incorporates outcomes thinking into a dynamic, data informed and participatory planning process. It also provides guidance on specific tools and resources that have been developed to help shape future development of the addiction service system and to assist counties with their planning and needs assessments efforts.

Outcomes management helps to guide all management functions aimed at improving client-level results and the return on investment. It is often described as a business-based or logic model designed to integrate organization-wide management and financial variables with performance metrics. This approach allows management to systematically measure progress towards intended outcomes.

OASAS has utilized outcome management for a number of years in a variety of ways to incorporate quality performance measures into resource allocation, including the Integrated Program Monitoring and Evaluation System (IPMES) to monitor performance of both funded and non-funded treatment programs, the Workslope Objective Attainment System (WOAS) to establish and monitor progress towards meeting program performance objectives for all OASAS-funded treatment programs, and the annual program performance reviews to evaluate each treatment provider in terms of overall program and fiscal management performance. Last year, OASAS developed the first ever Chemical Dependence Treatment Program Scorecard as part of the Gold Standard Initiative (GSI). The scorecards provide programs with a score and statewide comparative rating on a number of measures related to access, quality, outcome, efficiency and compliance.

Since 2007, the OASAS Strategic Map has defined what it means to be a premier system of addiction services and measures the agency's progress towards meeting this goal. The Strategic Map identifies five major destinations (i.e., the points on the map we want to reach over the next several years) and ten supporting metrics (i.e., the milepost or markers that we will use to measure our progress toward reaching the destinations). The current Strategic Map is summarized below. A detailed progress report on the metrics can be found in the [2011 Interim Report of the OASAS Statewide Comprehensive Plan 2010-2014](#), available on the OASAS website.

- I. Mission Outcomes:** Establish an effective, science-based program system which integrates prevention, treatment and recovery.
1. Reduce levels of gambling and substance abuse risk factors and increase protective factors in New York State communities;
 2. Increase the number of treatment programs comprehensively addressing patient needs, including the appropriate use of addiction medications and assistance in implementing individualized recovery goals;
 3. Increase the number of persons successfully managing their addiction within a recovery-oriented system of care;
 4. Increase the number of persons served who improve their health including engaging in healthy lifestyles.

2012 Local Services Plan Guidelines For Mental Hygiene Services

II. Provider Engagement and Performance: Develop a “gold standard,” system of service provision.

5. Increase provider engagement in the Gold Standard Initiative;
6. Increase providers' achievement of the OASAS gold standard objectives.

III. Leadership: Be the state resource on addiction and lead the nation in the field of chemical dependence and problem gambling.

7. Advance and support legislation, regulations, and other initiatives that improve access to prevention, treatment, and recovery services;
8. Generate positive media coverage for agency and field accomplishments.

IV. Talent Management: Become a “Profession of Choice” for attracting, selecting and developing talent.

9. Increase full knowledge, expertise and retention of a high-performing diverse staff throughout the field.

V. Financial Support: A system with strong return on taxpayer investment and stewardship of resources.

10. Increase or stabilize system funding resources while ensuring a strong return on taxpayer investment.

B. Local Needs Assessment and Planning

New York State Mental Hygiene Law requires the county to review existing prevention and treatment services and to determine the addiction service needs of the population within its area of responsibility. To meet this requirement, OASAS requires the county to conduct ongoing needs assessment and planning activities and to report on those activities annually in the local services plan. Identifying and assessing local needs is expected to be an ongoing inclusive process that engages consumers, providers and other stakeholders.

Historically, local needs assessment and planning activities were focused on each disability area separately and were reported separately in the county plan. However, since 2007, the focus of the mental hygiene plan guidelines has been to develop a planning process that is person-centered, data informed and outcomes focused. While each agency has its own mission, priorities, and programming strategies designed to address problems and needs within its own disability area, it is clear that there is significant overlap in constituencies and services provided. For example, the percentage of admissions to non-crisis chemical dependence treatment services of individuals with a co-occurring mental illness continues to grow every year and was 42% of the total reported in 2010, up from 35% in 2006.

A review of county plans over the past three years has also shown a gradual increase in the number of county priority outcomes focused on serving individuals with

2012 Local Services Plan Guidelines For Mental Hygiene Services

co-occurring disorders or addressing service needs across multiple disabilities. In the last planning cycle, 46 percent of all county priorities involved more than one mental hygiene disability, up from 38 percent two years earlier. Twenty-seven percent of all county priorities involved all three disabilities. These trends require a more integrated approach to local needs assessment and planning efforts. Clearly, the new integrated planning process that has evolved over that past four years has provided counties with an improved ability to focus their planning efforts on the needs of individuals rather than on the separate systems that serve those needs.

These guidelines will continue to challenge counties to identify ways to improve service availability and delivery to individuals whose needs involve multiple systems of care. As feedback from the annual [CPS User Satisfaction Survey](#) suggests, planning and needs assessment activities are often integrated and should be reported together in the county plan. Therefore, counties can now report their planning and needs assessment activities across disabilities in the same section of the plan. Where activities were integrated, they can be reported as such, and where activities were specific to a particular disability, they can be identified as such within the same section.

OASAS Prevalence and Service Need Methodologies

OASAS has developed and maintained county level, service specific need methodologies for a variety of purposes and applications for many years. Service specific need estimates coupled with current resources allow OASAS, counties and providers to determine the relative need for various services on an ongoing basis. Need estimates provide a planning ceiling for service development and have been applied as a criterion in the OASAS certification process for new or expanded programming. Need and unmet need can be utilized by policy makers, funding sources and planners to document and support specific program development initiatives.

The need for specific treatment services is based on estimates of the number of persons with a chemical dependence problem who could benefit from treatment and would likely seek treatment if it was available. Prevalence estimates utilized by OASAS are based on surveys and other information-gathering techniques which distinguish problem use, abuse and dependence estimates for alcohol, heroin, and non-opiate drugs. Separate estimates are generated for adolescents and adults. A detailed description of the OASAS [Chemical Dependence Need Methodology](#) and updated County Service Need Profiles are located in CPS to assist counties in their needs assessment and planning efforts.

Counties are strongly encouraged to conduct their own needs assessments to determine how unique local circumstances may influence treatment needs and demand. **If the county's own research contradicts the needs determined by the OASAS prevalence and service need methodologies, those differences should be documented in the plan so that they can be considered during the review of certification applications submitted to OASAS.**

Over the years, OASAS developed additional tools for counties when applying the service need methodology to local needs assessment efforts. For example, the ***OASAS Outpatient Sub-County Service Plan Form*** gives counties the opportunity to identify those local circumstances that may impact uniquely on the availability or delivery

2012 Local Services Plan Guidelines For Mental Hygiene Services

of outpatient treatment services in their particular jurisdiction. The OASAS adult outpatient need methodology can be applied to an approved sub-county outpatient service plan for project review and certification purposes. A completed sub-county service planning form must be submitted in the county's local services plan and approved by OASAS before it is implemented. Today, four counties are taking advantage of this tool. Additional guidance on using the Outpatient Sub-County Service Plan Form can be found in Chapter V.

Another need methodology tool that is available to counties is the **OASAS Community Residence Multi-County Collaborative Agreement** option. The OASAS service need methodology considers community residential services to be a county-level resource. However, in certain areas of the state where the county bed need estimate does not support the development of a community residence program or where community residence services could be more efficiently and cost effectively provided in a collaborative way among two or more neighboring counties, OASAS may approve a multi-county agreement to have the community residence need methodology applied at a multi-county level, rather than at the individual county level. Today, 14 counties in five separate multi-county areas are taking advantage of this tool. Additional guidance on using the Community Residence Multi-County Collaboration Agreement Form can be found in Chapter V.

OASAS Prevention Planning

In March 2010, the [OASAS Prevention Strategic Plan 2010-2014](#) was published on the OASAS website. It was developed from data on the consumption patterns and consequences of substance use in New York State and sets priorities that will guide the collaborative prevention efforts of OASAS, state partner agencies, counties, service providers, coalitions, and other stakeholders. It is intended to focus statewide prevention efforts on a limited number of data-driven priorities where measurable change can be achieved and to help guide prevention decision making and policy development at the state, county, and provider levels.

Based on a statewide epidemiological needs assessment process, the prevention strategic plan identified the following priorities targeted through evidence-based programs and practices:

- Reduce underage drinking, binge drinking, and alcohol misuse in the New York population across the lifespan;
- Reduce illegal drug abuse and medication misuse to include marijuana use and prescription painkiller abuse among youth;
- Reduce any gambling among youth and problem gambling among adults;
- Reduce parental attitudes favorable towards problem behavior and substance use; and
- Increase family opportunities for pro-social involvement and family attachment.

Strategies outlined in the prevention strategic plan are designed to increase the use of evidence-based services delivered in communities and increase the involvement of coalitions and other stakeholders. An implementation team of county and provider representatives is working to identify strategies to achieve the priorities identified in the plan.

2012 Local Services Plan Guidelines For Mental Hygiene Services

Data Resources Available for County Planning

OASAS has made significant amounts of data resources available to counties as part of the annual local services planning process for many years. Much of it was developed in collaboration with county planners who could best explain their data needs and the most ideal format in which to receive that data from OASAS. Historically, most data resources were updated on an annual basis, processed and provided to counties in hard copy, most notably in the County Resource Book. With the development of the online County Planning System, OASAS has been able to expand the number and types of data resources and provide them in electronic form on a much timelier basis.

The Data Needs Workgroup of the Mental Hygiene Planning Committee continues to meet on a regular basis throughout the year to identify county data needs and to collaborate with state agency staff to explore ways to develop and maintain up-to-date and relevant data resources that could best meet the needs of county planners. A significant new initiative has begun that will bring many of these data resources together in a county data dashboard, likely to be housed within CPS, that will allow county planners to access significant amounts of data and to view that data by drilling through multiple geographic and service levels. While only in the early planning stages, it is hoped that a small prototype dashboard may be available by the start of the 2013 local planning cycle. The goal is to have county planners test the dashboard and provide feedback to the workgroup. The dashboard will then be revised and expanded based on the feedback received.

This year, OASAS makes the following data resources available to county planners in CPS.

- **OASAS Fast Facts** – This is a series of brief reports that provide statewide data on special population groups, such as adolescents, persons with co-occurring disorders, senior, veterans, etc. Trends, client characteristics, and comparisons are presented for each special population. New reports are added on a regular basis.
- **OASAS Service Need Profiles** – These are 2-page profiles for each county, NYC and statewide containing relevant population, prevalence and treatment demand estimates, and specific service need estimates compared with existing certified capacities for most chemical dependence service categories. These profiles are updated every six months.
- **OASAS Medicaid Eligibility Profiles** - These profiles show the percent of the total Medicaid population in each county that receive any CD services during an enrollment year. Within counties, rates are shown for each aid category, that is, TANF, Safety net, MA only and SSI. The eligibility files are sourced from the New York State Department of Health, SURS On-Line file & eMedNY Data Warehouse for the last 6 state fiscal years. These profiles are updated on an annual basis.
- **OASAS Medicaid Recipient Profiles (RSP)** - These profiles are based upon Medicaid county of fiscal responsibility and shows what recipients received what services. Recipient counts, paid claim dollars and claim counts are shown for each type of Medicaid CD service and for a select group of non-CD health and mental health services that are also received by the CD cohort during these

2012 Local Services Plan Guidelines For Mental Hygiene Services

periods. Profiles are provided for all eligibility categories combined, including TANF, SSI, Safety Net Family Health Plus and MA only. The RSP files are sourced from the New York State Department of Health, eMedNY Data Warehouse for the last 7 state fiscal years. These profiles are updated on an annual basis.

- **OASAS Detailed Medicaid Recipient Profiles** - Similar to the 5-yr Medicaid Recipient Profiles, these profiles contain more detailed rows on Chemical Dependence (CD) claims and non-CD claims incurred by OASAS CD recipients, including general medical inpatient, outpatient and prescription claims as well as mental health inpatient, outpatient and prescription claims. These profiles are updated on an annual basis.
- **OASAS 2009 Summary of County Profiles** – This profile contains more than 50 different county level metrics from all OASAS corporate data bases and applications as well as statewide comparisons for each. Some of the metrics include prevalence and treatment need estimates, client characteristics, CD Medicaid claim dollars paid and clients served, service capacity, key treatment and prevention performance measures, OASAS funding and estimated OASAS system value each pertain to programs located in the county. The next update of these profiles is expected in June.
- **OASAS Chemical Dependence Treatment Profiles** – This is a more detailed profile than the Summary of County Profile and contains most of the same data elements focused on chemical dependence treatment services. These profiles are updated on an annual basis. The next update of these profiles is expected in June.
- **OASAS New York State and Regional Epidemiological Profiles** – The State & Regional Epidemiological Profiles provide information that supports policy making, planning and program development for prevention, treatment and recovery services. For many indicators, this profile presents data for four epidemiological regions: New York City, NYC Metropolitan Suburban, Upstate Metropolitan and Rural New York. Profile indicators have been organized to support a strategic prevention framework addressing: 1) risk and protective factors, 2) substance use and gambling behaviors, and 3) negative consequences. These profiles are updated on an annual basis.
- **OASAS 2008 Youth Development Survey Reports** – The 2008 NYS School Survey measured 21 risk and 11 protective factors that predict levels of youth substance use and other problem behaviors such as school drop-out, delinquency, violence and teen pregnancy. Profiles are included for 23 counties, New York City, and statewide.

C. How Local Plans Inform OASAS Priorities

OASAS carefully reviews all information collected through the annual local services planning process to inform and shape agency priorities. County priorities and other information gathered through the local plans represent a key component of OASAS' long-range planning efforts. A summary analysis of information collected from the 2011 planning cycle can be found in the [OASAS Statewide Comprehensive Plan 2010-2014](#), which is available on the OASAS website.

In addition to identifying county priority outcomes and related strategies in the annual plan, counties are also asked to provide a summary report on the planning

2012 Local Services Plan Guidelines For Mental Hygiene Services

activities conducted over the past year leading up to this year's plan. One of the primary reasons for reporting this information is to document how the county complied with State Mental Hygiene Law requiring a local assessment of addiction problems, needs and service gaps in the community. The county must also document that the process is a participatory one that engages providers, consumers, other agencies, and interested stakeholders.

The Planning Activities Report form also provides the county with an opportunity to provide input on a variety of state level policy issues. Previous topics counties were asked to focus attention on included an assessment of local recovery support services, suggestions for reform and reinvestment strategies, and an assessment of the local impact of drug law reform. This year, a number of policy issues are included, primarily focused on the governor's stated priorities, such as Medicaid Redesign and Mandate Relief Redesign.

Finally, OASAS will continue to use the local services planning process and CPS as a means to survey counties and providers on a variety of planning initiatives. It is important to note that each survey conducted through the local planning process provides OASAS with valuable information to support ongoing planning initiatives, needs assessments, or performance management activities. We make every effort to never ask questions (unless only to provide context) for which we already collect data through an existing reporting system. Summary analyses of the survey data are typically developed and published in the OASAS long-range plan and as separate analyses posted in CPS.

**2012 Local Services Plan Guidelines
For Mental Hygiene Services**

CHAPTER III: PLANNING FOR MENTAL HEALTH SERVICES AND SUPPORTS

A. Continuing the Momentum toward Effective Mental Health Planning

The 2012 Local Services Plan Guidelines provide a comprehensive look at the areas in which OMH is transforming its system of care and making policy, program, financing, and structural changes to improve the outcomes for persons with serious mental illness and their families. The Guidelines outline the context for mental health planning and priority setting at the State and local levels.

Recovery, resiliency, and transformation are the principles underlying reform. They help to anchor us in particularly challenging fiscal times. OMH continues to look for feasible effective actions and intentions to promote mental health at every level of the system of care and to build empowering services from the ground up. In collaboration with local governmental units (LGUs) and stakeholders OMH seeks simple, yet strong approaches to supporting recovery, resiliency and well-being. What follows is an update to last's year's Plan Guidelines.

