

# 2014

## Local Services Plan Guidelines

For Mental Hygiene Services

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# **2014 Local Services Plan Guidelines For Mental Hygiene Services**

## **Chapter I: Introduction**

### **A. The Local Services Planning Process**

New York State Mental Hygiene Law requires the Office of Alcoholism and Substance Abuse Services ([OASAS](#)), the Office of Mental Health ([OMH](#)) and the Office for People With Developmental Disabilities ([OPWDD](#)) to guide and facilitate the process of local planning (§41.16(a)). For many years, each state agency conducted its own local planning process which required local governmental units (LGUs) to comply with three separate and disconnected sets of planning requirements. Over the past five years, the three state agencies have collaborated to develop a single set of plan guidelines. These guidelines represent the sixth consecutive year of a fully integrated local services planning process where a single mental hygiene plan is completed and submitted to the state.

Mental Hygiene law also requires local governmental units (all counties and New York City) 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)). The law further requires that state goals and objectives embody the partnership between the state and LGUs (§5.07(a)(1d)) and that each agency's statewide comprehensive plan, therefore, be formulated from the LGU comprehensive plans (§5.07(b)(1)).

### **B. Mental Hygiene Planning Committee**

The current local services planning process is guided by the Mental Hygiene Planning Committee and is comprised of planners from the three state mental hygiene agencies, the NYS Conference of Local Mental Hygiene Directors ([CLMHD](#)), and several local governmental units (LGUs). This collaboration enables LGUs to conduct planning in a way that better addresses the needs of people with co-occurring disorders and who require services from multiple systems. The objective of an integrated person-centered local planning process is to create system-wide improvement in the quality of services and supports to individuals, families and communities.

In the five years since the integrated planning process began, county plans have become much more focused on developing priorities and strategies intended to address the needs of the whole person, particularly coordinating behavioral health care with primary health care and improving access to recovery support services. As a result of significant reforms facing the behavioral health care system, such as the Patient Protection and Affordable Care Act (ACA), Medicaid Redesign, and the evolution of regional Behavioral Health Organizations (BHOs) and Health Homes (HHs), the focus of the planning committee has evolved. Today, the committee is largely focused on ensuring that the important role of the LGUs in the provision and oversight of local behavioral health services for their populations is maintained. It is a priority of the committee that the LGUs provide timely and informed input into state policy decision-making regarding these reforms and to continue to manage their local service systems to achieve the cost effective care and better patient outcomes that we are all seeking.

Today, the local services planning process for mental hygiene services is much more dynamic than ever before. No longer is it sufficient for the LGUs to only submit a plan to

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the state once a year with goals and objectives that won't change over a two or three year planning horizon. Counties need to be more flexible in their strategies to address the problems and needs in their communities, particularly in light of the sweeping reforms in health care. The local planning process has become more fluid, with a rolling horizon that is more responsive to change. This dynamic process is facilitated by an active Mental Hygiene Planning Committee and workgroups, the web-based online County Planning System (CPS), more focused and strategic plan guidelines, and a mechanism for conducting rapid cycle surveys of local mental hygiene directors for swift and coordinated input on critical state policy and programming decisions.

### ***Data Needs Workgroup***

The Data Needs Workgroup of the Mental Hygiene Planning Committee consists of planners from several counties and the three state mental hygiene agencies and is chaired by a county planner. The purpose of the workgroup is to identify county data needs and to work with the state agencies to develop data resources that help them to perform their local planning and system management responsibilities. The workgroup meets periodically throughout the year. During the most recent local planning cycle, the workgroup achieved the following goals:

- Worked with OASAS staff to enhance existing Data Inquiry Reports available to counties through the OASAS Applications Portal. The new reports expand county access to client data, providing aggregate data previously only available at the program level, and output data in more usable formats for county planners. When completed in early 2013, a total of nine new County Inquiry Reports will be available to LGU staff.
- Worked with OMH staff to facilitate county access to the Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES). Appropriate access will continue to expand in the year ahead, and the first meeting of a new user's group is expected in early 2013.

### ***Community of Practice for Local Planners (CPLP)***

The Community of Practice for Local Planners (CPLP) was established in 2009 to promote best planning practices, techniques for assessing local needs, defining outcomes and strategies, and identifying and utilizing available data resources. This group is chaired by a county planner and includes representatives from county and state agencies. In that same year, a CPLP Page was developed in CPS to provide easy access to these resources.

Over the years, the CPLP has convened a number of webinars and in-person planning sessions that provide county planners with opportunities to learn about new state data systems and resources, local planning requirements and CPS enhancements, and to share planning practices that help them to perform their planning and system management responsibilities.

During the most recent planning cycle, the following webinars were conducted:

- **County Fiscal Dashboard** – Developed by the CLMHD Fiscal Workgroup, the dashboard displays financial measures identified as key measures to support

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- system oversight and monitoring. The report was designed to provide a general overview of the behavioral health system utilizing readily accessible data from the Consolidated Fiscal Report (CFR) and Medicaid Fee for Service data from the New York State Department of Health, eMedNY Data Warehouse.
- **Mental Hygiene Planner's Update** – Provided county planners with information on changes in the local services plan guidelines and to CPS. In addition to this webinar, an OASAS Learning Thursday presentation conducted jointly by the OASAS planner and a county director provided county planners with an overview of CPS and a practical application of selected data resources available in CPS.
  - **OMH Data Portal** – Provided county planners with information on how to utilize available data resources on the OMH website to guide their local planning efforts. The presentation included the use of the OMH County Profiles Portal and the Behavioral Health Organizations (BHO) Portal.