B. Context for Mental Health Planning and Priorities

The implementation of OMH's multi-year initiative to restructure the delivery and reimbursement of publicly supported mental health services began in October 2010. Clinic restructuring reflects a renewed emphasis on enabling people to regain meaningful lives in their communities, rather than focusing largely on stabilizing symptoms and bringing people into long-term treatment. Clinic restructuring responds to the insistence by persons engaged in services and their families to receive care that fosters the hope of recovery, builds on the strengths of the whole person, and assists people as they come to terms with illness and seek to build meaningful lives in their communities.

Table 1 below (which also appears in last year's Plan Guidelines), summarizes the principles guiding clinic restructuring. The transition to a new clinic system is not a simple process, given the complexity of financing mechanisms and regulation that have grown through the years. The Center for Medicare and Medicaid Services (CMS), for example, has not yet approved the amendment to the State Medicaid Plan for OMH-licensed mental health clinics. As a result, while Part 599 of New York Codes and Regulation went into effect on October 1, 2010, mental health clinics cannot transition to Ambulatory Patient Group (APG) claiming until CMS approval is received.

2012 Local Services Plan Guidelines For Mental Hygiene Services

**Table 1
Principles Guiding Clinic Restructuring**

“Clinic” is treatment relying upon a defined set of services (see Table 2)

Restructuring should facilitate improvements in the quality of care, including:

- Promotion of recovery, resiliency, wellness, and family and peer support.
- Commitment to individualized treatment planning and individual recovery
- Identification and engagement of clients
- Access to treatment services (including off-site and in-home services)
- Clinical assessments, including those for co-occurring disorders
- Presumption that clinic is the "clinical home"* for most clients
- Regular use of evidence-based and promising treatment practices

Financial restructuring should:

- Pay based on the efficient and economical cost of providing quality services
- Phase out rate add-ons
- Provide regular evaluation of prices and cost
- Set differential payments for procedures that reflect cost differences based on type of population, geography, staffing, venue, and service
- Provide sufficient funding to allow training and supervision that enhances the implementation of evidence-based and promising treatment practices
- Provide incentives for risk-adjusted positive outcomes (to be developed)
- Allow billing for multiple services in the same day
- Use HIPAA-compliant billing codes

Restructuring should address workforce issues, including the need to:

- Promote staff retention and workforce development.
- Examine how future professionals (e.g., MSW and psychology interns) receive training in the delivery of clinic treatment services.

Restructuring should address the funding of indigent care and address Medicaid managed care plans' underpayments to providers.

Reforming Clinic Financing

The goals driving the reform in the financing of mental health clinic services are to ensure quality, fairness, and consistency with federal requirements, and to sustain current investment levels. Reforms are taking place in five strategic areas:

- 1. *Redefined and More Responsive Set of Clinic Treatment Services and Greater Accountability for Outcomes*** - Clinic treatment, the foundation of the mental health system, provides an array of required and optional services based on the best scientific evidence, with licensed staff responsible for delivering clinical services. Reimbursement emphasizes consistent payment for equivalent services across different clinics. Payment for the pro-vision of offsite services is pending approval from CMS as part of the State Medicaid Plan amendment.

2012 Local Services Plan Guidelines For Mental Hygiene Services

- 2. Increased, Consistent Medicaid Clinic Rates and Phase Out of “COPs”** – Once federal approval of the State Medicaid Plan is granted, claims for services delivered after October 1, 2010, will be automatically re-processed under APGs.
- 3. HIPAA-Compliant, Procedure-Based Payment System**
- 4. Managed Care Underpayments** - To counter barriers to access, upon approval of the State Medicaid Plan, DOH will mandate that managed care companies pay “equivalent rates” to fee-for-service and, when indicated, appropriate out-of-network fees.
- 5. Indigent Care Provisions** - Procedures are in place for implementation of indigent care provisions for mental health care following federal approval of the State Medicaid Plan amendment. OMH has helped to ready localities for clinic reform by providing training and making available materials on specific topics (e.g., the clinical model, Part 599 clinic regulations overview, uncompensated care pool) on the [Clinic Restructuring](#) section of the OMH website. OMH staff members are also monitoring the claims process and providing technical billing assistance, where indicated. A shareholder group is working with OMH on designing an evaluation to monitor patterns of care and to identify areas for improvement.

Restructuring Clinical Services

Restructuring efforts are taking place across the continuum of care and directed toward improved services and supports for children, families, and adults.

Child and Family Services - Two important initiatives are the Children’s Plan and Ambulatory Restructuring for children’s services:

- **The Children’s Plan** – A 2009 amendment to the *Children’s Mental Health Act of 2006* formalized the involvement of nine State child-caring agencies and family and youth partners in implementing the recommendations of the Children’s Plan of 2008. The amendment also placed the coordinating function of specific Plan recommendations within the Council on Children and Families (CCF). The collective goals are to strengthen child and family resilience and reverse patterns of mal-treatment, neglect, school expulsion, academic failure, violence, substance use, institutionalization and premature death.

A Children’s Plan Statewide Director and a Statewide Systems of Care Director were designated in 2009 and tasked with reporting to the heads of both CCF and Families Together in New York State, a voluntary, family-led organization. In 2010, regional youth partners were hired to serve as cross-system peer support specialists to promote Plan initiatives and ensure youth input. And, over the last year, the platform for communicating information about the Children’s Plan has been strengthened to facilitate work of the Plan. (For more information, read the [2010 Children’s Plan](#) report.)

- **Children’s Ambulatory Restructuring Project** – As ambulatory restructuring is under way in the adult system of care, similar work is taking place in the children’s system. The OMH Child and Family Ambulatory Reform Project

2012 Local Services Plan Guidelines For Mental Hygiene Services

recently conducted a review of the current system of care and strategies for holding down costs while maintaining quality treatment and supports for children with serious emotional disturbances and their families. While these children have complex needs and are often served in multiple systems (e.g., social services, juvenile justice, education), the children and families are better served with coordinated and integrated care across such systems.

The Project Team this past year sponsored numerous interagency and stakeholder meetings and obtained input for making service design recommendations for intensive community-based, waiver, and case management programs as well as for the mechanism by which children and families access these services - the Children and Youth Single Point of Access (SPOA) Program and fiscal recommendations were finalized late in 2010 and are currently under review by the OMH Division of Children and Family Services staff in consultation with national experts.

Better integration of care and focus on wellness – Because people with the most serious mental illnesses face challenging physical health issues, may fall through the cracks, and experience lapses in care that place them at greater risk of poor health outcomes, OMH continues to push for improved, coordinated and integrated care. Among priority areas are:

- ***Care monitoring*** – In the wake of several highly publicized violent incidents involving individuals with mental illnesses and recommendations from a joint State/City panel in 2008, the NYC Mental Health Care Monitoring Project was initiated. It relies upon care monitoring teams in the City to identify adults with high need, uses data systems to monitor mental health care, identifies lapses in services, and works with providers to identify strategies and actions to better engage and retain adults with high needs in care. Teams are operating in Brooklyn and Bronx. A recent evaluation of the project points to the importance of targeting individuals with the greatest needs and complicated conditions to achieve quality, cost-effective care. A description of the project can be found in the January issue of [*Psychiatric Services*](#) and in an [*article*](#) co-authored by the OMH Medical Director and Project Director that focuses on effective care coordination and management for persons with high need.

- ***Improved care for people with co-occurring mental health and alcohol/drug problems*** – In collaboration with the Center for Practice Innovations at Columbia University, OMH and OASAS are supporting integrated treatment through the delivery of distance learning modules OMH-licensed and OASAS-certified clinic staff state-wide. Integrated mental health and addictions treatment for co-occurring disorders is a proven strategy for helping people achieve and sustain recovery. The curriculum, called Focus on Integrated Treatment (FIT), provides a series of robust, flexible and concise half-hour learning modules that allow practitioners to choose when and where to take their training. The award-winning series of modules includes inspiring personal recovery stories, clinical vignettes, interactive exercises, and expert panel presentations to promote evidence-based screening and assessment, stage-wise treatment, motivational interviewing, and more as well as skills development for sustaining practices.

2012 Local Services Plan Guidelines For Mental Hygiene Services

- ***Improved prescribing practices and enhanced health monitoring*** – In partnership with DOH, OMH continues to employ the Psychiatric Clinical Knowledge Exchange System (PSYCKES), which is in use among State-operated psychiatric hospitals and licensed outpatient clinics serving Medicaid beneficiaries. Using Medicaid data, clinicians focus on the appropriate use of multiple medicines to manage serious mental illness and the reduction of risk from cardio-metabolic conditions associated with medication use.

Via PSYCKES, OMH-operated adult clinic services regularly monitor three critical indicators of physical health and medical risk, smoking status, body mass index (BMI) and blood pressure (BP). Adults hospitalized in OMH-operated psychiatric centers are also routinely tested for cholesterol and other lipids, fasting blood sugar, and smoking status. OMH-operated child and youth clinic and day treatment programs measure quarterly BMI, activity levels, and in youth 13 and over, cigarette smoking and alcohol and drug abuse. To reduce risk and prevent illness, OMH is focusing on diet, activity, smoking cessation, and the use of the evidence-based practice of Wellness Self-Management to support healthy lifestyle choices as part of recovery.

Expanding and Reforming Housing

Reducing reliance on more costly traditional mental health housing models and improving the supply of supportive housing remain top priorities for OMH. It works closely with the providers of housing services and stakeholders to evaluate and convert, where possible, staffed housing programs to integrated mixed housing settings, supported housing, and treatment apartments.

OMH is also responding to the court decision that requires adults with mental illness living in one of 28 adult homes in New York City to be offered the opportunity to move to supported housing in the community. Following the release of a request for proposals, OMH in late January announced eight recipients of funding for the development and operation of supported housing for adults living in one of 28 identified adult homes. The funding supports three phases for the development and operation of up to 4,500 units of supported housing at the rate of 1,500 units per phase.

Collaborating with Mental Hygiene Agencies

Three major areas of collaboration for OMH include:

- The Mental Hygiene County Planning Committee, in collaboration with the Conference of Local Mental Hygiene Directors, and under the purview of the Inter-Office Coordinating Council (IOCC), is promoting a more efficient and uniform local services planning process that links more closely local governmental and state planning.
- The Most Integrated Setting Coordinating Council (MISCC) continues address the housing, employment, and transportation needs of New Yorkers with disabilities.

2012 Local Services Plan Guidelines For Mental Hygiene Services

- Close work with Office of Persons with Developmental Disabilities (OPWDD) is helping to promote the development of dual diagnosis teams and integrated care training.

Collaborating with Criminal Justice Agencies

Collaborations help to ensure quality care for persons who are incarcerated and have serious mental illness and they improve community responses to people with mental illness who have contact with the criminal justice system. As noted in previous Interim Reports, partners include the State Division of Criminal Justice Services, the Department of Correctional Services, and Division of Parole. Private partnerships also are also crucial. In 2010, the Center for Urban Community Services in New York City received recognition for its Reentry Coordination System, a federally funded “Projects for Assistance in Transition from Homelessness” (PATH) initiative administered by the Center for OMH. The award acknowledged exemplary practice by the Center, which since 2009, has been using its Reentry Coordination System to gain access to supportive housing units in the City for individuals being released from prison with mental illness and who would otherwise be homeless upon release. During its first year, the system was used to make 420 housing referrals; 79 inmates were placed into permanent housing and 38 were awaiting permanent housing.

Recovery, Resiliency and Transformation in Action

As noted in the introduction, recovery, resiliency, and transformation are the framework for reform of mental health services. Some examples of these concepts in action include:

- ***New York Makes Work Pay*** – The State is entering its third year of Medicaid Infrastructure Grant funding from CMS designed to improve the infrastructure to support competitive employment opportunities and outcomes for people with disabilities. *New York Makes Work Pay* is a series of initiatives spearheaded by OMH, in partnership with Cornell University’s Employment and Disability Institute and Syracuse University’s Burton Blatt Institute, on behalf of all State agencies that come into contact with individuals with disabilities seeking employment opportunities or employment-related supports. A priority for *New York Makes Work Pay* is the development of a comprehensive and integrated cross-agency employment services data system that gives job seekers immediate access to job opportunities and makes enhancements that will allow providers to more readily employ people with disabilities. A target date of June 2011 has been set to have the redesigned system available throughout most of OMH, as well as several other agencies.

A priority is to develop a comprehensive and integrated cross-agency job-matching and employment support system. Current silos of employment-related information and fragmented approaches to assist New Yorkers with disabilities to find employment will be replaced with a redesigned version of the State Department of Labor’s One-Stop Operating System, which will be used by all providers of employment supports and assistance. Under the redesigned system, job seekers will have immediate access to job opportunities and skills matching technology that identifies skills individuals possess based on their

2012 Local Services Plan Guidelines For Mental Hygiene Services

unique experiences, assist with resume development, and pre-match their skills with job opportunities seeking such talent. The system will also benefit businesses and employment providers by streamlining documentation, enhancing receipt of tax incentives for hiring individuals with disabilities for example, as they endeavor to aid persons achieve employment outcomes. A target date of June 2011 has been set to have the re-designed system available throughout most of OMH, as well as several other agencies.

- **Personalized Recovery-Oriented Services (PROS)** – This best practice assists individuals in recovering from the disabling effects of mental illness through coordinated and customized rehabilitation, treatment and support services. Regulatory changes made by OMH have helped to diminish programmatic barriers to PROS adoption, with substantial growth in the program over the last year. An area of increasing focus in PROS programs is the introduction of [Individual Placement and Support \(IPS\)](#), considered the gold standard for helping people gain employment readily with ongoing support. The goal is to shift the focus of programs such as day treatment largely from socialization to support of each person's desire to attain more meaningful community living.

- **Peer Recovery and Technical Assistance Centers** – Through targeted investment, modest federal grant funding and active stakeholder participation, OMH has designated a technical assistance center this year to assist local peer programs to evolve into full-fledged recovery centers. Through a request for proposals, OMH has selected the University of Medicine and Dentistry of New Jersey School of Health Related Professions to create a curriculum that will support transformation and be offered through an online self-help/peer support school. The curriculum will aid increasing peer-run organization staff competencies, enhancing leadership and business management capabilities, and providing training to enable peer-run organizations to offer recovery-oriented evidenced-based services.

C. Local Services Planning and Priorities

County input is crucial in scanning environmental trends and challenges, identifying priority areas to be addressed, and creating conditions for promoting recovery, resiliency and transformation. OMH continues to embrace local planning from the ground up, emphasizing person-centered, recovery-oriented services and supports and more inclusive planning processes that reflect local needs, gaps and possible solutions.

Strategic directions at the State and local levels since 2008 continue to be driven by three transformational goals: 1) sustaining an aggressive change agenda, balanced by thoughtful management and attention to the challenges of change; 2) maintaining the quality of care and the pace of reform in the context of staff freezes, resource limits, and heightened oversight controls; and 3) continuously collaborating and communicating internally, laterally, and with all stakeholders. These goals are expected to evolve more over the next year as changes at the State level are adopted (e.g., Medicaid Redesign, Spending and Government Efficiency Commission) to make government more efficient and cost-effective.

2012 Local Services Plan Guidelines For Mental Hygiene Services

Supporting Planning Data Information Needs

The Office of Planning continues to work closely with the Mental Hygiene Planning Committee and its County Data Need Subcommittee (CDNS) to make data more accessible to county planners, thereby strengthening their ability to use data for informed local decision making. The [County Mental Health Profiles Portal](#) is publicly accessible to county planners for use in analyzing data, identifying mental health service gaps and disparities, and using data to improve the quality of service delivery. In addition to the Adult Medicaid Expenditures report, individual county profiles have been added that summarize key indicators across several domains (e.g., community characteristics, summary Medicaid spending, wellness indicators).

This year the portal will be enhanced by the addition of a mental health Medicaid recipient utilization report that includes recipients of substance abuse services, children's Medicaid and other key child/family indicators, forensics, and Medicaid managed care data. OMH will continue to participate in the Committee's Community of Practice to provide overviews of data being introduced and ways that it could be utilized.

Office of Planning Support of Local Planning Efforts

During the coming year, the Office of Planning will continue to meet with internal and external stakeholders to obtain input into the development of the annual Statewide Plan, encourage better alignment between adult State psychiatric center and local planning activities, continue to actively participate in the Mental Hygiene Planning Committee, provide ongoing support and technical assistance to the Commissioner's policy advisory board, the Mental Health Services Council, and maintain a [Planning Resources](#) web page on the OMH website.

2012 Local Services Plan Guidelines For Mental Hygiene Services

CHAPTER IV: PLANNING FOR DEVELOPMENTAL DISABILITY SERVICES

A. Background

This year's *Local Services Plan Guidelines* build upon our successful partnership with the Conference of Local Mental Hygiene Directors, the Office of Alcoholism and Substance Abuse Services (OASAS), and the Office of Mental Health (OMH). In the 2011 planning cycle, OPWDD continued to invest in an integrative planning approach which allows for improved outcomes for individuals with disabilities and streamlined processes for counties.

The purpose of the local services planning process is to assist OPWDD in determining local priorities for services and inform the agency's strategic plan. Counties specify outcomes that identify what the future service system should look like and strategies to reach these outcomes. Counties should also consider opportunities for increased collaboration around cross systems concerns, or issues which require cooperation between different service systems.

The guidelines for developmental disability services highlight OPWDD's commitment to "Putting People First" by supporting individuals with developmental disabilities to live richer lives through individualized, person-centered services. To better align the county planning process with the OPWDD mission and vision, the [OPWDD Statewide Comprehensive Plan: 2010-2014](#), which is located on the OPWDD Website, has also been made available on the county data page of CPS. Counties will be able to connect their local priorities with priorities shared throughout the state as described in the Plan.

As in previous years, we emphasize the need for involving all stakeholders in the planning process, including individuals with developmental disabilities, their family members, advocates, providers, state and local government staff. This can be done many different ways, including public forums or hearings, focus group discussions, interviews or surveys. Information and opinions should be solicited on an ongoing basis from stakeholders, and steps should be taken to address issues that may cross various systems of services delivery. Regular dialogue between consumer councils, planning committees, and the Community Services Board subcommittee is strongly encouraged. In this year's plan guidelines, counties are asked to describe these activities in more detail.

For the past three years, OASAS, OMH and OPWDD have worked cooperatively with our county partners to design, implement, and improve upon the local services planning process through the development of CPS. Much has been accomplished through this collaboration, and OPWDD is excited about what the future holds.

B. Guiding Principles

As required by Article 41 of the New York Mental Hygiene Law (MHL), it is the responsibility of the county to work with the state to develop a local services program and plan for its citizens with mental retardation and developmental disabilities. To develop a comprehensive, coordinated Local Services Plan for people with developmental disabilities, the county must research, review and determine local best

2012 Local Services Plan Guidelines For Mental Hygiene Services

practices, issues, concerns and needs in terms of supports, services, and infrastructure. The county may also assume a leadership role in promoting public understanding and awareness of, and facilitating interagency collaboration to meet the needs of people with developmental disabilities.

To that end, the county is required by Article 41 to submit to OPWDD an annual plan. This plan is developed by the county in collaboration with the local Developmental Disabilities Services Office and all local stakeholders. To facilitate a more meaningful and efficient process, the planning processes of OPWDD, OMH and OASAS are integrated as one process through the CPS.

Counties have a responsibility to ensure information on concerns for all disability populations is regularly updated, keeping in mind a three year outlook in planning for the future. Each year the county will assume a leadership role in identifying the most important local issues of concern and an action plan for responding to these issues. It is anticipated many outcomes and strategies will be continued from year to year in the plan. The county will build upon information from each prior year by reporting progress on the previously identified outcomes and updating the outcomes for the current year. It is important to understand that the Local Services Plan does not have to be inclusive of all services planned, although local services and proposed projects should be consistent with the Plan. The Plan should not be project- or provider-specific, but rather should set directions for future planning.

In planning for OPWDD services, counties must develop their priority outcomes based on OPWDD's mission and vision for individuals with developmental disabilities:

Mission Statement: *We help people with developmental disabilities live richer lives.*

Vision Statement: *People with developmental disabilities enjoy meaningful relationships with friends, family and others in their lives, experience personal health and growth, live in a home of their choice, and fully participate in their communities.*

- **People First:** People who have developmental disabilities have plans, supports, and services that are person centered and as self-directed as they choose.
- **Home of Choice:** People who have developmental disabilities are living in the home of their choice.
- **Work or Contributing to the Community:** People who have developmental disabilities are able to work at paying jobs and/or participate in communities through meaningful activities.
- **Relationships:** People who have developmental disabilities have meaningful relationships with friends, family, and others of their choice.
- **Good Health:** People who have developmental disabilities have good health.

Each of the "people first" areas guide the *OPWDD Statewide Comprehensive Plan for 2010-2014*. Also, the *OPWDD Strategic Framework* in the county data section of CPS offers a concise presentation of statewide goals, outcomes, and key activity areas. The key outcomes and activities correspond to areas identified as important by self-advocates, family members, providers, and other stakeholders. Local priorities should be carefully balanced with these statewide priority areas:

2012 Local Services Plan Guidelines For Mental Hygiene Services

People First

- Person-centered Planning.
- Self-directed Supports and Services.
- Self-Advocacy.
- Brokerage.
- Simplified and Streamlined Processes for Individualized Services.
- Provider Capacity to Deliver Individualized Supports and Services.

Home of Choice

- Supporting Families.
- Congregate Community Living.
- Individual Support Services.
- Housing Initiatives.
- Shared Living.
- Family Care.
- Children's Residential Services.
- Nursing Home Diversion.
- Developmental Center Services.

Work or Contributing to the Community

- Employment.
- Transition Planning.
- Seamless Supports between Work and Habilitation.
- Volunteerism.
- Fostering Community Acceptance.

Relationships

- Community Inclusion.
- Building Relationships with Staff.
- Staff Recognition and Mentorship for Inclusion.
- Community Participation.
- Faith-Based Initiatives.

Good Health

- Prevention.
- Smoking Cessation.
- Quality Dental and Medical Care.
- Telemedicine.
- Osteoporosis.
- Medication Management.
- Nutrition.
- Article 16 Clinical Services.
- Behavioral Health.
- Electronic Records.
- Medicaid Managed Care.
- Medicare.
- Guardianship, Advance Health Care Directives, and Surrogate Decision-Making.

Themes Affecting All Services

- Quality Management.
- Workforce Development.
- Personal Responsibility.
- Special Populations.
- Interagency Collaboration.
- Public Information and Outreach.
- Crisis Intervention.
- Access to Services.
- Coordination of Services.
- Research and Best Practices Identification.
- Regulatory or Policy Reform.

The county may also consider other topic areas that impact services for people with developmental disabilities that do not readily fall into one of these categories.

The planning process incorporates input from the local constituency to inform the local Developmental Disabilities Services Office (DDSO) of critical needs and priorities. DDSOs consider the identified key outcomes when issuing "Requests for Proposals" and when partnering with stakeholders in forums promoting any "new" services development, and enrollments for *NYS-CARES*, *Family Support Services (FSS)* and *Home and*

2012 Local Services Plan Guidelines For Mental Hygiene Services

Community Based Services (HCBS). The county plans are also analyzed for themes that help determine the state's strategic planning and annual budget requests.

The county is jointly responsible, in partnership with the state, for the policies, administration and supervision of developmental disabilities services within the locality. Cooperation with other county departments and access to all local resources should also be sought to ensure advancement of the plan.

A unified and comprehensive planning process will enable people with developmental disabilities, families, providers, planners, funders, regulators and legislators to participate as full planning partners. It is very important to involve individuals with developmental disabilities in developing the plan so their input can provide the foundation for service planning.

C. The Planning Process

1. **A working relationship between DDSOs, counties or boroughs, individuals with developmental disabilities, their families or advocates, voluntary providers and other state agencies** must be formed as a first step in the planning process. This collaboration between the county, the DDSO and other stakeholders is essential to the production of a meaningful plan reflecting the needs of all county residents.
2. The new plan will be for the year **2012**, but the outlook should be for three years.
3. The identification of local issues and needs through **a discovery process** and the development of strategies should occur through an ongoing needs assessment process. In preparing the Local Services Plan, counties are requested to periodically conduct discovery activities in order to identify and measure the issues, concerns, problems or service gaps that exist within the local community. The discovery process should be representative of the stakeholders in the county.
 - A. Counties can gather information from various constituent groups, including:
 - Individuals with developmental disabilities
 - Families
 - Existing advocacy entities, such as Consumer Councils, Borough Councils and self-advocacy groups
 - Providers of services for people with developmental disabilities, including Medicaid Service Coordinators
 - Community Service Boards
 - Schools and Boards of Education
 - Early Intervention Officials
 - Hospitals
 - Other organizations that may support people with developmental disabilities, such as Departments of Social Services, Mental Health providers or Offices for the Aging

2012 Local Services Plan Guidelines For Mental Hygiene Services

Constituents consulted and key participants to the planning process should be identified under the **Planning Activities Report** tab of the Web-based application. In addition, the **DD Subcommittee Membership Form** tab is for identifying the members of the Community Services Board Subcommittee on Developmental Disabilities.

B. Various methods of discovery can be conducted including:

- Surveys.
- Community forums.
- Key informant interviews.
- Focus groups on topics of targeted interest or for specific populations.
- OPWDD county specific data upon request to Director/NYCRO Associate Commissioner.
- Analysis of prevalence, demographic, and risk indicator data available through other resources:
 - CDC Metropolitan Atlanta Developmental Disabilities Study (provides US population-based epidemiological data on the prevalence of mental retardation, cerebral palsy, epilepsy, visual impairments and hearing loss in school-aged children).
www.cdc.gov/ncbddd/dd/madds.htm
 - State of the States in Developmental Disabilities (profiles NY's long term care services and supports for children and adults with developmental disabilities; 2008 is now available for purchase).
www.cu.edu/ColemanInstitute/stateofthestates/
 - US Census Bureau statistics. www.census.gov/
 - The American Community Survey.
http://www.factfinder.census.gov/servlet/DatasetMainPageServlet?_program=ACS&_submenuId=&_lang=en&_ts=
 - CDC National Center for Health Statistics. www.cdc.gov/nchs/
 - CDC National Center on Birth Defects and Developmental Disabilities.
www.cdc.gov/ncbddd/
 - Disability and Health State Chartbook – 2006
<http://www.cdc.gov/ncbddd/disabilityandhealth/chartbook/states.html>
 - NYS Touchstones/Kids COUNT Data Book.
 - <http://www.omh.state.ny.us/omhweb/PCS/survey07/>
 - NYS Office for the Aging. <http://www.aging.ny.gov/Index.cfm>
 - NYS Department of Health Community Health Data Set and other data links.
http://www.health.state.ny.us/statistics/chac/nysdoh_program_data.htm
 - Vital Statistics. www.health.state.ny.us/statistics/
 - County Health Indicator Profiles.
www.health.state.ny.us/statistics/chip/index.htm
 - NYS Department of Health SPARCS Annual Report.
<http://www.health.state.ny.us/statistics/sparcs/annual.htm>
 - Congenital Malformations Registry.
http://www.health.state.ny.us/diseases/congenital_malformations/2006/index.htm

2012 Local Services Plan Guidelines For Mental Hygiene Services

- Number of Medicaid Eligibles by Category of Eligibility by Social Service District.
<http://www.health.state.ny.us/nysdoh/medstat/medicaid.htm>
- Community Health Assessment Clearinghouse links.
<http://www.health.state.ny.us/statistics/chac/>
- Administration on Aging.
http://www.aoa.gov/AoARoot/Aging_Statistics/index.aspx
- Disability Data at InfoUse.
<http://www.infouse.com/disabilitydata/home/index.php>
- National Institutes of Health. <http://report.nih.gov/>
- National Institute on Disability and Rehabilitation Research.
<http://www.ed.gov/about/offices/list/osers/nidrr/index.html>
- 2008 Disability Status Report for the US.
<http://www.disabilitystatistics.org>
- Disability Statistics Center. <http://dsc.ucsf.edu/main.php>
- National Dissemination Center for Children with Disabilities.
<http://www.nichcy.org/Pages/Home.aspx>
- Bureau of Justice Statistics. www.ojp.usdoj.gov/bjs/
- FEDSTATS (lists many resources). <http://www.fedstats.gov/>

Methods of discovery should be documented under the **Planning Activities Report** tab of the Web-based application. Counties are asked to select the specific method used and describe how it was used, key participants included, and outcomes achieved.

- C. The discovery process will provide the means to confirm and document what is observed or reported anecdotally about problems and needs within a community. **It is important that the outcomes identified as the most important for the development of an action plan be validated by the planning group based upon documentation from at least two different types of information sources.**
- D. **The discovery process should be used to develop outcome statements in common language which describe a three year plan for the county service system.** These outcomes will guide the county in discussing what activities and strategies may be necessary to move the local system in the desired directions. *Examples of outcome statements are:*
- *Increased accessible housing for young adults waiting to move out of their family homes.*
 - *Greater choice and control of individualized services.*
 - *Increased access to psychiatry services for children.*
 - *More systems collaboration to support people with challenging dual diagnoses needs.*

A way to collect this information is to ask stakeholders to identify **what their vision is for a “better system,” what is currently working, what is not working well, and what should be done to reach the “better system.”**

**2012 Local Services Plan Guidelines
For Mental Hygiene Services**

- E. OPWDD will continue to provide current registration data on the number of people who are registered for out-of-home residential opportunities as documented through the NYS-CARES program. This information is available under the **County Data** tab of the Web-based application.
4. **Following the identification of outcomes, the county will facilitate a decision-making process to build consensus between planning stakeholders regarding the most important outcomes to address over the next three years. These outcomes do not need to be ranked in order of importance, but will provide guidance on the local priorities for service development.** The selected outcomes should not be viewed as excluding development in other areas.

Selected priority outcome statements should be documented on the **Priority Outcomes** tab of the Web-based application.

5. Following development of a list of the selected outcomes to be addressed, the county will begin dialogue with the various stakeholders on the **strategies and action steps necessary to resolve or begin to address the identified issues. Strategies are required and should be documented on the appropriate planning form; a detailed action plan is not required for submission.** However, a general action plan will be necessary in order to assess progress each year towards reaching desired outcomes. The county should consider timeframes, and which stakeholders will assume responsibility in follow-up activities. An action plan would appropriately identify:
- A. Those activities that OPWDD would need to support/implement,
 - B. Those activities that local provider agencies will engage in,
 - C. Those activities families and advocates can best address, and
 - D. Those activities the county is best prepared to respond to.

Stakeholders other than OPWDD may be better poised to address gaps in services between systems or may provide resources to help facilitate bridges for service gaps.

6. In order to develop an action plan, counties will need to **assess the local capacity and resources** currently available that can address the identified needs. OPWDD will provide data annually in the **County Data** section of the Web-based application on the number of service-specific enrollments and the average costs of services. More detailed enrollment data reports by agency may be available upon request from the NYCRO or DDSO. Also, though OPWDD makes every effort to assure that the data provided is correct, there may be some differences between the information in the **County Data** reports and the most recent DDSO data. DDSOs should be consulted for verification.

The action plan should also identify an inventory of generic services available within the county that can meet the needs of people with developmental disabilities and their families (e.g., health and medical services, education, housing options, transportation, mental health services, drug and alcohol services, organized recreational opportunities, senior services, social services).

2012 Local Services Plan Guidelines For Mental Hygiene Services

Identifying these resources will help to ensure they are being utilized to the fullest extent, to define barriers to access, and to develop strategies to address those barriers as appropriate.

The **County Data** section provides annual average per person funded amounts for the services and supports in your region. These amounts are derived from the Fiscal Year 2009-2010 budgeted amounts for these services in your region. The regions are defined for budgeting purposes as follows:

Region I: The five counties (boroughs) of New York City

Region II: Nassau, Orange, Rockland, Suffolk, Sullivan, Westchester Counties

Region III: All counties not in Regions I and II

The budget figures included in the **County Data** are regional averages and as such may not reflect specific local amounts. Counties may estimate the approximate total public funding by multiplying the regional per person funding amounts with the number of people with developmental disabilities in each service category (in their county). Regional funding information and amounts for all funding elements were not available for all service categories.