Much of the recent work of the CPLP has been focused on promoting local planning as an active and ongoing process, and not just an annual document; "planning" as a verb, and not just a noun. The recent rapid cycle surveys that have gathered feedback from counties are an example of an effort to create an ongoing dialogue between state agencies and counties, as part of this planning effort. In 2013, CPLP efforts will focus on insuring that local planners have access to both data tools and the knowledge of their peers to enhance their local planning efforts. Given the large number of new Directors of Community Services and county planners, the CPLP will work to insure that those who are new to planning roles have the opportunity to learn about all of the available resources and tools that can aid their efforts.

### **C. The Online County Planning System (CPS)**

The online County Planning System (CPS) was developed by OASAS in 2004 and implemented statewide in 2005 to enable counties and their service providers to complete and submit required annual local planning forms to the state electronically. CPS quickly became a state-of-the-art platform from which counties could access relevant 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 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. Prevention and Treatment providers also have the ability to manage their presence in CPS by approving user accounts for staff that need to complete planning surveys for OASAS or to access county plans and the data resources available to them in CPS.

In 2007, OASAS agreed to collect county mental health priorities through CPS. The following year, county developmental disability priorities were incorporated, thereby creating the first ever fully integrated mental hygiene local services planning process in New York State. For the first time, counties had the ability to develop and submit a single integrated mental hygiene local services plan to all three state agencies at once.

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Today, there are more than 2,400 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. In addition to user roles for the three state agencies, LGUs and OASAS providers, a Guest Viewer role was created for those interested in accessing CPS content but who are not staff within any of the above referenced organizations. There are approximately 300 CPS users in the Guest Viewer role with read-only access to all completed county plans and most planning resources currently housed in CPS. A CPS account may be requested by completing the online registration form at <https://cps.oasas.ny.gov/cps/>. The following table describes the major CPS user roles and the entitlements granted to each role. **NOTE: In 2013, anyone interested in establishing a user account in any OASAS web application, including CPS, will first need to have an approved OASAS Applications account. To request an OASAS Applications account, submit a completed OASAS External User Access Request, [IRM-15](#), to OASAS. Once approved, a CPS account can be established using the new OASAS Applications user name and password.**

**Primary CPS User Roles and Entitlements**

User Role	User 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 CPS administrator within the organization for approval. State agency staff roles have read-only access to the entire system. A special role was created for Developmental Disabilities Services Offices (DDSO) staff that allows them to approve the OPWDD components of a county's plan. LGU and provider staff roles can be approved by any administrator from the same organization. State agency staff roles are approved by the appropriate state agency administrators.
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. LGU and provider staff roles can be approved by any administrator from the same organization. The Guest Viewer role is approved by OASAS.
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 source for recommending CPS enhancements, developing planning data resources, and providing communication and technical assistance on planning related matters. A major part of this effort is the feedback received through the annual CPS User Satisfaction Survey and input received from users throughout the year. CPS continues to be supported by all three mental hygiene agencies, administered by the OASAS Bureau of State and

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Local Planning, and maintained by the OASAS Bureau of Information Technology. CPS login problems should be directed to the OASAS Help Desk at 518-485-2379. All other questions related to CPS should be directed to the OASAS Bureau of State and Local Planning at [osasplanning@osas.ny.gov](mailto:osasplanning@osas.ny.gov) or at 518-485-2410.

**Local Services Planning Timeline**

The following timeline highlights the critical points in the local services planning process and is intended to provide continuity in planning expectations from year to year.

<b>2014 Local Services Planning Process Timeline</b>	
Ongoing planning and needs assessment conducted by counties	Year round
Local Services Plan (LSP) Guidelines published; CPS updates available	March 1, 2013
LSP and CPS training for county planners	March/April (TBD)
<b>Due date for completed OASAS provider planning surveys in CPS</b>	<b>Monday, April 1</b>
<b>Due date for completed LGU Plans in CPS</b>	<b>Monday, June 3</b>
State summary analyses of county and provider plans completed	September 1
OASAS, OMH, OPWDD Statewide Comprehensive Plans released	November 1
OASAS, OMH, OWPDD Interim Reports released	March 15, 2014

**D. 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 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 67 percent of priorities cut across two or more disability areas, up from 37 percent four years earlier, suggesting that the integrated mental hygiene planning process and CPS are serving as catalysts for more coordinated and focused planning across multiple systems of care.

The local services planning process and the priorities identified in county plans, particularly the cross-system priorities, inform each state agency's policy, programming and budgeting decisions in a way that is more timely and comprehensive than previously possible. Additionally, the Rapid Cycle Surveys conducted by the Mental Hygiene Planning Committee enhance the ability of the LGUs to inform and influence state decision-making on emerging issues and developing policy in a more proactive and effective way than was previously possible. To help ensure that policies support people with mental illness, developmental disabilities and/or addictions are planned, developed and implemented comprehensively, OASAS, OMH, and OPWDD will continue to look to the local services planning process and the annual plan submissions as primary sources of input.

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### **CHAPTER II: Planning for Mental Hygiene Services**

#### **A. The Context for Planning in an Atmosphere of Change**

While OASAS, OMH and OPWDD face unique challenges in overseeing their respective service systems, several federal and state regulations and policies influence current operating environments and strategic directions across these agencies. Understanding the factors that influence the state's mental hygiene service system empowers LGUs to align their strategic direction with statewide goals and objectives. These factors include: the Olmstead Decision; the Affordable Care Act; Medicaid Redesign; the Substance Abuse and Mental Health Services Administration's (SAMSHA) Strategic Initiative; and the Protection of People with Special Needs Act. The following is a brief summary of each.