Space for narrative information and a grid are provided in the **Planning Activities Report** for documenting the current local services capacity, but **submission to OPWDD is optional**. Specific information related to the local capacity to provide services to people with cross systems disability needs is provided on the **Multiple Disabilities Consideration Form**.

The **County Data** also contains two sources of data regarding counties and participation of residents in campus programs such as developmental centers. One source provides a count of the number of people in various campus programs who live in the county. In some instances, these numbers will be large and reflect the presence of a developmental center in the county.

The **County Data** contains another dataset that presents a summary of enrollment of former county residents in campus programs, labeled *County of Interest/Origin*. This data presents the number of people living in a DC (Developmental Center), Autism unit, MDU (multiple disabilities unit), CIT (Center for Intensive Treatment), RBTU (Regional Behavioral Treatment Unit), LIT (Local Intensive Treatment Unit), RIT (Regional Intensive Treatment Unit) or SRU (Small Residential Unit).

For people who have a reported county of interest, the county of *interest* is used; for people with no county of interest on record, the county of *origin* is used. The county of interest is *the county to which a person would return if he or she was discharged from a campus program today*, whereas the county of origin is *the county in which the person lived when he or she was first admitted to a developmental center*.

This total provides the best available count of county residents enrolled in campus services. There may be charge-backs to counties under the Criminal

**2012 Local Services Plan Guidelines
For Mental Hygiene Services**

Procedures Law for some, but not all, of the people who have enrolled in campus services.

7. **For outcomes already underway, progress on strategies should be reported and priorities updated** as needed. Specific elements for reporting include:
 - Statement of progress on previously selected outcomes.
 - Explanation of specific actions undertaken to resolve issues.
 - Best or promising practices.
 - Obstacles or barriers in achieving progress.
 - Planned actions or recommendations for overcoming obstacles.
8. The **preliminary draft** should be made available for public review and comment with special attention given to the input of individuals with developmental disabilities and their families.
9. Upon receipt of all comments to the preliminary draft, a **final plan** should be developed which incorporates the input received.
10. The final Local Services Plan **must be approved by the County Director of Community Services and the DDSO Director**. The plan should be submitted first to the County Director for certification and subsequently to the DDSO Director, who is acting as the OPWDD Commissioner's designee for the purposes of compliance with Article 41. **The DDSO Director is requested to respond to the proposed plan within 30 days of receipt of the completed Plan**. All portions of the Plan to which OPWDD agrees shall be promptly approved and such approvals shall not be delayed pending approval of other portions of the plan whenever permissible. Article 41 provides additional guidance for those portions of plans not approved.
11. If you have questions, please contact:

Ray Pierce
Planning and Research
OPWDD
44 Holland Avenue
Albany, New York 12229
518 474-4904
Raymond.L.Pierce@opwdd.ny.gov

**2012 Local Services Plan Guidelines
For Mental Hygiene Services**

CHAPTER V: COUNTY PLAN FORMS

A. County Planning Activities Report Form

Planning is an ongoing activity that occurs throughout the year. Provider meetings, Community Services Board Subcommittee meetings, public forums, and analysis of data from a variety of sources are all part of the county's efforts to assess problems and needs and to develop strategies that could be pursued to address those problems and needs. The County Planning Activities Report Form is the part of the local services plan that describes these activities in detail to not only demonstrate compliance with the State Mental Hygiene Law, but also to provide support documentation for the county's priorities described in the plan. Planning and needs assessment activities should identify participants and describe the contributions they made to the planning process. Collaborations with other service systems that contribute to the local planning process should also be documented. This form is also used as a means to collect information from counties on specific policy issues of importance to the State that varies from year to year.

This year, Part A of the County Planning Activities Report Form (Items 1-3) pertains to needs assessment and planning activities for all mental hygiene services. Feedback from last year's CPS User Satisfaction Survey suggested that separating this section by disability created redundancy in the reporting, since much of the needs assessment and planning activities conducted by the county crossed disability areas. Therefore, the needs assessment and planning activities for all three disabilities can now be reported together in one section. If certain activities pertained to only one disability, simply identify it as such and include it in the same section. County planners are encouraged to use the planning resources available in CPS on the County Data Page and in the CPLP section in their needs assessments.

Instructions for Completing the County Planning Activities Report

The County Planning Activities Report Form must be completed and certified in CPS. If the county would like to include additional planning activity material that does not specifically respond to one of the eight items on the form, a separate report can be attached to this form in CPS.

Part A: Needs Assessment

1. **Assessment of Mental Hygiene Problems** – Provide a brief geographic and demographic description of the service area. Based on all the planning and needs assessment activities conducted over the past year, define the nature and extent of mental hygiene problems in the county. Include only the results of qualitative and quantitative activities in this section and describe those activities in more detail in Item #3 below. Describe how specific resources available on the CPS County Data Page were used in your needs assessment.
2. **Analysis of Service Needs and Gaps** - Based on the needs assessment results reported in Item #1 above, describe and quantify the mental hygiene prevention and treatment service needs of the population, including recovery support services and other individualized person-centered supports and services. Describe the capacity of

2012 Local Services Plan Guidelines For Mental Hygiene Services

existing resources available to meet the identified needs, including those services that are accessed outside of the county and outside the funded and certified service system. Describe and quantify the gaps between services needed and services provided. Describe existing barriers to accessing needed services. Use this section to identify target populations and specialized service needs. Use this section to describe changes in the current configuration of the local service system that you believe would better meet the needs of individuals and families in your county, and identify any capital improvement needs within the local mental hygiene service system. This item provides the basis for developing priority outcomes and related strategies designed to achieve those outcomes.

3. **Effective Assessment Techniques and Practices Utilized** – One of the objectives of the Community of Practice for Local Planners (CPLP) is to identify effective or innovative planning and needs assessment practices being used in the local planning process that could be shared with other county planners across the state to improve their own planning efforts. This may also include innovative process change activities that have resulted in a more efficient use of time and resources employed in the planning process. This section contains a list of common needs assessment techniques that could be used to assess the mental hygiene problems and service needs in the population. Indicate each technique or practice that was utilized in your county's planning process and provide a brief description of how it was used, who participated, and what the result was. If you used specific data gathering techniques such as Nominal Group Technique, other brainstorming approaches, Fishbone Diagram, Flow Charting, or other strategies that you have used to gather data in the meetings and processes, please describe under the appropriate technique. You are encouraged to describe variations to these practices and other practices not listed that you believe were effective and may find success in other counties. The CPLP is interested in following up with counties that have demonstrated success in using these techniques and practices to develop a practice guide that will be made available to all counties as a resource document for conducting their own local needs assessment and planning activities. The following is a list of potential assessment techniques and practices:

- **Community Forum** - A community or public forum is an easy and inexpensive way to get input from citizens on important issues that impact the community. It is also an excellent way to gauge the readiness of the community to address those issues. Community forums are usually preceded by a public announcement inviting all interested citizens and community groups to attend. Issues prepared ahead of time are presented and testimony is taken from the attendees. Several counties conduct community forums as a routine part of their annual planning process.
- **Focus Groups** – Unlike a community forum, a focus group is a more structured and focused assessment tool that is generally concentrated on a specific subject or problem, such as identifying the problems and needs of homeless individuals in the community, or how to respond to the problem of teen access to tobacco and alcohol sold by local retail establishments. Effective focus groups are limited in size (generally 8 to 12 participants) and run by a facilitator who can keep the group focused and on schedule to accomplish all the desired objectives. Typically, each focus group has a recorder to write down all the important information so that it can be written up or reported out to a larger audience.
- **Advisory Groups/Task Forces/Coalitions** – Several counties use these standing groups to address specific topics on an ongoing basis, such as adolescent issues, housing, co-occurring disorders, etc. These organized groups can provide an excellent

2012 Local Services Plan Guidelines For Mental Hygiene Services

resource of community-based multi-disciplinary expertise, often producing their own studies, grant applications, and in-depth reports.

- **Key Informant Interviews** – Interviewing and soliciting the opinions and experiences of individuals in the community who may be familiar with the needs of general or special populations can be an effective approach to identifying needs. Typically, key informants are health care professionals, community advocates, public officials, law enforcement officials, and consumers. They typically complete a questionnaire or are interviewed to obtain their impressions of community needs. This is considered to be a less reliable needs assessment approach because often a key informant is either a member of the population being studied or someone who has a personal or professional stake in the development of services for a particular population. However, it is a relatively inexpensive approach that could open lines of communication between groups and may lead to partnerships that could benefit the populations in need of services.
- **Population Surveys** – Surveys of the general population or target populations within defined geographic areas are an excellent way to gather information on a variety of important topics such as alcohol and substance abuse, mental illness, employment, transportation and child care needs, etc. For example, the OASAS New York State population surveys form the foundation of state-level needs assessment efforts and the basis for the development of prevalence and service need estimates. Targeted surveys allow you to assess the special needs of a segment of the population that may not be represented in a survey of the general population. For example, a county may conduct its own surveys at schools, shelters, senior centers or any location where there may be a group of individuals that you want to learn something more about.
- **Provider Surveys** – A survey of professional staff providing direct care services to the population is an excellent way to learn about issues related to the people they serve, the service models being delivered and a wide variety of topics related to access to care, support service needs, etc. OASAS regularly includes provider and program-level surveys in the annual plan guidelines to help OASAS assess the changing needs across the state on a variety of important topics and to provide baseline data on specific planning initiatives where such data does not exist in any existing data reporting systems.
- **Patient Satisfaction Surveys** - A Patient Satisfaction Survey is a short, easily administered questionnaire that provides information and insight on the patient's view of the services they receive. Survey results can be used to assess quality of care design, establish benchmarks for goal setting, and track quality improvement over time. This type of patient-centered approach to quality management is especially important in an environment of shrinking budgets and an increased focus on performance monitoring by allowing for a proactive search for ways to improve service delivery. These surveys not only empower patients, they provide insightful feedback that can be measured, interpreted and acted upon. Patient satisfaction surveys can focus on a wide variety of important topics, such as wait times, staff courtesy and compassion, facility access, effectiveness of services, etc.
- **Analysis of Secondary Data** – Secondary data, including social indicators and data collected through previous surveys and other collection methods, can be used to form characteristics of a population, obtain insights about their well-being, and to help estimate service needs. This approach assumes that socio-demographic characteristics correlate with the needs of a population and can be used as a surrogate of need. Indicator data may be direct or indirect measures of events that allow reliable and regular comparisons to be made between sub-populations and geographic areas. This approach uses descriptive statistics such as census data, drug-related arrests, DWI arrests, treatment admissions, hospital discharge diagnoses, and teen pregnancies. Because these statistics are generally collected and published already, this type of analysis is inexpensive, but care must be taken in the interpretation of the data which must have some documented, defensible basis.

2012 Local Services Plan Guidelines For Mental Hygiene Services

Part B: Policy and Planning

1. **Recovery Support Awareness Efforts (OASAS)** – Recovery support services are those non-clinical services that assist individuals in their recovery from alcohol and substance abuse and contribute to their wellness and improved quality of life. Supports may include such things as transportation, housing assistance, vocational and education assistance, health and wellness services, child care, peer-to-peer services, and self-help (including AA, NA, and other community-based and faith-based supports). This question focuses on three particular components of recovery supports that OASAS would like to see increasingly integrated within treatment protocols.

In the wake of the court ruling in *DeStefano v. Emergency Housing Group* in 2001, OASAS issued a local services bulletin [LSB 2002-05](#) clarifying what providers could and could not do regarding attendance at AA meetings or other community-based and faith-based self-help meetings. Recent analysis of discharge data from OASAS-certified treatment programs shows a declining percentage of patients having attended a self-help meeting in the 30 days prior to discharge, suggesting that there may be some misunderstanding of this guidance. Research indicates that a referral made at discharge rarely results in any kind of engagement with recovery supports. It is strongly recommended that people be connected while they are still in treatment so that the clinical team can see if the person is actually integrating the new support, how effective it is for the person etc.

- a. What effort has the county made, or is making, to ensure that providers understand the guidance provided in [LSB 2002-05](#) and are connecting individuals to community and faith-based recovery supports such as AA or other self-help groups while they are still participating in treatment?

Recovery Coaching is part of peer-based recovery services designed to engage individuals in recovery stabilization and maintenance. Peer interventions, such as recovery coaching, have been shown to improve engagement and retention of people seeking services and improve long-term treatment outcomes. **Telephone Recovery Support** is another non-clinical activity that has been shown, anecdotally, to improve successful transitions between levels of care (i.e., from acute/inpatient care to outpatient care). It is a very cost effective volunteer activity that typically involves weekly check-up calls at pre-arranged times. Trained volunteers in recovery make telephone calls to people newly in recovery to support them along their journey and refer them to services when appropriate.

- b. What effort has the county made, or is making, to increase the awareness of providers of these two recovery support activities?

2. **Medicaid Redesign (Optional)** - In New York State, Medicaid pays over \$53 billion a year to provide health care to more than 4.7 million people in need. In effect,

2012 Local Services Plan Guidelines For Mental Hygiene Services

Medicaid is the largest health insurance program in New York State, with the costs being borne by state, county and federal taxpayers. In Governor Andrew M. Cuomo's State of the State address on January 5, 2011, he stated that *"It is of compelling public importance that the State conduct a fundamental restructuring of its Medicaid program to achieve measurable improvement in health outcomes, sustainable cost control and a more efficient administrative structure."*

One of Cuomo's first acts as governor was to establish a Medicaid Redesign Team consisting of representatives from business, the insurance industry, the health care industry, patient advocacy, and government. The objective of the redesign team is to find ways to reduce costs and increase quality and efficiency in the Medicaid program for the upcoming 2011-12 Fiscal Year. The team is required to submit its first report with findings and recommendations to the Governor by March 1 for consideration in the budget process, and will submit quarterly reports thereafter until the end of Fiscal Year 2011-12, when it will disband.

Part of this effort includes seeking ideas from the public at large, as well as experts in health care delivery and insurance, the health care workforce, economics, business, consumer rights and other relevant areas. Eight regional public hearings were held across the state in January and February to solicit ideas from the public on ways to reduce costs and improve the quality of the Medicaid program. These guidelines provide counties with an additional opportunity to provide input into this process. A summary of the responses to the following questions will be shared with the OASAS, OMH, and OPWDD representatives on the Medicaid Redesign Team and presented to the team later this year.

- a. What specific system or program reforms/changes have you enacted, or are you proposing to enact during the reporting period, that will improve quality and/or reduce costs to the Medicaid program?
- b. What specific regulatory or administrative changes have you implemented locally (in partnership with your Medicaid Managed Care companies or local Commissioners of Social Services/Human Services) to lower costs and/or improve quality within the Medicaid program?
- c. What current elements of your local Medicaid program or system of care do you find have truly worked to control costs and enhance quality, and that you feel should be preserved or expanded?
- d. What other recommendations do you propose to restructure the State Medicaid program that could *"...achieve measurable improvement in health outcomes, sustainable cost control and a more efficient administrative structure?"*

3. **Mandate Relief Redesign (Optional)** - Also in January, the Governor established a Mandate Relief Redesign Team to review unfunded and underfunded mandates imposed by the New York State government on school districts, local governments, and other local taxing districts. Unfunded and underfunded mandates drive up costs of schools, municipalities, and the property taxes that support them. Due in part to these mandates, New York now has some of the highest taxes in the nation.

2012 Local Services Plan Guidelines For Mental Hygiene Services

The Mandate Relief Redesign Team includes representatives from private industry, education, labor, and government and will look for ways to reduce the costs of mandated programs, identify mandates that are ineffective and outdated, and determine how school districts and local governments can have greater ability to control expenses. Specifically, the team will:

- Look for ways to reduce the costs of mandated programs on schools and local governments by determining how school districts and local governments may be given greater ability to control costs.
- Look at the reason for delays in state reimbursement for mandated programs.
- Look at the practice of cost-shifting of mandated programs.
- Identify opportunities for eliminating or reducing unfunded and underfunded mandates imposed by the New York State government on local governments and school districts.
- Make its final recommendations to the Governor not later than the end of the State Fiscal Year 2011-12.