##### ***Olmstead Decision***

The 1999 U.S. Supreme Court ruling in *Olmstead v. L.C.* held that unnecessary institutionalization of individuals with disabilities violates the Americans with Disabilities Act (ADA). The ruling found that individuals should be allowed to receive services and supports in the most integrated setting appropriate to their needs. To meet their obligations under the Americans with Disabilities Act (ADA), states must demonstrate they have an effective plan to transition eligible individuals with disabilities to integrated community settings.

In 2012, Governor Andrew M. Cuomo signed Executive Order number 84 establishing an Olmstead Plan Development and Implementation Cabinet to provide guidance and advice to the Governor. The Cabinet will produce recommendations concerning the implementation, and coordination of New York State's Olmstead Plan by May 31, 2013. The Olmstead Plan will include goals, strategies, and targets related to services that will assist individuals with disabilities to live in the most integrated community settings. The Olmstead Plan will address access to integrated housing and employment, as well as, transportation and community services.

New York State's three mental hygiene agencies have been, and are continuing to, focus on increasing the availability and accessibility community-based services and supports, person-centered services, strength-based treatment, and peer-oriented supports.

##### ***Affordable Care Act***

The 2010 Patient Protection and Affordable Care Act (ACA) established new policies and incentives for states to expand access to Medicaid's Home and Community Based Service (HCBS) programs. The ACA contains provisions to expand coverage, mitigate health care costs, and improve service delivery. ACA reforms and protections that impact New York's with disabilities include:

- **Health care coverage:** The ACA expands eligibility (to 138% of the FPL<sup>1</sup>), prohibits annual coverage limits in health plans and insurance policies, and

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<sup>1</sup> 138% of the Federal Poverty Level (FPL) for a family of four is approximately \$30,000 per year.

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- makes healthcare coverage for all individuals regardless of disability or pre-existing conditions possible.
- **Service and supports:** The ACA requires healthcare plans to include rehabilitative and habilitative services and devices as covered benefits and provides states the option to expand community-based attendant services through Community First Choice (CFC).
  - **Health care costs:** The ACA creates a temporary 90% federal match for states to provide health homes for individuals with chronic conditions and extends the Money Follows the Person (MFP) Rebalancing Demonstration through September 30, 2016.

The New York State Department of Health (DOH) is participating in the Community First Choice (CFC) option, which will expand participant directed and agency-based attendant care supports as part of the Medicaid state plan.

### ***Medicaid Redesign***

In response to the passage of the Affordable Care Act (ACA), poor patient outcomes and exorbitant health care costs in the Medicaid system, Governor Andrew M. Cuomo established the Medicaid Redesign Team (MRT) in 2011, which was comprised of stakeholders, patient advocates, and experts from across the state. The primary objective of the MRT was to develop specific cost saving and quality improvement recommendations for redesigning the Medicaid program in New York State according to changes and processes required under ACA. One of the areas the MRT focused on was identifying ways to improve care management for Medicaid beneficiaries with complex health conditions, including those with mental health and substance use disorders.

The MRT's Behavioral Health Reform Work Group made twelve recommendations, including the creation of Behavioral Health Organizations (BHOs). In Phase I, OASAS and OMH contracted with five regional Behavioral Health Organizations (BHOs) to manage services which are currently carved-out of mandatory Medicaid managed care (i.e., fee-for-service medically managed detoxification and inpatient rehabilitation). In Phase II, scheduled to begin in 2013, BHOs will contract with specialty managed care plans to address the needs of those individuals whose benefits have been carved-out, in integrated plan arrangements, allowing for the transition to a fully managed system of care coordination. During the transition period, behavioral health services will continue to be reimbursed on a fee-for-service basis. When completed, all Medicaid programs will be transitioned to managed care.

Under authorization by ACA, New York State is establishing Health Homes to improve care coordination among the Medicaid population with complex and/or chronic conditions, including those with mental health, substance use disorders, developmental disabilities who also have other chronic health problems. Medicaid eligible individuals must have: (1) two chronic conditions; (2) one chronic condition and are at risk for a second chronic condition; or (3) one serious persistent mental health condition to qualify for health home services. Under the Health Home model, a patient's care is managed and addressed in a comprehensive manner by a network of service providers working together to meet the needs of the individual. In addition to comprehensive care management and coordination, Health Homes will provide individual and family support

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services, referral to community and social support services, and will utilize health information technology to better link service providers. Each enrollee will have a dedicated care manager who will be responsible for overall management of the enrollee's plan of care.

Health Homes will be required to have policies and procedures in place with LGUs to ensure care coordination, have a systematic follow-up protocol in place to assure timely follow-up care, develop policies and procedures to support collaboration with community-based resources, meet Health Information Technology (HIT) standards as a condition for approval as a health home provider, and ensure that enrollees (or their guardian) are actively involved in the enrollee's plan of care.

Health homes are being implemented across the state in three phases. The DOH website provides detailed information on the [health home implementation plan](#), including which counties are in each phase of the implementation, the number of health home networks in any given area and the lead agency, and participating providers in each network. Phase I was implemented in August 2012, Phase II is anticipated to begin in February 2013 and Phase III implementation will follow shortly thereafter. For a more detailed description of the development of the Behavioral Health Organizations and Health Homes, please see the OASAS-OMH Common Chapter in each agency's Statewide Comprehensive Plan for 2012-2016.