The team is soliciting suggestions and recommendations for mandate relief in the following categories and whether the recommendation is a statutory or regulatory change:

1. Employee Relations/Workforce Issues
2. Education/School Districts
3. Public Safety
4. Social Services
5. Health & Environment
6. Business/Private Sector
7. Local Government Organization
8. Local Taxation
9. Procurement & Government Operations
10. Fees and Other Local Revenues
11. Other (specify)

For each recommendation for mandate relief, indicate the category from the list above and whether it is a recommendation for statutory or regulatory relief.

4. **Integration of Mental Hygiene Services (Optional)** – It was noted earlier that 46 percent of all county priorities reported in last year’s plans involved multiple mental hygiene disabilities, and 29 percent involved all three disabilities. Two of the most frequently mentioned priority areas included “Cross-system collaboration” and “Serving people with co-occurring disabilities.” Other priority areas, such as housing and transportation, are common to all three disabilities but often identified separately.

Another top priority of the new governor is “...reinventing, reorganizing and redesigning government programs and agencies.” He established the Spending and Government Efficiency (SAGE) Commission in part to identify more efficient and cost effective ways to deliver government services, increase accountability and save taxpayers’ money.

2012 Local Services Plan Guidelines For Mental Hygiene Services

Given the current fiscal climate and dire budget projections for the years ahead, and given the ongoing efforts of LGUs to find more efficient and effective ways to meet the needs of people with co-occurring disabilities or to meet common needs across the different mental hygiene service systems, and given the priority of the governor to reduce the cost of needed services, counties are being asked to identify potential strategies that will meet these objectives.

- a. Identify efforts the county has undertaken, or plans to undertake, that will lead to efficiencies and improved quality of care.
- b. Identify strategies for service integration and care coordination.
- c. Identify potential strategies beyond the Medicaid redesign and mandate relief strategies covered in the two previous questions that can or should be employed at the state government level that will create a more favorable environment for the county and providers to provide more efficient and quality services.

B. OASAS Outpatient Sub-County Service Plan Form (Optional)

The outpatient sub-county service planning option gives counties the opportunity to identify those local circumstances that may uniquely affect the availability or delivery of outpatient treatment services in their particular jurisdiction. The OASAS outpatient need methodology would be applied to an approved sub-county outpatient service plan for project review and certification purposes. A completed sub-county service planning form must be submitted in the county's local services plan and approved by OASAS before it is implemented.

A sub-county plan may only be completed for the adult population which means that adolescent visits are removed from the utilization data that is applied to the sub-county service areas. In most counties, this adjustment is not significant. The service need and utilization matrix should be completed using the countywide visit totals for adults from the most recent County Service Need Profile and distributing across service areas based to the adult population (aged 18+) distribution. A map delineating the sub-county service areas must be included in the plan.

Counties that have an approved outpatient sub-county service plan need only update the data in the Service Need and Utilization section. Unless the sub-county service area map previously submitted by the county has changed, a new map does not need to be submitted. Counties with an approved Outpatient Sub-County Plan include Broome, Erie, Orange, and Ulster Counties.

Instructions for Completing the Outpatient Sub-County Service Planning Form

STEP 1: Rationale for Sub-County Service Planning - The narrative should include a brief description of the local circumstances that may affect the availability of or access to outpatient services in the county. Factors for delineating service area boundaries may include population density or distribution (e.g., presence of a major central city and

2012 Local Services Plan Guidelines For Mental Hygiene Services

significant outlying rural areas in the county), natural boundaries that may isolate certain parts of the county (e.g., rivers, mountains), or significant political subdivisions (e.g., towns, groupings of towns, school districts, etc.). If a county delineates sub-county service areas, it must provide the most current adult population data for each service area. **Note: While OASAS does not limit the number of sub-county service areas within a county, no service area should contain an adult population that is not sufficiently large enough to reasonably support a small outpatient clinic.**

STEP 2: Service Need and Utilization Distribution - The most recent adult population should be shown for the county and each sub-county service area. The percentage distribution of the population in each service area should be determined. The countywide service need estimate (from the county's current Service Need Profile) should then be proportioned across all service areas based on the percentage distribution of the county's adult population. Once a need estimate is determined for each service area, the most recent annual service volume (total primary visits of at least 30 minutes) should be subtracted from the total need estimate to determine the unmet need in each service area. (Note: The service volume provided at an additional location should be applied to the service area in which it is located; i.e., additional location service volume reported to the main clinic located in another service area should be subtracted from that service area total and applied to the service area of the additional location. You may need to contact the OASAS Planning Unit for assistance in determining the adult population served by each program and additional location.

STEP 3: Delineation of Sub-county Service Areas on a Map - A county map clearly delineating the outpatient sub-county service areas must be included in the sub-county service plan. The location of existing outpatient clinics and additional locations should be indicated on the map. The map should be attached to the sub-county plan form.

C. OASAS Community Residence Multi-County Collaboration (Optional)

The OASAS chemical dependence need methodology identifies the community residence service category as one that could be considered a multi-county resource in certain areas of the state where the county bed need estimate does not support the development of a community residence program or where community residence services could be more efficiently and cost effectively provided in a collaborative way among two or more counties. In some counties, this has been the practice, if not the stated policy.

In 2004, OASAS asked that these arrangements be formally documented in the plan of each county involved in the collaboration, for two very important reasons. First, it establishes such arrangements as official policy in a public planning document. Second, it provides OASAS with the basis for applying the need methodology at a geographic level other than the standard county level. The following 14 counties have entered into five separate Community Residence Multi-County Collaborative Agreements.

- Broome, Chenango, Delaware, Otsego, Tioga
- Genesee, Orleans
- Warren, Washington
- Essex, Franklin
- Schuyler, Seneca, Yates

2012 Local Services Plan Guidelines For Mental Hygiene Services

Based on an approved collaborative agreement, the need methodology would redefine the community residence service area to include all counties signing the agreement. That means the combined certified community residence capacity in the multi-county collaborative would be compared against the combined estimated bed need in the collaborative. It also means that any application for new or expanded community residence bed capacity that is submitted to OASAS will be reviewed against the combined estimated unmet need in the collaborative.

Instructions for Completing the Community Residence Multi-County Collaboration Agreement Form

The Community Residence Multi-County Collaboration Agreement should be completed and submitted in CPS. Each county that is in an approved collaboration is asked to complete and certify the form so that it will become part of the online plan submission. Each year, the form would only need to be edited (if necessary) and recertified. The agreement states that:

1. The counties agreeing to enter into this collaborative agreement shall plan and develop community residence services based on the combined geographic service areas covered by each county;
2. All existing and future community residence services in each county in the collaborative shall be a shared resource that is accessible to residents of each county in the collaborative;
3. The counties agreeing to enter into this collaborative agreement request that OASAS apply the existing combined certified community residence bed capacity of all counties in the collaborative against the combined estimated bed need of all counties in the collaborative;
4. Any application submitted to OASAS for new or expanded community residence bed capacity under an approved collaborative agreement shall be reviewed against the combined estimated unmet need in the collaborative; and
5. This Community Residence Multi-County Collaborative Agreement shall remain in effect until OASAS approves a county's written request to be removed from the collaborative agreement.

If any county in the collaborative wishes to opt out of the agreement, it must do so in writing. Each remaining county must amend its collaborative agreement to reflect the names of the remaining counties. Once a Community Residence Multi-county Collaboration Agreement has been approved, the OASAS Certification Bureau will be notified and all future certification applications for new or expanded community residence services from any county in the collaborative will be considered based on the need and capacity of the combined counties.

2012 Local Services Plan Guidelines For Mental Hygiene Services

D. County Mental Hygiene Priority Outcomes Form

The County Mental Hygiene Priority Outcomes Form was introduced in the 2009 Plan Guidelines as the first fully integrated county plan form. The 2012 Priority Outcomes Form builds on this effort to create an integrated, people-first planning process that encourages cross-system collaboration. The Priority Outcomes Form is designed to provide counties with a process for developing priorities in a consistent manner across the three mental hygiene disabilities. It improves the ability of counties to direct local planning efforts and develop priorities consistent with state goals and priorities and to inform the Conference of Local Mental Hygiene Directors of planning issues and priorities.

This is the fourth year this form is being used and, as with the 2011 form, counties will again have the opportunity to provide progress reports on existing strategies. In addition, priorities and strategies that have been accomplished or are no longer being pursued can be dropped and new priorities and strategies can be added.

Once again, counties are asked to identify the “top two” priorities in each disability area. This allows each state agency to weigh priorities without requiring the county to assign a rank order to all priorities. At the top of the 2012 Priority Outcomes page in CPS, you will see a link labeled “Select top priority outcomes”. When you click on that link, the system will display all recorded priority outcomes by disability area. You will be instructed to select the top two under each disability category. Once the top two priorities are selected in each disability area, they will display on the form as a “selected top priority outcome.”

For 2012 the “Focus Area” is again associated with the strategies rather than outcomes because strategies are specific actions and are therefore more appropriately associated with a targeted focus area. The more narrowly-defined sub-focus areas were eliminated last year so counties again only select from 13 choices, compared to the 123 choices previously listed. Each focus area is defined below and will be hyperlinked to a definition on the Priority Outcomes Form itself.

The Mental Hygiene Priority Outcomes Form is largely driven by a series of menu options that will help to organize and categorize the county’s priorities. The information in the form is presented by tabs located on the main page of the Form, and begins with either the addition of a new priority outcome on the “Outcome Description” tab or the addition of progress on the previously entered priority outcome. If the priority outcome is being updated from last year, select “Modify” then “Outcome Description” and then edit the text in the “Priority Outcome Statement” and/or “Detailed Description of Outcome Statement.”

Instructions for completing the Priority Outcomes Form

The Priority Outcomes Form consists of priority outcomes and strategies designed to achieve the priority outcome. A priority outcome is a broad statement of a realistic and desirable goal the County hopes to achieve over a period of time. A strategy is a specific, measurable statement about what change needs to occur in order to achieve the stated outcome.

**2012 Local Services Plan Guidelines
For Mental Hygiene Services**

ADDING OR UPDATING A PRIORITY OUTCOME

From the initial Priority Outcomes Form page you can choose to add a new priority outcome or update an existing priority outcome. Selecting either of these options will bring up a page with three tabs: 1) the Outcome Description tab; 2) the Status tab; and 3) the Agency tab.

Outcome Description Tab

Priority Outcome Statement: A Priority Outcome is a demonstrated benefit or change in an individual or population after a targeted effort or intervention. The focus is on the results rather than the process. Priority outcome statements should be succinct and clearly convey expected results. The priority outcome statement should reflect the mission, vision, and values of the local system of care and should be constructed in a way that permits the articulation of a multi-year plan of action toward outcome achievement.

Example: *To ensure that individuals with co-occurring disorders have improved access to case management and coordination of care services.*

Detailed Description of Outcome Statement: Use this space to provide an expanded explanation of the Priority Outcome Statement.

While a planning process, which often includes sequential activities, typically must be followed in order to achieve a desired outcome, the primary focus of this form should be on the outcome rather than the process. **County plans must include at least three (3) priority outcomes for each disability group.** A single priority outcome that applies to multiple state mental hygiene agencies and is intended to address a cross-systems issue may count towards the required number of outcomes for each disability identified in the outcome.

Status Tab

Current Status:

- In Progress
- Accomplished
- Dropped

Anticipated Year of Completion: (Calendar Year)

- 2011
- 2012
- 2013
- 2014

Agency Tab

Applicable State Agency: (Check all that apply)

- OASAS
- OMH
- OPWDD

2012 Local Services Plan Guidelines For Mental Hygiene Services

ADDING OR UPDATING A STRATEGY ASSOCIATED WITH A PRIORITY OUTCOME

Outcome Strategies: A strategy must be clear and unambiguous so that there is no confusion about what it means and how it will be measured. It should be realistic and achievable within a particular identified timeframe (ideally, not longer than three years). For example: “Engage in strategy x in order to achieve y”. Strategies reflect the shared values of stakeholders, incorporate the identification of potential solutions to challenges encountered, and ultimately help shape state mental hygiene policy and programming directions that are consistent with the mission, vision, and values of each mental hygiene agency. A strategy could include recommendations for state agencies or actions that need to be taken by the county or providers. Strategy should include *identification of potential solutions* to those problems that could help shape state and local policy, programming direction and long-term priorities and outcomes. Note: A priority outcome may have more than one strategy.

From the initial Priority Outcomes Form page you can choose to add a new strategy or update an existing strategy. Selecting either of these options will bring up a page with three tabs: 1) the Strategy Description tab; 2) the Status/Progress Report tab; and 3) the Strategy Focus tab.

Strategy Description Tab

Strategy Description: Provide a clear description of the strategy, including what expected change will occur by accomplishing the strategy. Identify what is to be measured and the desired change in the measure. For example: “Engage in strategy x in order to achieve y.”

Applicable State Agency: You will not be able to select an agency that was not selected for the priority outcome to which this strategy is associated. If you need to select an agency that is not currently selectable, you will first need to go back to the priority outcome tab and select it there.

Status/Progress Report Tab

Status/Progress Report: Under **Current Status**, the default setting for all strategies will be “In Progress”. If all strategies are accomplished or dropped, the priority outcome will no longer be carried forward to the next plan cycle. Anticipated year of completion can be 2011, 2012, 2013 or 2014.

Current Status:

- In Progress
- Accomplished
- Dropped

Anticipated Year of Completion: (Calendar Year)

- 2011
- 2012
- 2013
- 2014

Accomplished: Specific strategy has been accomplished. If all strategies have been accomplished for a Priority Outcome, the Priority Outcome is considered accomplished.

2012 Local Services Plan Guidelines For Mental Hygiene Services

Dropped: Specific strategy has been dropped; please explain barriers and reasons why strategy has been dropped. If all strategies for a priority outcome have been dropped, priority outcome is considered dropped.

Anticipated Year of Completion: What year you project that specific strategy will be accomplished.

Describe Progress: Report on activities completed, obstacles, barriers and collaborations. Progress should include success or failure in achieving that particular strategy. Progress should also include any metrics or measures incorporated to achieve the outcomes and anticipated action steps needed to be taken on the Priority Outcome.

Innovative Practice Tab

Innovative Practice: This section is included in the plan to highlight innovative and effective practices used by local planners in determining need or affecting solutions. An innovative practice brings a fresh perspective or approach to a challenge or problem. Please identify county level innovations which could be replicated by your colleagues. In one county, for example, suicide rates are adjusted based on data from the coroner. While this may not seem innovative to some, it is indeed a unique way to ensure that the suicide rate is accurately reported for the county. By sharing innovative practices through the Community of Practice resource center in CPS we will be supporting and promoting excellence in both planning and program development.

Is this an innovative practice that you would like to share with others?

- Yes
 No

Strategy Focus Tab

Strategy Focus: Focus areas for strategies should be selected to refine and reflect specific areas of action for the particular strategy. ***No more than two focus areas should be selected.*** The following list of focus areas is available to categorize each strategy.

1. **HOUSING** - Housing represents a person's home and is the place where an individual has tenancy or ownership. The focus is on increasing access to housing, the positive changes that lead to stability in an individual's housing situation, or the supports necessary to allow a person to live in the chosen home setting.
2. **EMPLOYMENT/ EDUCATION** - The focus of this area is on increasing skills related to work, facilitating change in the status of an individual's employment or school, or engaging people in other meaningful activity.
3. **HEALTH & WELLNESS** - Health and wellness relate to a state of well-being, free from disease and attainment of good physical and mental health, especially when maintained by proper diet, exercise, and habits.

**2012 Local Services Plan Guidelines
For Mental Hygiene Services**

4. **SOCIAL CONNECTEDNESS/INCLUSION/SOCIAL SUPPORT** - This focus area emphasizes the quality and number of connections an individual has with other people in his or her social circle of family, friends and acquaintances.
5. **SELF-DIRECTION** - The focus is on how self-directed or guided by oneself a person is. It refers especially to the ability of an individual to act as an independent agent.
6. **TRANSPORTATION** - Transportation refers to the means and equipment necessary to enable persons to move from place to place in their communities, whether to doctor's appointments, services or social activities.
7. **SERVICE ACCESS (CAPACITY)** - The focus is on improved or changed access to services. Access and capacity are terms used interchangeably to describe the availability of services, how easy or difficult it is to obtain them, and obstacles that may stand in the way of a person's engagement in services. Such obstacles could include appointment delays, inconvenient operating locations/hours, linguistic or cultural issues, geographic proximity, acceptability of services, service costs, and other factors. Capacity and access may be measured by the number of persons served by age and other demographic characteristics, such as gender, race and ethnicity.
8. **CRIMINAL JUSTICE** - The focus of the priority outcome is on ensuring appropriate mental hygiene services and decreasing a person's involvement in the criminal and juvenile justice systems.
9. **SERVICE ENGAGEMENT** - Service Engagement relates to increasing treatment or service participation, access to preventive and evidence-based programs and strategies, a reduction in the utilization of inpatient care, and a reduction in readmission to care.
10. **QUALITY MANAGEMENT** - The focus is on using data to assure quality services and supports, improving services and supports, ensuring the coordination and continuity of services and supports across providers and systems of care, and assessing outcomes of services and supports.
11. **CROSS SYSTEMS COLLABORATION** - Cross-systems collaboration is the process of linking governments, disciplines, and entire systems to improve coordination, integration, and alignment of agency structures and functions.
12. **MENTAL HYGIENE WORKFORCE DEVELOPMENT** - The focus is to examine and advance incentives to recruit and retain a qualified workforce, share best practices, ensure staff competencies to deliver quality supports and services and increase the number of individuals who choose careers in the mental hygiene fields.
13. **OTHER** – please describe:

**2012 Local Services Plan Guidelines
For Mental Hygiene Services**

E. 2012 Local Services Planning Assurance Form

LGU: _____

Pursuant to Article 41 of the Mental Hygiene Law, we assure and certify that:

Representatives of facilities of the offices of the department; directors of district developmental services offices; directors of hospital-based mental health services; directors of community mental health centers, voluntary agencies; persons and families who receive services and advocates; other providers of services have been formally invited to participate in, and provide information for, the local planning process relative to the development of the Local Services Plan;

The Community Services Board and the Subcommittees for Alcoholism and Substance Abuse, Mental Health, and Developmental Disabilities have provided advice to the Director of Community Services and have participated in the development of the Local Services Plan. The full Board and the Subcommittees have had an opportunity to review and comment on the contents of the plan and have received the completed document. Any disputes which may have arisen, as part of the local planning process regarding elements of the plan, have been or will be addressed in accordance with procedures outlined in Mental Hygiene Law Section 41.16(c);

The Community Services Board and the Subcommittees for Alcoholism and Substance Abuse, Mental Health, and Developmental Disabilities meet regularly during the year, and the Board has established bylaws for its operation, has defined the number of officers and members that will comprise a quorum, and has membership which is broadly representative of the age, sex, race, and other ethnic characteristics of the area served. The Board has established procedures to ensure that all meetings are conducted in accordance with the Open Meetings Law, which requires that meetings of public bodies be open to the general public, that advance public notice of meetings be given, and that minutes be taken of all meetings and be available to the public.

OASAS, OMH and OPWDD accept the certified 2012 Local Services Planning Assurance form in the Online County Planning System as the official LGU assurance that the above conditions have been met for the 2012 local services planning process.

**2012 Local Services Plan Guidelines
For Mental Hygiene Services**

F. 2012 Multiple Disabilities Consideration Form

LGU: _____

The term “multiple disabilities” means, in this context, persons who have at least two of the following disabling conditions: a developmental disability, a mental illness, or an addiction. In order to effectively meet the needs of these individuals, several aspects should be addressed in a comprehensive plan for services. Accordingly:

1. Is there a component of the local governmental unit which is responsible for identifying persons with multiple disabilities?

Yes No

If yes, briefly describe the mechanism used to identify such persons:

2. Is there a component of the local governmental unit which is responsible for planning of services for persons with multiple disabilities?

Yes No

If yes, briefly describe the mechanism used in the planning process:

3. Are there mechanisms at the local or county level, either formal or informal in nature, for resolving disputes concerning provider responsibility for serving persons with multiple disabilities?

Yes No

If yes, describe the process(es), either formal or informal, for resolving disputes at the local or county level and/or at other levels of organization for those persons affected by multiple disabilities:

**2012 Local Services Plan Guidelines
For Mental Hygiene Services**

G. 2012 Community Services Board Roster (New York City)

Community Services Board Chair

Name: _____
 Physician Psychologist
Represents: _____
NYC Borough: _____
Term Expires: Month ____ Year ____
Email Address: _____

Name: _____
 Physician Psychologist
Represents: _____
NYC Borough: _____
Term Expires: Month ____ Year ____
Email Address: _____

Name: _____
 Physician Psychologist
Represents: _____
NYC Borough: _____
Term Expires: Month ____ Year ____
Email Address: _____

Name: _____
 Physician Psychologist
Represents: _____
NYC Borough: _____
Term Expires: Month ____ Year ____
Email Address: _____

•
•
•

•
•
•

Note: There must be 15 board members including at least two residents from each borough. Indicate if member is a licensed physician or certified psychologist. Under item labeled "Represents", enter the name of the member's organization or enter "Consumer", "Family", "Public Representative", etc. to indicate the particular community interest being represented. Members shall serve four-year staggered terms.

**2012 Local Services Plan Guidelines
For Mental Hygiene Services**

H. 2012 Community Services Board Roster (Counties outside NYC)

LGU: _____

Community Services Board Chair

Name: _____
 Physician Psychologist
Represents: _____
Term Expires: Month ____ Year ____
Email Address: _____

Name: _____
 Physician Psychologist
Represents: _____
Term Expires: Month ____ Year ____
Email Address: _____

Name: _____
 Physician Psychologist
Represents: _____
Term Expires: Month ____ Year ____
Email Address: _____

Name: _____
 Physician Psychologist
Represents: _____
Term Expires: Month ____ Year ____
Email Address: _____

•
•
•

•
•
•

Note: There must be 15 board members (counties under 100,000 population may opt for a 9-member board). Indicate if member is a licensed physician or certified psychologist. Under item labeled "Represents", enter the name of the member's organization or enter "Consumer", "Family", "Public Representative", etc. to indicate the perspective the member brings to the board. Members shall serve four-year staggered terms.

**2012 Local Services Plan Guidelines
For Mental Hygiene Services**

I. 2012 Alcoholism and Substance Abuse Subcommittee Roster

Subcommittee Chair

Name: _____
CSB Member: Yes No
Represents: _____
Email Address: _____

Name: _____
CSB Member: Yes No
Represents: _____
Email Address: _____

Name: _____
CSB Member: Yes No
Represents: _____
Email Address: _____

Name: _____
CSB Member: Yes No
Represents: _____
Email Address: _____

Name: _____
CSB Member: Yes No
Represents: _____
Email Address: _____

Name: _____
CSB Member: Yes No
Represents: _____
Email Address: _____

Name: _____
CSB Member: Yes No
Represents: _____
Email Address: _____

Name: _____
CSB Member: Yes No
Represents: _____
Email Address: _____

Name: _____
CSB Member: Yes No
Represents: _____
Email Address: _____

Note: The subcommittee shall have no more than nine members. Three subcommittee members must be members of the board; those members should be identified here. Under item labeled "Represents", enter the name of the member's organization or enter "Consumer", "Family", "Public Representative", etc. to indicate the perspective the member brings to the subcommittee.

**2012 Local Services Plan Guidelines
For Mental Hygiene Services**

J. 2012 Mental Health Subcommittee Roster

Subcommittee Chair

Name: _____
CSB Member: Yes No
Represents: _____
Email Address: _____

Name: _____
CSB Member: Yes No
Represents: _____
Email Address: _____

Name: _____
CSB Member: Yes No
Represents: _____
Email Address: _____

Name: _____
CSB Member: Yes No
Represents: _____
Email Address: _____

Name: _____
CSB Member: Yes No
Represents: _____
Email Address: _____

Name: _____
CSB Member: Yes No
Represents: _____
Email Address: _____

Name: _____
CSB Member: Yes No
Represents: _____
Email Address: _____

Name: _____
CSB Member: Yes No
Represents: _____
Email Address: _____

Name: _____
CSB Member: Yes No
Represents: _____
Email Address: _____

Note: The subcommittee shall have no more than nine members. Three subcommittee members must be members of the board; those members should be identified here. Under item labeled "Represents", enter the name of the member's organization or enter "Consumer", "Family", "Public Representative", etc. to indicate the perspective the member brings to the subcommittee.

**2012 Local Services Plan Guidelines
For Mental Hygiene Services**

K. 2012 Developmental Disabilities Subcommittee Roster

Subcommittee Chair

Name: _____
CSB Member: Yes No
Represents: _____
Email Address: _____

Name: _____
CSB Member: Yes No
Represents: _____
Email Address: _____

Name: _____
CSB Member: Yes No
Represents: _____
Email Address: _____

Name: _____
CSB Member: Yes No
Represents: _____
Email Address: _____

Name: _____
CSB Member: Yes No
Represents: _____
Email Address: _____

Name: _____
CSB Member: Yes No
Represents: _____
Email Address: _____

Name: _____
CSB Member: Yes No
Represents: _____
Email Address: _____

Name: _____
CSB Member: Yes No
Represents: _____
Email Address: _____

Name: _____
CSB Member: Yes No
Represents: _____
Email Address: _____

Note: The subcommittee shall have no more than nine members. Three subcommittee members must be members of the board; those members should be identified here. Under item labeled "Represents", enter the name of the member's organization or enter "Consumer", "Family", "Public Representative", etc. to indicate the perspective the member brings to the subcommittee.

**2012 Local Services Plan Guidelines
For Mental Hygiene Services**

L. 2012 DDSO Plan Approval Form

LGU: _____

On behalf of the Commissioner of the New York State Office for People With Developmental Disabilities, I, as Director of the DDSO, assure and certify that the development and content of the Local Government Plan which is noted as applicable to OPWDD represent reasonable and appropriate efforts by OPWDD, local, voluntary and other community stakeholders to extend and/or improve local, community-based services for persons with mental retardation or developmental disabilities in accordance with OPWDD statewide priorities and goals, and are in compliance with the requirements of Article 41 of the Mental Hygiene Law.

DDSO Director Name: _____ Date: _____

--- OR ---

On behalf of the Commissioner of the New York State Office for People With Developmental Disabilities, I, as Director of the DDSO, assure and certify that the development and content of the Local Government Plan which is noted as applicable to OPWDD, with any exceptions as noted below, represent reasonable and appropriate efforts by OPWDD, local, voluntary and other community stakeholders to extend and/or improve local community-based services for persons with mental retardation or developmental disabilities in accordance with OPWDD statewide priorities and goals, and are in compliance with the requirements of Article 41 of the Mental Hygiene Law.

DDSO Director Name: _____ Date: _____

Exceptions:

Parts of Plan applicable to OPWDD Not Approved:

2012 Local Services Plan Guidelines For Mental Hygiene Services

M. OASAS Outcomes Management Survey

For the past three years, OASAS has been committed to using and promoting [outcomes management](#), which we define as the systematic use of client and program level data to set targets, assess and improve performance. As we develop ways to support its use in the field, we continue to track changes in the use of this approach by both counties and providers. Once again this year OASAS is administering the Outcomes Management Survey as part of the annual County Planning process. All questions regarding this survey should be directed to Ms. Constance Burke at 518-485-0501 or at ConstanceBurke@oasas.state.ny.us.

Survey Questions

[Consult the LSP Guidelines for additional guidance on completing this exercise.](#)

1. Does your county agency have an active [outcomes management](#) program in place?
 a) Yes
 b) No (go to #3)

2. How long has your county agency been involved with outcomes management?
 a) At least five years
 b) At least three, but less than five years
 c) At least one, but less than three years
 d) Less than one year

3. Does your county agency set outcomes/performance targets based on client and/or program level data?
 a) Yes
 b) No (go to #9)

4. How often does your county agency review progress towards the performance targets?
 a) At Least Monthly
 b) Quarterly
 c) Semi-Annually
 d) Annually
 e) Less than Annually

5. Which of the following data sources does your county agency use to track the progress of your contracted programs toward [performance targets](#)? (check all that apply)
 a) Program Scorecard (go to #6)
 b) IPMES (go to #6)
 c) Other Data Source (please specify): (go to #5a)
 d) None (go to #6)

- 5a. Does your county agency collect, maintain and analyze data using an electronic database system?
 a) Yes (go to #5b)
 b) No (go to #6)

- 5b. What system does your county agency use to maintain and analyze this data?
 a) Celerity
 b) Foothold
 c) Self Developed (specify the software you use; e.g., Microsoft Access, Excel, SPSS, etc.):
 d) Other (please specify):

2012 Local Services Plan Guidelines For Mental Hygiene Services

6. With whom does your county agency regularly discuss the performance and progress toward achieving outcomes of your contracted programs? (Check all that apply)
- a) Community Services Board
 - b) Program Administrators
 - c) OASAS Field Office
 - d) Other (please specify):
7. Which methods does your county agency use to disseminate data and/or summary information about the performance of your contracted programs? (Check all that apply)
- a) County-level Dashboard or Report Card
 - b) Annual Report
 - c) County Agency Website
 - d) Grant Applications
 - e) Other (please specify):
 - f) None
8. In which areas of program management does your county agency use performance information to support decision making? (Check all that apply)
- a) Planning
 - b) Program Services
 - c) Policy Development
 - d) Budget Development
 - e) Other (please specify):
 - f) None
9. Is your county agency interested in participating in an Outcomes Management [Community of Practice](#) (CoP) to share your experience in using performance measures to track program outcomes or to learn from others' experience in using this approach to program management?
- a) Yes
 - b) No
10. How often has your county agency accessed information available on the OASAS [Gold Standard Initiative](#) web page about Outcomes Management (OM), which includes tools and resources to support the implementation of OM within your program?
- a) Often
 - b) Occasionally
 - c) Once
 - d) Never

Terms Defined for this Survey

Outcomes Management – An outcome is a desired result from a program or client perspective; outcomes management, also referred to as performance management, is the systematic use of client and program level data to set performance targets, assess and improve performance.

Performance Target – the intended result or goal a program intends to achieve for a client or other customer as a result of program operations or service provision

Community of Practice - Communities of practice are formed by people who engage in regular interaction over a shared topic of interest. Participants learn and develop skills around a topic whether by way of explicit learning objectives or as a secondary effect of sharing experiences, tools and resources, providing peer support or problem solving around an issue. The benefits of participating in a Community of Practice (CoP) include: access to shared resources; insight from others who are trying to do the same or similar things; and, an established support network as you try new approaches to improving performance and patient outcomes.

Gold Standard Initiative – an opportunity for programs to participate in a comprehensive, relevant review of program infrastructure and performance which is designed to define, support and recognize excellence in the provider community by way of enhanced operating certificates and Gold Standard recognition.

**2012 Local Services Plan Guidelines
For Mental Hygiene Services**

CHAPTER VI: PROVIDER PLAN FORMS (OASAS)

A. Outcomes Management Survey (all providers)

For the past three years, OASAS has been committed to using and promoting [outcomes management](#), which we define as the systematic use of client and program level data to set targets, assess and improve performance. As we develop ways to support its use in the field, we continue to track changes in the use of this approach by both counties and providers. Once again this year OASAS is administering the Outcomes Management Survey as part of the annual County Planning process. All questions regarding this survey should be directed to Ms. Constance Burke at 518-485-0501 or at ConstanceBurke@oasas.state.ny.us.