OPWDD has begun the process of seeking significant programmatic and fiscal improvements to the service system through the People First Waiver (a 1915 b/c Medicaid waiver). Under the People First Waiver, coordinated comprehensive services and supports will be offered by Developmental Disabilities Individual Supports and Care Coordination Organizations (DISCOs). Over a two-year period, starting in 2013, OPWDD will pilot DISCOs allowing individuals to opt into the managed care program. The People First Waiver will combine long-term care, physical health and mental health services for people with developmental disabilities.

### ***Protection of People with Special Needs Act***

In June, 2012 the New York State Legislature passed the Protection of People with Special Needs Act, which created the Justice Center, a new agency to ensure the safety of individuals served in residential and day programs by provider agencies operated, licensed or certified by the State. The Justice Center will absorb all functions and responsibilities of the Commission on Quality of Care and Advocacy for Persons with Disabilities (CQCAPD), with the exception of the Federal Protection and Advocacy and Client Assistance Programs which will be designated to a qualified nonprofit. The Act requires all state agencies overseeing these systems to develop and implement consistent incident management procedures, including a process to ensure timely reporting, investigation, and review of allegations of reportable incidents that could subject a person to harm.

### ***Changes to the NYS Mental Hygiene Law***

Amendments to the NYS Mental Hygiene Law in 2012 will provide a mechanism for the integration of the OASAS and OMH statewide comprehensive planning processes. Section 5.06 was amended to replace the OMH Mental Health Services Council and the

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OASAS Advisory Council on Alcoholism and Substance Abuse Services with a newly created Behavioral Health Services Advisory Council (BHSAC). The BHSAC will comprise 28 individuals with varying degrees of experience and expertise, including consumers of behavioral health services, family members, non-providers, providers of mental health and substance use disorder services, individuals with experience serving veterans with mental health and substance use disorders, state and local governmental agency representatives, and members of DOH's Public Health and Health Planning Council. The Chair of the Conference of the Local Mental Hygiene Directors (CLMHD) will serve on the BHSAC.

The BHSAC's responsibilities will also include advising the Commissioners of OMH and OASAS on matters related to behavioral health service delivery, financing of behavioral health services, integration of behavioral health services with primary health services, services to people with co-occurring disorders, prevention of behavioral health disorders, and improvements in care to people served by the behavioral health system. In addition, the BHSAC will review applications seeking OASAS/OMH certification to provide behavioral health services, and review all proposed OASAS/OMH rules and regulations prior to enactment. The BHSAC will be responsible for developing statewide goals and objectives that will guide the respective OASAS and OMH planning processes and the potential merger of those separate planning processes into a single Statewide Comprehensive Plan for both agencies.

Section 5.07 was amended to authorize OASAS and OMH to develop joint Statewide Comprehensive Plans and Interim Reports. The date for submission of the Statewide Comprehensive Plan will move from October 1 to November 1 and submission of the Interim Report will move from February 15 to March 15. These changes will not take effect until the OASAS and OMH commissioners have certified that the BHSAC has sufficient confirmed membership to perform its functions. OASAS is working closely with OMH to implement changes in the statewide comprehensive planning process which will enhance the ability of the addictions and mental health systems to deliver more integrated services.

### **B. Planning for Addiction Services**

Planning for addiction services in New York State is guided, in part, by the OASAS Strategic Framework. This framework incorporates outcomes that are derived from an agency's mission and priorities into a dynamic, data informed and participatory planning process where those desired outcomes are aimed at improving program performance, client results, and return on investment. It allows management to systematically measure progress towards intended outcomes and to adjust strategies over time to accommodate changing events and circumstances that impact the service system.

A dynamic local planning process that is data informed and focused on outcomes allows the LGU to develop meaningful and realistic strategies, track and measure progress, and ultimately achieve the desired change. It establishes a systematic way to monitor performance and inform management when adjustments are necessary, which increases the likelihood of improved system performance.

While Mental Hygiene Law requires the LGU to develop goals and objectives that are consistent with statewide goals and objectives, each LGU must determine its priorities

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and strategies based on its own assessment of local problems and needs. By having an on-going local planning process that engages consumers and stakeholders, the LGU can more effectively meet those local needs in a manner that is consistent with state level direction, and at the same time be in a stronger position to inform the development of statewide priorities.

### ***DOH Prevention Agenda***

In December 2012, the New York State Department of Health (DOH) distributed guidelines describing the essential elements of a local health department (LHD) Community Health Assessment and Community Health Improvement Plan, as well as the requirements for hospital Community Service Plans. These guidelines reflect the Prevention Agenda 2013-2017 which was developed in conjunction with the agency's new health improvement plan. LHDs and hospitals are encouraged to collaborate with each other and additional community partners on the development of these documents. DOH believes that collaboration to develop a community health assessment and community health improvement plan will reduce duplication in a more efficient and effective manner.

In the previous Prevention Agenda 2008-2012, LHDs were asked to select at least two of ten local priorities and develop action plans to achieve measurable progress toward health improvement in their communities. One of the ten priority areas that they were asked to choose from was ***Promote Mental Health and Prevent Substance Abuse***. Thirteen LHDs selected this priority to address in their Community Health Improvement Plan. Several of those plans identified collaboration with additional county partners.

In the current Prevention Agenda 2013-2017, the number of priority areas to select from was reduced from ten to five. However, Promoting Mental Health and Preventing Substance Abuse received enough attention in the previous cycle that it remains as one of only five priority areas. At least one of the priorities should address a health disparity. The five priority areas include:

- Prevent Chronic Diseases
- Promote a Healthy and Safe Environment
- Promote Healthy Women, Infants and Children
- Promote Mental Health and Prevent Substance Abuse
- Prevent HIV, STDs, Vaccine Preventable Diseases and Healthcare Associated Infections

DOH, OASAS and OMH staff, along with professionals from the field and other interested stakeholder organizations participated on a Promote Mental Health and Prevent Substance Abuse workgroup that developed specific guidance for the LHDs and hospitals that included seven goals and seventeen objectives under three primary focus areas:

- Promote Mental, Emotional and Behavioral (MEB) Well-Being in Communities
- Prevent Substance Abuse and Other Mental Emotional Behavioral Disorders
- Strengthen Infrastructure Across Systems

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OASAS and OMH each endorsed the Prevention Agenda 2013-2017 and strongly encourage LGUs to proactively reach out to their LHDs to collaborate on the Promote Mental Health and Prevent Substance Abuse priority.

### ***Recovery Oriented System of Care (ROSC)***

Recovery is a process of change in which an individual, family member, or family moves from impairment to an endearing and holistic focus on self-awareness, understanding of others, and improved quality of life. Ingrained in health care reform is the public health model that supports ROSC through its vision of prevention, screening and early intervention, treatment, and recovery, integrated with primary health care.

In SAMSHA's 2011-2014 strategic plan, it identified recovery support as one of eight strategic initiatives. The purpose of the recovery support initiative is to establish partnerships between counties, states, treatment and prevention programs, individuals in recovery and other stakeholders to guide behavioral health systems to promote individual, program, and system-level approaches that foster health and resilience, increase permanent housing, employment, education and vocational services, and reduce discriminatory barriers. Health, home, purpose and community will be the pillars of person-centered, evidence-based, quality-driven systems that support recovery coaches, peer specialists, recovery academies, recovery centers and Recovery Oriented Systems of Care (ROSCs).

SAMHSA defines a ROSC as a *“coordinated network of community-based services & supports that is person-centered and builds on the strengths and resiliencies of individuals, families, and communities to achieve abstinence and improved health, wellness, and quality of life for those with or at risk of alcohol and drug problems.”* The central focus of a ROSC is to build an infrastructure or “system of care” with the resources to effectively address the full range of substance abuse problems within communities. The Mission of a ROSC is improvement of health, wellness and recovery for individuals and families, who are at risk of substance abuse problems, to promote safe, healthy communities. The goal of a ROSC is to improve outcomes by improving access to care, quality of care and effectiveness of care. Core functions of a ROSC include: education and community awareness, dissemination of information, advocacy, policy and practice changes, provision of a continuum of care that is coordinated and managed for ongoing quality improvement and a public health model approach.

OASAS has addressed recovery support services and the building of a ROSC by the creation of three Recovery Community Centers, the receipt of a four-year Access-to-Recovery Grant from SAMSHA, and the implementation of NY Service Opportunities for Accessing Recovery successfully (SOARS). OASAS also believes that safe and affordable housing and vocational services are essential components of a ROSC. Permanent supportive housing units have been established across the state, and in 2011, the OASAS housing portfolio for people in recovery expanded from 1,365 to 1,460 units.

### **Recovery Coaching:**

OASAS is encouraging the development of Peer Recovery Coaches to provide support and guidance to individuals in recovery. More than 632 individuals have completed the

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five-day Recovery Coach training that is offered free of charge by OASAS. This intensive five-day training is provided over two consecutive weeks and covers the Connecticut Center for Addiction Recovery (CCAR) model for peer specialist roles and responsibilities. It is designed to promote understanding of recovery from addiction and develop supports in partnership with people in recovery. Graduates receive a Recovery Coach certificate and a standardized OASAS certificate of completion that may be used to meet credentialing requirements for the CASAC, CPP and CPS.

These newly-trained individuals help to initiate and sustain an individual/family in their recovery from substance abuse or addiction; promote recovery by removing barriers and obstacles to recovery; and serve as a personal guide and mentor for people seeking, or already in, recovery. Recovery Coaching is a peer-based service that is non-clinical and designed to engage individuals beyond recovery initiation through stabilization and into recovery maintenance. Similar peer interventions in clinical settings have been shown to improve engagement and retention of people seeking services. It is also known that long-term treatment outcomes are improved by assertive linkages to community-based recovery supports such as Recovery Coaching.

OASAS recognizes that New York State's Medicaid redesign initiative and healthcare reform will create new workforce demands, including the need for more recovery coaches. Through 2012, over 90 Peer Recovery Coaches were certified to provide Peer Recovery Coach training. A NY Certification Board was needed to oversee the continued growth of recovery coaches and trainers and to set standards for certification. OASAS is collaborating with the statewide provider association, the Alcoholism and Substance Abuse Providers of NYS (ASAP) to create a New York Certification Board (NYCB) and launch a Certified Addiction Recovery Coach credential within the next year. The NYCB mission, to strengthen health and human services outcomes by enhancing the recovery-oriented skills and capacity of the workforce, will be achieved through the provision of high-quality credentialing, testing, technical assistance and training/education services.