Survey Questions

[Consult the LSP Guidelines for additional guidance on completing this exercise.](#)

1. Does this agency have an active [outcomes management](#) program in place?
 a) Yes
 b) No (go to #3)
2. How long has this agency been involved with outcomes management?
 a) At least five years
 b) At least three, but less than five years
 c) At least one, but less than three years
 d) Less than one year
3. Does this agency set outcomes/performance targets based on client and/or program level data?
 e) Yes
 f) No (go to #9)
4. How often does this agency review progress towards the performance targets?
 a) At Least Monthly
 b) Quarterly
 c) Semi-Annually
 d) Annually
 e) Less than Annually
5. Which of the following data sources does this agency use to track progress toward [performance targets](#)? (check all that apply)
 a) Scorecard (go to #6)
 b) IPMES (go to #6)
 c) STAR-QI (go to #6)
 d) Focus Groups (go to #5a)
 e) Client Surveys (go to #5a)
 f) Other Data Source (please specify): (answer #5a)
 g) None (go to #6)
- 5a. Is this data collected, maintained and analyzed using an electronic database system?
 a) Yes (go to #5b)
 b) No (skip to #6)

**2012 Local Services Plan Guidelines
For Mental Hygiene Services**

- 5b. What system does this agency use to maintain and analyze this data?
- a) Celerity
 - b) Foothold
 - c) Self Developed (specify the software you use; e.g., Microsoft Access, Excel, SPSS, etc.):
 - d) Other (please specify):
6. With whom does this agency regularly discuss program performance and progress toward achieving outcomes? (Check all that apply)
- a) Board of Directors
 - b) Program Administrators
 - c) Program Staff
 - d) OASAS Field Office
 - e) LGU
 - f) Other (please specify):
7. Which methods does this agency use to disseminate data and/or summary information about program performance? (Check all that apply)
- a) Agency or program dashboard or report card
 - b) Annual report
 - c) Program brochures
 - d) Agency web page
 - e) Grant applications
 - f) Other (please specify):
 - g) None
8. In which areas of program management does this agency use performance information to support decision making? (Check all that apply)
- a) Planning
 - b) Program services
 - c) Policy development
 - d) Budget development
 - e) Staff performance appraisals
 - f) Individual staff supervision or staff meetings
 - g) Other (please specify):
 - h) None
9. Is this agency interested in participating in an Outcomes Management [Community of Practice](#) (CoP) to share your experience in using performance measures to track program outcomes or to learn from others' experience in using this approach to program management?
- a) Yes
 - b) No
10. How often has this agency accessed information available on the OASAS [Gold Standard Initiative](#) web page about Outcomes Management (OM), which includes tools and resources to support the implementation of OM within your program?
- a) Often
 - b) Occasionally
 - c) Once
 - d) Never

Terms Defined for this Survey

Outcomes Management – An outcome is a desired result from a program or client perspective; outcomes management, also referred to as performance management, is the systematic use of client and program level data to set performance targets, assess and improve performance.

2012 Local Services Plan Guidelines For Mental Hygiene Services

Performance Target – the intended result or goal a program intends to achieve for a client or other customer as a result of program operations or service provision

Community of Practice - Communities of practice are formed by people who engage in regular interaction over a shared topic of interest. Participants learn and develop skills around a topic whether by way of explicit learning objectives or as a secondary effect of sharing experiences, tools and resources, providing peer support or problem solving around an issue. The benefits of participating in a Community of Practice (CoP) include: access to shared resources; insight from others who are trying to do the same or similar things; and, an established support network as you try new approaches to improving performance and patient outcomes.

Gold Standard Initiative – an opportunity for programs to participate in a comprehensive, relevant review of program infrastructure and performance which is designed to define, support and recognize excellence in the provider community by way of enhanced operating certificates and Gold Standard recognition.

B. Health Coordinator Form (treatment programs)

Under New York State regulations, providers certified under the following parts are required to “have a qualified individual designated as the Health Coordinator who will ensure the provision of education, risk reduction, counseling and referral services to all patients regarding HIV and AIDS, tuberculosis, hepatitis, sexually transmitted diseases, and other communicable diseases”:

- Chemical Dependence Residential Rehabilitation Services for Youth (Part 817)
- Chemical Dependence Inpatient Rehabilitation Services (Part 818)
- Chemical Dependence Residential Services (Part 819)
- Non-Medically Supervised Chemical Dependence Outpatient Services (Part 821)
- Chemical Dependence Outpatient Services (Part 822)
- Opioid Treatment for Addiction (Part 828)

Regulatory requirements regarding Health Coordinators and comprehensive treatment plans are defined for each chemical dependence treatment service category in the Official Compilation of the Codes, Rules and Regulations of the State of New York. For additional information, please refer to the applicable regulations located on the OASAS Website: <http://www.oasas.state.ny.us/regs/>

The **Health Coordinator Form** documents compliance with OASAS regulations and, for those programs that are funded by OASAS, additionally documents requirements of the Federal Substance Abuse Prevention and Treatment (SAPT) Block Grant. Early HIV Intervention Services (EIS), which under the SAPT Block Grant must be provided on site of chemical dependence treatment, are defined as: pre- and post-test counseling for HIV, the actual testing of individuals for the presence of HIV and testing to determine the extent of the deficiency in the immune system, and the provision of therapeutic measures to address an individual’s HIV status. OASAS has determined that Health Coordinators and OTP comprehensive treatment planning provide EIS.

This survey should be completed by all OASAS certified treatment programs, and should be completed in CPS. The questions that follow are the questions you will find in CPS. All responses to the questions on this form should be based on 2010 Fiscal Year data. If an individual is responsible for carrying out the Health Coordinator function in more than one program, the data must be entered separately for each program reporting unit. Any questions related to this survey should be directed to Shonna Clinton by phone at 518-485-0505, or by e-mail at ShonnaClinton@oasas.state.ny.us.

2012 Local Services Plan Guidelines For Mental Hygiene Services

Form Questions

[Consult the LSP Guidelines for additional guidance on completing this exercise.](#)

All questions on this form should be answered as they pertain to this program only. Providers that operate multiple treatment programs will complete this form for each program. The responses to each survey should be coordinated to ensure accuracy of responses across all programs within the organization. Any questions related to this survey should be directed to Shonna Clinton by phone at 518-485-2410, or by e-mail at ShonnaClinton@oasas.state.ny.us.

1. How are **health coordination** services provided to patients in this program? (check all that apply)
 - a) Provider Staff
 - b) Contracted Services
 - c) In-kind Staff, meaning volunteer staff or staff from within your agency

2. Where do patients in this program receive health coordination services?
 - a) On-site (within this program)
 - b) On-site (within a different part of the facility)
 - c) Off-site (not within this program or facility)

3. OASAS is interested in maintaining an email database of designated Health Coordinators for periodic communications related to health services and relevant to the Health Coordinator function. Please provide us with the name and email address of this program's primary Health Coordinator.
 - a) Health Coordinator Name: _____
 - b) Email Address: _____

If your answer to Question #1 was "a", answer question #4.

4. A number of programs have indicated that the Health Coordinator function within this program is carried out by more than one person or that the person performing the Health Coordinator function within this program also performs the same function within other programs. In order for OASAS to obtain accurate information on the cost of performing the Health Coordinator function, please provide the following information for each person performing the Health Coordinator function **within this program only**.

Name	<u>Total Annual Salary</u> (In all agency roles)	<u>Agency Fringe Benefit Rate</u> , if applicable	Average Hours per Week In Health Coordinator Role Within this Program

If your answer to Question #1 was "b", answer questions #5 and #6.

5. What is the hourly contracted rate (in dollars) paid to carry out the Health Coordinator function within this program?
 _____ Hourly Rate (format: \$XX.XX)

6. How many contracted hours per week are typically devoted to carrying out the Health Coordinator function within this program?
 _____ Hours per week (format: XX.XX)

2012 Local Services Plan Guidelines For Mental Hygiene Services

Terms Defined for this Form

Total Annual Salary – The total amount of wages paid to an individual staff person over the course of a full year by this organization, whether it is a part-time salary or a full-time salary.

Agency Fringe Benefit Rate - An employment benefit granted by an employer that has a monetary value but does not affect basic wage rates (life insurance, long term disability insurance, social security, NYS unemployment insurance, NYS disability insurance, workmen's compensation, health insurance, dental insurance, tuition assistance, sick leave, pension, postretirement health insurance, paid vacation, etc), The fringe rate is the portion of the fringe benefit costs to the wage rates.

C. Clinical Supervision and Qualifications Survey (Treatment Programs)

As the OASAS service delivery system prepares for a number of major changes that will impact its talent management efforts, such as health care reform, Ambulatory Patient Group reimbursement protocols and the sunset of the Social Work Licensure exemption, the necessity to better understand the composition of our workforce and its supervisory structure has become increasingly clear. Key to this understanding will be determining who currently serves in a Clinical Supervision capacity, who they supervise, and how they divide their time between administrative tasks and staff supervision.

With this information, OASAS and its Talent Management Committee can devise a series of strategies which will help to implement a more structured career ladder for counselors, introduce scopes of practice which define competencies at each step in the ladder, and roll-out a new comprehensive Clinical Supervision training program, based on the newly released [TIP 52 – Clinical Supervision and Professional Development of the Substance Abuse Counselor](#).

More importantly, by better understanding the challenges that Clinical Supervisors in our system currently face, OASAS can look to build a viable and ongoing technical support capability to enhance the role of Clinical Supervisors through a combination of classroom education, on-line coursework, and continuing skill development through practice, observation and feedback. All questions regarding this survey should be directed to Mr. Doug Rosenberry at 518-485-2033 or at DougRosenberry@oasas.state.ny.us.

Survey Questions

[Consult the LSP Guidelines for additional guidance on completing this exercise.](#)

Please provide the following information for each individual who is performing clinical supervision in this program. **NOTE: If an individual splits time between multiple programs, the information should be reported separately under each program.**

1. Contact Information:

- a) Last Name:
- b) First Name:
- c) Email Address:
- d) Phone Number:

2. How many hours per week does this clinical supervisor work in this program?

**2012 Local Services Plan Guidelines
For Mental Hygiene Services**

3. Of the hours per week indicated in #2 above, how many hours are devoted to each of the following activities?
- a) Individual face-to-face supervision with clinical staff
- b) Group supervision with clinical staff
- c) Case conferences with clinical staff
- d) Managing own caseload
- e) Administrative functions
4. Indicate the credentials this clinical supervisor currently has. (check all that apply)
- a) LCSW
- b) LMSW
- c) CASAC
- d) CASAC Trainee
- e) CPP
- f) CPS
- g) Gambling Specialty Designation (CASAC- G or CPP-G)
- h) CPGC
- i) LMHC
- j) LMFT
- k) Certified Rehab Counselor
- l) Other QHP (specify):
- m) Non-QHP currently, will be QHP by July 2013
- n) Non-QHP currently, will not be a QHP by July 2013
5. How many counselors does this clinical supervisor currently supervise?
-
6. Of those staff included in #5 above, indicate the total number of credentials they hold between them.
- a) LCSW
- b) LMSW
- c) CASAC
- d) CASAC Trainee
- e) CPP
- f) CPS
- g) Gambling Specialty Designation (CASAC- G or CPP-G)
- h) CPGC
- i) LMHC
- j) LMFT
- k) Certified Rehab Counselor
- l) Other QHP (specify):
- m) Non-QHP currently, will be QHP by July 2013
- n) Non-QHP currently, will not be a QHP by July 2013
7. List any Evidence-Based Practices this supervisor is currently supervising counselors to implement.
-
8. Do you want to enter information on another clinical supervisor for this program?
- a) Yes (loop questions 1-8)
- b) No (end of survey)

**2012 Local Services Plan Guidelines
For Mental Hygiene Services**

D. Domestic Violence Assessment and Referral Survey (treatment programs)

NYS OASAS is a member of the Governor's Advisory Board for The NYS Office of the Prevention of Domestic Violence (OPDV). As part of its participation on this Board, OASAS added to the discharge data collected through the Client Data System whether or not a client was a victim/survivor or perpetrator of domestic violence. Treatment discharge data for the period of January 1, 2010 through October 15, 2010 showed that 11.3 percent reported being a victim/survivor with another 18.1 percent undetermined, while 5.1 percent reported being a perpetrator with another 19.5 percent undetermined. Although substance use disorders and domestic violence are not perceived to have a causal relationship to each other, the interrelationship between the two complicates treating individuals affected by both. If both problems are not addressed, the effectiveness of interventions for each could be seriously compromised.

It is believed that the number of victims and perpetrators of domestic violence may be under reported. This survey seeks to determine the extent to which treatment programs are assessing and referring individuals to the domestic violence provider system when appropriate. The survey results will provide OASAS and OPDV with additional information to better meet the needs of individuals affected by both substance use disorders and domestic violence. All questions regarding this survey should be directed to Ms. Julia Fesko at 518-485-2027 or at JuliaFesko@oasas.state.ny.us.

Survey Questions

[Consult the LSP Guidelines for additional guidance on completing this exercise.](#)

The following questions pertain to clients in your program that may have a history as a domestic violence victim/survivor or perpetrator and services that may be available to them.

1. Does this program's assessment protocol screen whether or not a client has a history as a domestic violence victim/survivor?
 a) Yes (go to #2)
 b) No (go to #4)
2. Does this program refer those clients identified as a victim/survivor to appropriate services?
 a) Yes (go to #3)
 b) No (go to #4)
3. Please identify the program(s) to which this program refers victims/survivors of domestic violence?
4. Does this program's assessment screen whether or not a client has a history as a domestic violence perpetrator?
 a) Yes (go to #5)
 b) No (end of survey)
5. Does this program refer those clients identified as a perpetrator to appropriate services?
 a) Yes (go to #6)
 b) No (end of survey)
6. Please identify the program(s) to which this program refers perpetrators of domestic violence?

**2012 Local Services Plan Guidelines
For Mental Hygiene Services**

E. Older Adult Services Survey (selected treatment programs)

This survey is designed to obtain first-hand information from OASAS-certified treatment programs to assist OASAS in the development of a practical plan targeting the age-sensitive services for older adults (defined here as aged 60 and over). Key to this plan will be engaging OASAS providers with community organizations that are already involved in providing services to older adults. OASAS is seeking to identify Best Practices currently used by and available to programs. The goal is to assist programs and professionals in adapting protocols and enhancing skills that will improve the availability and accessibility of quality services tailored to the needs of older adults.

The Substance Abuse and Mental Health Services Administration (SAMHSA) estimates that approximately 17 percent of the 60-plus population experiences some level of alcohol and substance abuse problems. As many as 612,000 older adults in New York are already experiencing, or may be at risk for developing, problems associated with alcohol and drug use.

The information provided through this survey will assist OASAS' efforts to: 1) support service providers in the adoption of program design and protocols; 2) enhance professional skills, and 3) engage addiction services providers in multi-faceted community service networks that are designed, supported and monitored as they move ahead to improve the availability and quality of services provided to older adults. The screening/assessment tools selected for this survey are identified in SAMHSA's [Treatment Improvement Protocol \(TIP\) #26: Substance Abuse among Older Adults](#) as being effective for use among adults.

All questions regarding this survey should be directed to Mr. Robert Higgins at 518-485-2156 or at RobertHiggins@oasas.state.ny.us.