### **Perception of Care Survey:**

OASAS developed a web-based substance abuse perception of care (POC) system in 2012 for utilization by all treatment and recovery organizations. The system provides the infrastructure for both treatment and recovery program participants to be heard and demonstrates that program administrators care to listen and act upon their participants' feedback. Each organization may survey their participants quarterly to obtain their direct feedback on services in the following domains: access and quality; social connectedness; perceived outcomes; commitment to change; and program recommendation. In addition, the survey provides space for participants to respond to three qualitative questions to help identify what the program is doing well; improvement recommendations; and aspects of the program that may annoy the participant.

The POC system provides immediate graphical indicator reports to the providers that may be filtered by several different demographics as well as length of stay within the program, presenting problem and criminal justice involvement. The goal is to assist all treatment and recovery organizations to understand their customer and to act upon their participant data in a planned, structured method as part of their quality improvement and program evaluation processes. The system provides guidance in the conduct of plan-

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do-study-act cycles and technical assistance is available to programs upon request. Programs are encouraged to provide feedback reports to their participants to foster continuous quality improvement.

The POC system also includes the capacity for programs to compare their participant data from one quarter or year with another quarter or year. The programs can easily identify if they are moving or trending in the right direction after they have implemented programmatic modifications in direct response to their participant's feedback. OASAS and all LGUs will have the capacity to monitor utilization of the system by all treatment and recovery organizations, by service type, and access to actual program data. The POC system is located on the Applications page of the OASAS website, and accessible to all providers with an existing OASAS Applications account. Individuals that do not already have an OASAS Applications account must submit a completed [IRM-15](#) form to OASAS.

### ***Integrated Licensure Project***

New Yorkers with serious mental illness and substance use disorders frequently suffer from chronic illnesses such as hypertension, diabetes, obesity, and cardiovascular disease. While many individuals receive behavioral health services in one setting, they typically receive primary health care in a different setting or not at all. This disconnected care presents serious obstacles to individuals who must navigate multiple and complex health care systems that often results in avoidable and costly emergency department visits and hospitalizations.

As authorized in the 2012-13 New York State Budget, OASAS, OMH and DOH are collaborating on an Integrated Licensing Project aimed at reducing preventable hospital utilization among people with mental illness and substance use disorders and improving their overall health status and quality of life. This will be achieved by co-locating and integrating behavioral health care with primary health care. The approval and oversight process for clinics interested in providing services from more than one agency at a single location will be streamlined which should improve the quality and coordination of care provided to people with multiple needs.

### ***Supporting Tobacco-free Treatment***

OASAS continues to monitor regulation 856, requiring all OASAS certified and funded programs to implement a tobacco-free policy and address tobacco as part of a client's treatment plan. Addressing tobacco with clients continues to be a valuable benefit and enhances health and recovery. Data is collected at treatment admission and discharge to capture the tobacco free status of clients. The number of individuals who enter their next level of service as tobacco free is growing and attributable to the program leadership, commitment and dedicated staff who work with the client and support their efforts to live a tobacco-free lifestyle.

Since implementation in 2008, this regulation has become a standard of practice and the OASAS Office of Medical Direction, Health and Wellness continues to offer guidance and support to providers. There are a variety of trainings and other resources available to providers on the [OASAS Tobacco Independence Webpage](#), and several of the [trainings](#) offer free credentialing credit.

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### **C. Planning for Mental Health Services**

Currently, planning for mental health services can seem challenging, and even daunting, given the ever-changing landscape of our many inter-connected service systems. In light of the significant federal, state and local changes in policies, laws and regulations, many of which were mentioned previously, it can be like trying to hit a moving target. However, with all these changes underway, the prospect for substantial improvements to the mental health system, the promise of recovery, and the possibility for full and meaningful participation in ones' community have never been greater for New Yorkers.

In the context of these changes, we have the opportunity for enhancing our capacity for integrated care, increased communication amongst service providers, a greater focus on recovery-oriented services, and better accountability for quality of care. It is these opportunities that guide the future of the mental health system and our planning efforts.

#### ***Integrated Behavioral Health and Physical Health Care***

As was outlined earlier in this chapter, NYS is engaged in the creation of Behavioral Health Organizations (BHOs) and Health Homes to improve care coordination and management for the Medicaid population. Under these two large scale efforts, NYS has the opportunity to move towards enhanced multi-system collaboration and communication to improve health outcomes.

In alignment with these systemic changes, the Office of Mental Health (OMH) has committed to a variety of efforts to support improvements in behavioral health services and coordination with physical health providers. Such efforts include the Integrated Licensure Project, highlighted earlier by OASAS, as well as the following:

**New York State Clinical Records Initiative (NYSCRI):** The [New York State Clinical Records Initiative \(NYSCRI\)](#) offers licensed OMH and OASAS community-based treatment providers an opportunity to standardize and streamline their clinical records. NYSCRI offers providers a standardized [set of clinical case record forms](#) designed to enhance compliance with state, federal, and accreditation requirements.

**Collaborative Care:** To improve outcomes, OMH and DOH are engaged in an initiative to implement the *Collaborative Care* approach to addressing common mental health conditions in primary care settings. The *Collaborative Care* approach incorporates a standardized measurement of depression to detect and track the progress of depressed patients; this monitoring allows primary care doctors to change or intensify treatment if clinical improvements are not achieved as expected.

**Co-Location of Clinics in Primary Care:** OMH has made funds available to promote the establishment of licensed children's satellite mental health clinics co-located within a pediatric or family practice primary care setting as part of a larger vision to identify children with social and emotional problems earlier, and to increase access to mental health services for those children and their families who are in need.

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### ***Early Identification and Intervention Strategies***

OMH is focused on supporting increased efforts to identify and provide appropriate treatment for mental health conditions before they become more challenging, more disabling for individuals, and more expensive to treat. Initiatives focused on early identification and intervention include collaborative efforts with the Department of Health (DOH) on the DOH Prevention Agenda mentioned earlier, as well as:

**First Episode Psychosis:** OMH is seeking to improve early identification and treatment for individuals with psychotic disorders such as schizophrenia through an approach currently referred to as *First Episode Psychosis* (FEP). The ultimate goal of the FEP initiative is to minimize disability so often associated with schizophrenia and to maximize recovery.

**Suicide Prevention:** As part of its larger Suicide Prevention Initiative, which focuses on preventing suicide across the life span and across all communities, New York State has developed and is implementing a plan to effectively manage suicide risk, eliminate suicide deaths and reduce suicide attempts by people receiving behavioral health care. OMH's plan is informed by the work of the National Action Alliance for Suicide Prevention which highlights the point that a systemic approach can comprehensively address suicide risk.

**Early Recognition Coordination and Screening Project:** This project funds full time early recognition specialists in children's natural settings, such as schools, day cares or pediatrician offices, helps to identify children and youth with social and behavioral challenges early and establish the necessary linkages to further assessment and treatment services.

### ***Promotion of Recovery and Resilience in Community Services***

An integral component of effective treatment is a recovery-oriented approach to care that supports individuals' capacity to live at home and in their communities with all the needed services and supports. OMH continues to make significant efforts to provide individuals with mental illness the opportunity to participate as complete members of our communities and society as a whole. Efforts underway include:

**New York Employment Services System:** OMH has lead the efforts designed to support competitive employment opportunities and outcomes for people with disabilities through a comprehensive job matching/employment supports coordination and data system – the [New York Employment Services System \(NYESS\)](#). NYESS will serve as a single point of access for all New Yorkers seeking employment and employment supports, regardless of an individual's abilities/disabilities and regardless of the state agency system from which they receive employment services/supports.

**Family Peer and Youth Support Services:** OMH funds and supports a variety of peer-run and peer-oriented services and programs, including peer specialists, family and parent advisors, and youth peer advocates, to help individuals on their journey towards recovery and family members who struggle to access supports and services for children and youth with social and behavioral challenges.

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**Recovery Centers:** Recovery Centers build on the existing best practices already established in self-help/peer support/mutual support. Utilizing specific staff competencies, Recovery Centers are designed to both model and facilitate recovery. Over the past year and a half, more than 15 Recovery Centers have become operational though support from OMH, with additional Recovery Centers becoming operational into the future.

### ***Accountability and Ensuring High Quality of Care***

OMH maintains a strong emphasis on continuous quality improvement effort, whether that be from a clinical perspective or from a systems perspective - through the use of data and information to measure outcomes or support for evidence-based treatment approaches.

**OMH Data Portals:** The [OMH data portals](#) are designed to improve accountability and transparency in New York State government by allowing anyone to use OMH data to make more informed choices about services that best meet their needs and to assess the progress the agency is making toward improving public mental health care.

**Electronic Medical Record:** Consistent with the direction of the Affordable Care Act and numerous initiatives at the state level to develop such capacity, OMH is currently in the process of developing an EMR that will serve as the source for all clinical information concerning all individuals receiving services and supports from OMH-operated facilities and programs.

**Center for Practice Innovations:** Stemming from OMH's research efforts and the affiliation between OMH's New York State Psychiatric Institute and Columbia University, the [Center for Practice Innovations](#) (CPI) assists OMH in promoting the widespread availability of evidence-based practices to improve mental health services, ensure accountability, and promote recovery-oriented outcomes.

More information on any of the initiatives outlined above can be found in our [Statewide Comprehensive Plan 2011-2015](#).

### **D. Planning for Developmental Disability Services**

While Mental Hygiene Law requires the LGU to develop goals and objectives that are consistent with the statewide mission, vision, goals and objectives, each LGU must determine its priorities and strategies based on its own assessment of local problems and needs. OPWDD's mission is to help people with developmental disabilities live richer lives. OPWDD's vision is for people with developmental disabilities to 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 participates in their communities.

More specifically, OPWDD is committed to achieving five basic outcomes for people with developmental disabilities:

- **Person First.** Individuals with developmental disabilities have plans, supports, and services that are person-centered and as self-directed as they choose.

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- **Home of Choice.** Individuals with developmental disabilities are living in the home of their choice.
- **Work and Meaningful Activities.** Individuals with developmental disabilities are able to work at paying jobs and/or participate in their communities through meaningful activities.
- **Relationships.** Individuals with developmental disabilities have meaningful relationships with friends, family, and others of their choice.
- **Health and Safety.** People with developmental disabilities experience good health and are safe in their home and community.

### ***System Transformation***

Creating lasting changes in culture requires an alignment of agency values and policies, as well as alignment of personal values held by employees throughout the system. To support the creation of the desired culture, OPWDD has undertaken, several initiatives including: health and safety reforms; the adoption of the National Alliance for Direct Support Professionals' Code of Ethics; establishing core competencies for DSPs and DSP supervisors; implementing a new system-wide standard for service provision called Positive Relationships Offer More Opportunities to Everyone (PROMOTE); shifting to a person-centered service delivery model under the People First Waiver; and an agency reorganization to create consistency in practice and maximize efficiency and support improved service delivery.