Survey Questions

[Consult the LSP Guidelines for additional guidance on completing this exercise.](#)

1. Approximately what percentage of your service population is aged 60 and older?
 - a) 40% or more
 - b) 30% to 39%
 - c) 20% to 29%
 - d) 10% to 19%
 - e) Less than 10%

2. How are older adults referred to this program? (check all that apply)
 - a) Criminal Justice System
 - b) Drinking Driver Program
 - c) Health Care System
 - d) Family Member
 - e) Senior Center
 - f) Self-Referral
 - g) Other (please specify):

**2012 Local Services Plan Guidelines
For Mental Hygiene Services**

3. Is this program handicapped accessible?
- a) Yes
- b) No
4. Which of the following screening/assessment tools developed for older adults are utilized by this program? (check all that apply)?
- a) [CAGE](#)
- b) Michigan Alcohol Screening Test-Geriatric Version ([MAST-G](#))
- c) Alcohol Use Disorders Identification Test ([AUDIT](#))
- d) Geriatric Depression Scale ([GDS](#))
- e) Instrumental Activities of Daily Living Scale ([IADL](#))
- f) Other (please specify):
5. Does this program provide discrete specialized services targeting older adults?
- a) Yes (go to #5a)
- b) No (go to #6)
- 5a. Has at least one staff member completed training courses in gerontology?
- a) Yes
- b) No
- 5b. Which of the following service approaches are delivered by this program? (check all that apply)
- a) Cognitive-behavioral approaches
- b) [Reminiscence Therapy](#)
- c) Group-based approaches
- d) Individual counseling
- e) Marital and family involvement/family therapy
- f) Specialized "adult focused" case management
- g) Nicotine Replacement Therapy (NRT)
- h) Medication supported recovery (exclusive of NRT)
- i) Outreach to other service providers, caregivers, health specialists, volunteer organizations, etc.
- j) Other (please specify):
- 5c. Has this program accommodated older patients' sensory decline and deficits through any of the following? (check all that apply)
- a) Simultaneous visual and audible presentation of material
- b) Enlarged Print
- c) Voice enhancers
- d) Blackboard/Flipcharts
- e) Other (please specify):
6. Does this program utilize peer supports, such as "recovery coaches" to work with older adults?
- a) Yes
- b) No
7. Does this program have any formal [written] service provider agreements with any community based service providers in order to improve the accessibility and coordination of addiction services for older adults? **NOTE: This refers not just to coordination of addiction services, but also comprehensive care and coordination with other needed services.**
- a) Yes (go to #7a)
- b) No

2012 Local Services Plan Guidelines For Mental Hygiene Services

7a. With which of the following community-based service entities does this program coordinates services?
(check all that apply)

- a) Local Area Agency on the Aging (AAA)
- b) Veterans Administration Services
- c) Adult Protective Services
- d) Visiting Nurses
- e) Senior Centers
- f) United Way
- g) Pharmacists
- h) Housing Service Providers
- i) Mental Health Service Providers
- j) Crisis/Detox Services
- k) Bereavement Services
- l) Meals on Wheels
- m) Hospitals
- n) Naturally Occurring Retirement Communities (NORCs)
- o) Other (please specify):

Terms Defined for this Survey

CAGE – The CAGE Questionnaire is one of the most widely used alcohol screens consisting of four questions, can be self-administered even by those with low literacy reading skills and can be modified to screen for use of other drugs. Although two or more positive responses are considered indicative of an alcohol problem, a positive response to any one of these questions should prompt further exploration among older adults. The CAGE is most effective in identifying more serious problem drinkers, including those with abuse and dependence, and less effective for women problem drinkers than their male counterparts.

MAST-G – This tool was developed specifically for older adults and has high sensitivity and specificity among older adults recruited from a wide range of settings, including primary care clinics, nursing homes, and older adult congregate housing locations.

AUDIT – This screening tool can be used in a variety of primary care settings by persons who have different kinds of training and professional backgrounds. The core AUDIT is designed to be used as a brief structured interview or self-report survey that can easily be incorporated into a general health interview, lifestyle questionnaire, or medical history. Because there are few culturally sensitive screening instruments, SAMHSA indicates that the AUDIT may prove useful for identifying alcohol problems among older members of ethnic minority groups.

GDS - This is a 15-question tool designed to identify depression. For clinical purposes, a score greater than 5 suggests depression and warrants a follow-up interview. A score greater than 10 indicates depression.

IADL – This tool provides information regarding a person's capacity to perform instrumental activities of daily living (IADLs), which include managing finances, preparing meals, shopping, taking medications, and using the phone. The IADL provides information related to disabilities that can be major risk factors for institutionalization and are more likely than physical illness or mental health problems to prompt older adults to seek treatment.

Reminiscence Therapy – This therapy uses prompts, such as photos, music or familiar items from the past, to encourage the patient to talk about earlier memories. It's generally offered to people in their later years who have mood or memory problems, or need help dealing with the difficulties that come along with aging. Reminiscence therapy can be conducted formally or informally with individuals, families, or groups. Sessions can last from 30 to 60 minutes and occur weekly or even several times per week. Depending on the training of the clinician, the patient's needs and the setting, the goal may be to: a) improve communication; b) foster a person's sense of self; c) improve mood; or d) provide an enjoyable social activity.

Naturally Occurring Retirement Community (NORC) - A community-based intervention program designed to reduce service fragmentation and create healthy, integrated communities in which seniors living in NORCs are able to age-in-place with greater comfort and security in their own homes. In general, NORC Supportive Services Programs are flexible and responsive to client needs and preferences, which are based upon community and client assessments and changes over time. NORCs are anchored in apartment buildings or housing complex that were not specifically built for the elderly in which many of the residents have aged in place and are in need of support services to enable them to continue living in their homes. In general NORC Supportive Service Programs develop an interdisciplinary approach to services and programs offered to older adults.

**2012 Local Services Plan Guidelines
For Mental Hygiene Services**

F. Veterans/Military Services Survey (selected treatment programs)

The New York State Office of Alcoholism and Substance Abuse Services (OASAS) is seeking to develop and integrate effective services for veterans, as well as current and former members of the military and their families throughout its service system. The purpose of this survey is to help assess existing services provided to this population, identify gaps in needed services, and identify ways to improve the quality and delivery of addiction services for veterans and their families. OASAS will use the information obtained in this survey to develop a strategic plan for further refinement and development of quality addiction services. **Note: for the purposes of this survey a veteran is defined as an individual who has served or is presently serving in the armed forces of the United States. This includes service in any of the five branches as a member of the full time (regular), reserve, or National Guard forces.** All questions regarding this survey should be directed to Mr. Paul Noonan at 518-485-7091 or at PaulNoonan@oasas.state.ny.us.

Survey Questions

[Consult the LSP Guidelines for additional guidance on completing this exercise.](#)

1. Did your program provide treatment services to any veterans, as defined above, during the past 12 months?
 a) Yes
 b) No (end of survey)

2. If “yes”, do you operate a veteran’s specific track or group, maintained and conducted separately from programs for non-veterans?
 a) Yes
 b) No

3. Are you collaborating, or coordinating services, with any of the following:
 a) US Department of Veterans Affairs (VA)
 b) NYS Division of Veterans Affairs (DVA)
 c) County-level veterans agencies
 d) Other veterans agencies or service organizations (please identify):

4. Does your program currently utilize any of the following treatment approaches with veterans? (please check all that apply)
 a) Motivational Interviewing
 b) Motivational Enhancement Therapy
 c) Cognitive Behavioral Therapy
 d) Trauma-informed care
 e) Behavioral Therapy
 f) Relapse Prevention Therapy
 g) Other (please describe):

5. Does your program offer vocational education services for veterans?
 a) Yes
 b) No

2012 Local Services Plan Guidelines For Mental Hygiene Services

6. Do you utilize staff who are veterans in the provision of clinical services to veteran clients?
 a) Yes
 b) No
7. Does your program offer veterans-oriented recovery services?
 a) Yes
 b) No
8. Is your program utilizing any specific Evidence-Based Practice (EBP) for veterans?
 a) Yes
 b) No
If "yes", please describe:
9. Does your program offer any services for family members of veterans?
 a) Yes
 b) No
If "yes", please describe:
10. Indicate which topic area would be most beneficial in meeting your program's staff training and development needs with respect to veteran's services?
 a) **Competency Level Training** (e.g., working with co-occurring disorders, engaging the family, nicotine addiction, gambling, etc.)
 b) **Skill Building Training** (use of specific evidence based practices)

G. Capital Funding Request Form - Schedule C (optional)

OASAS Bonded Capital Funding

Capital costs are defined as the acquisition of real property, design, construction, reconstruction, rehabilitation and improvement, original furnishings and equipment, site development, and appurtenances of the local facility. Capital costs do not include operating costs; payments of principal, interest, or other charges on obligations; or costs for which State Aid is claimed or paid under provisions of law other than the Mental Hygiene Law. For 2011, capacity expansions, new programs or existing programs that would require additional state aid will NOT be considered for capital funding.

Capital projects will be reviewed by OASAS staff to determine the priority that should be given to Schedule C requests and if they meet OASAS criteria for project development. For 2011, any new capital funding will be used primarily for preservation, relocation or purchase of existing sites. Preservation is not limited to projects which specifically address structural repairs, but rather any project that is necessary or advisable to allow the site to continue to serve as an acceptable space for the provision of services of the particular kind and to the particular populations served (i.e., capital funds may be requested for improvements in space layout, improvement in the service environment, improved amenities, upgraded electrical, plumbing or HVAC systems, rearranged space and facilities to adapt to changing service requirements, etc.) OASAS recognizes that some facilities are in premises which cannot be economically preserved. In these circumstances, funding may be made available for relocation or reconstruction of programs.

2012 Local Services Plan Guidelines For Mental Hygiene Services

MH Facilities Improvement Bond Program (MHFIBP), a bond-backed financing program, permits voluntary providers to borrow 100 percent of their capital project costs at fixed interest rates for 20-30 year periods. The loans made to providers for capital construction and acquisition of property secured by a mortgage on the property necessitates a first lien on the entire site. Debt service (payments for principal and interest on the borrowing) is repaid through the OASAS local assistance account.

To take advantage of the MHFIBP financing program, voluntary providers must be in good standing with the New York State Department of State, possess the powers to enter into the mortgage agreement in accordance with incorporation documents, and receive appropriate boards of directors' approvals. In addition, providers must have an effective notification from the Internal Revenue Service that qualifies the provider as a tax-exempt organization under Section 501(c) (3) of the Internal Revenue Code.

Providers will be expected to sign a waiver or assignment agreement authorizing OASAS to intercept local assistance payments otherwise due to providers for the purposes of paying debt service on the mortgage. OASAS will make debt service payments directly to the Dormitory Authority (DA) on a semi-annual or other agreed upon basis.

To be eligible for tax-exempt bond financing on leased property, the lease term must exceed the economic life of the building, must constitute the equivalent of tax ownership, and must be at least 5 years longer than the term of the bond. Projects under \$300,000 are generally considered too small to warrant the cost of bond issuance.

Other OASAS Capital Funding Available

Minor Maintenance

OASAS also has funding available to address capital needs for rehabilitation of existing facilities that do not qualify for the bond-backed mortgage program. If the estimated cost of a project is less than \$100,000, a PAS-34 Minor Rehabilitation Request form should be completed and submitted directly to the Field Office. It should not be submitted in the local services plan. Minor maintenance project requests will be reviewed and approved on a continuous basis. The PAS-34 form is available on the OASAS Website.

Capital Projects Costing \$100,000 or More

For all other projects (i.e., those projects costing at least \$100,000), **a completed Schedule C form must be submitted via the Online County Planning System.** Projects that will be considered for funding include:

- Program relocation
- Purchase of existing leased space
- Regulatory compliance
- Health and safety improvements
- Access for physically disabled
- General preservation

OASAS will review all projects proposed on a Schedule C form and submitted through the local services planning process based solely on the information provided.

2012 Local Services Plan Guidelines For Mental Hygiene Services

All project proposals that have a strong justification in relation to program, physical plant and community need, OASAS capital plans, their cost, the provider's ability to provide or arrange interim financing, and OASAS' anticipated capital funding authority will be considered. Staff will be assigned to arrange performance of feasibility studies and appraisals. The provider will have to complete an application for approval in accordance with Part 810 of OASAS regulations. OASAS will provide advice and assistance in completing the Schedule C form. After a capital request is approved and all detailed information about the project is submitted, a decision will be made by OASAS on whether the project will be funded or not. If OASAS approves the project, it will seek Division of the Budget (DOB) approval. After DOB approval, a capital contract will be executed with the provider and an architect engaged to begin design.

Considering the routine State budget process, the Part 810 review process, and the time it takes to get DOB approval, major capital projects must be considered multi-year efforts. Even after a contract is executed, project design, other approvals, construction bidding, and construction will take two to three years or longer for very large projects. Thus, as OASAS reviews and approves projects for development, the agency will schedule the projects over a number of years. Therefore, funding will come from appropriations made over a number of years as well. Providers submitting proposals for major projects should be aware that regardless of the speed of the initial decision, the conduct of the approved project is a long-term effort.

Instructions for the Capital Project Funding Request Form - Schedule C

A Schedule C "OASAS Capital Project Funding Request Form" should be completed by any provider that wants to request capital funds as described above. The completed form must be completed and submitted in CPS. Each Schedule C will be reviewed and considered by OASAS on a case-by-case basis. Further information may be requested, as needed.

For the **2012 Local Services Plan**, a Schedule C should be completed for each project that meets the criteria for fundable capital projects. The focus of all capital funding will be on preservation of existing sites, with the highest priority being given to correction of code and regulatory violations, health and safety matters and maintenance of service delivery space. All provider and project site information at the top of the form must be completed. Specific instructions follow:

Question #1 - Project Purpose: Place an "X" in the box next to each purpose which applies to the project proposed.

- a. **Relocation:** Check this box if the project is intended to physically relocate an existing program or site to a new location.
- b. **Purchase of Existing Leased Space:** Check this box if the project involves the possible purchase of an existing program that is in leased space. For example: with skyrocketing lease costs, it may be more financially feasible to pay debt service on a mortgage as opposed to a lease with large escalator clauses.
- c. **Regulatory Compliance:** Check this box if the project is intended to bring the program and/or its space into compliance with building, health or safety codes or OASAS regulatory requirements. These violations may be ones you have identified by outside inspectors including, but not limited to, OASAS inspectors.

**2012 Local Services Plan Guidelines
For Mental Hygiene Services**

- d. **Health and Safety Improvements:** Check this box if the project is intended to improve health and safety of the space in ways not required by code or regulation. Examples might include rehabilitation of bathroom fixtures and plumbing, upgrading smoke detection and alarm systems, replacing kitchen floors and finishes, etc.
- e. **Access for Physically Disabled:** Check this box if the project is to improve access to or use of all or part of the site by physically challenged persons. Examples include construction of wheelchair ramps at entrances, installations of lifts, handrails and grab bars, installation of special bathroom equipment, and acquisition and installation of calling devices for summoning assistance.
- f. **General Preservation:** Check this box if the project is to preserve an existing facility. Projects in this category are intended to maintain or protect the use of an existing facility and do not materially extend the useful life or provide enhancement of the environment or program, for example, replacement of a deteriorated bathroom, replacement of heating system, roof, kitchen, driveway, etc.

Question #6: Provide a detailed statement of the need for the project and a justification for it. Describe the need/benefit to the program's operation, to the improvement of the physical plant and the need/benefit to the financial operation of the facility.

- **Program need/benefit** refers to correction/improvement of client safety, access, privacy, space layout and traffic flow, or number and types of spaces for patient services and staff activity, etc.
- **Physical need/benefit** refers to correction/improvement of inadequate functioning of building or mechanical systems (plumbing, electric, HVAC etc.), structural safety and adequacy, energy efficiency, building integrity (leaky roof windows etc.), building security or internal security of property, supplies, personnel, etc.
- **Financial need/benefit** refers to improved financial circumstances resulting from projects which increase energy efficiency, reduce property costs, allow more efficient use of space allowing reduced space use, or reduction of space and cost due to program reorganization or contraction, etc.

A sample of the Schedule C form appears on the following pages.

**2012 Local Services Plan Guidelines
For Mental Hygiene Services**

Schedule C – OASAS Capital Project Funding Request Form (Page 1)

Corporate Headquarters			Date:	
Provider Name (full legal name):			Provider Number:	
Street/P.O. Box:	City:	State:	Zip:	
Project Site				
Street/P.O. Box:	City:	State:	Zip:	
Service Category:		PRU:	County:	
Contact Person:		Title:		
Telephone:	E-mail:	Certified Capacity:	Funded Capacity:	
<p>1. Project Purpose:</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <input type="checkbox"/> a) Program Relocation <input type="checkbox"/> b) Purchase of Existing Leased Space <input type="checkbox"/> c) Regulatory Compliance </div> <div style="width: 45%;"> <input type="checkbox"/> d) Health and Safety Improvements <input type="checkbox"/> e) Access for Physically Disabled <input type="checkbox"/> f) General Preservation </div> </div>				
2. Estimated Project Cost: _____		If the estimated cost is less than \$100,000, a PAS-34 Minor Rehabilitation Request should be submitted separately to the Field Office.		
<p>3. Briefly describe the physical plant problem and corrective work required:</p>				
<p>4. Indicate approximate square footage of space to be added or affected by the proposed capital project: _____ ft²</p>				
<p>5. Briefly describe the proposed scope of work in the project:</p>				