### ***People First Waiver and DISCOs***

The most significant step to transforming the service delivery system will be the People First Waiver. OPWDD continues to dialogue with the Center for Medicare and Medicaid Services (CMS) to define the system reforms embodied in the forthcoming People First Waiver agreements. Specifically, OPWDD is working to more clearly define systems reforms that will support:

- Advancements in employment for individuals with developmental disabilities;
- Creation of additional housing opportunities for individuals, particularly in non-certified settings;
- Expanded opportunities for self-direction of services and supports as individuals come through OPWDD's front door; and ensuring that people with developmental disabilities live the richest and most integrated lives possible by participating in the Governor's Olmstead plan which will move people out of institutions and into the least restrictive environments possible.

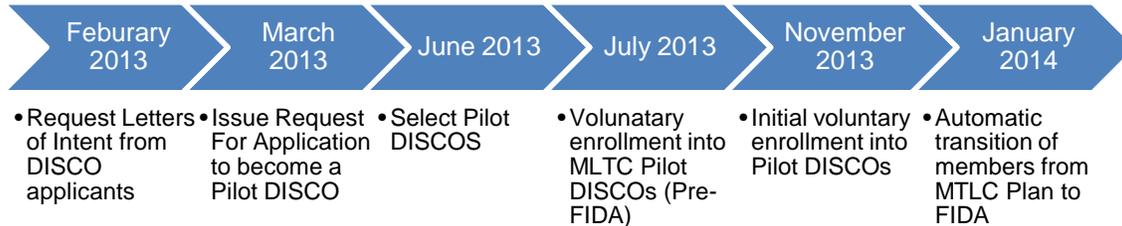
The People First Waiver is the vehicle by which OPWDD will transition to managed care. Over a two-year period, OPWDD, with the support and oversight of DOH, will pilot specialized managed care organizations. These new entities, charged with coordinating comprehensive supports and services under the People First Waiver, will be known as Developmental Disabilities Individual Supports and Care Coordination Organizations (DISCOs).

During the pilot period, slated to start in 2013, individuals will voluntarily opt to enroll in the pilot DISCO and DISCOs will be selected. DISCOs will be required to describe how they will: provide person-centered planning; promote living and active engagement in the

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most integrated setting; ensure that each individual who chooses to do so can self-direct his or her services, including the option for budget and employer authority; and promote paid employment for individuals. Figure 1 highlights key milestones in the People First Waiver timeline.

**Figure 1: People First Waiver Implementation Timeline**



Recognizing that the full transition to managed care will be accomplished in a few years, OPWDD is implementing additional system reforms that will improve access to individualized supports, crisis intervention services and training for the developmental disability workforce.

### ***Individualized and Community Supports (ICS)***

Individual and Community Supports (ICS) is a person-centered practice to developing plans of support for people which will allow consistent, streamlined, statewide access to individualized service options prior to full implementation of the People First Waiver. ICS is consistent with the direction and structure of the People First Waiver in that it is based on: person-centered practices; informed choice of supports and services; utilizes paid and natural community supports; has statewide consistency in funding and availability of individualized and self-directed service options; and facilitates quality oversight.

### ***Positive Relationships Offer More Opportunities to Everyone (PROMOTE)***

Positive Relationships Offer More Opportunities to Everyone (PROMOTE) is the OPWDD-approved staff training curriculum designed to support individuals with developmental disabilities and to assist staff in safely and effectively addressing potential behavioral challenges. PROMOTE is intended to reduce the likelihood of challenging behaviors by fostering positive relationships and environments.

### ***Crisis Prevention and Intervention through Systemic, Therapeutic, Assessment, Respite and Treatment (START) Services***

OPWDD is redesigning its system for providing community-based crisis prevention and intervention services to individuals with developmental disabilities and co-occurring behavioral health needs based on an evidence-based program called Systemic, Therapeutic, Assessment, Respite and Treatment (START) services. The goals of START services are to create an infrastructure that offers crisis response and prevention services and cross-systems linkages and care coordination between OPWDD and other state and voluntary provider agencies.

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### **CHAPTER III: County Plan Guidance and Forms**

The mental hygiene local services planning process is intended to be an ongoing, data driven process that engages providers, individuals with disabilities, and other stakeholders in identifying local needs and developing strategies to address those needs. As noted in Chapter I of these guidelines, NYS Mental Hygiene Law 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. The law also requires that each agency's statewide comprehensive plan be formulated from the LGU comprehensive plans. In addition to meeting statutory mandates, LGUs are required to comply with other requirements that support statewide planning efforts.

This chapter provides guidance to assist counties in meeting those requirements. All local services plans will be completed and submitted using electronic forms contained in the Online County Planning System (CPS). At the discretion of the LGU, additional support documentation may be attached to the online forms.

#### **A. Planning Activities Report Form**

The Planning Activities Report Form must be completed and certified in CPS. Part I of the form asks the LGU to report on any collaborative activity related to the Prevention Agenda 2013-2017 and any related priority outcomes and strategies included in this year's plan. Part II of the form asks the LGU to provide updated information on their Comprehensive Emergency Management Plan specific to OASAS providers.

#### **Part I: Collaboration on the Prevention Agenda 2013-2017**

In December 2012, the New York State Department of Health (DOH) distributed guidelines describing the essential elements of a local health department (LHD) Community Health Assessment and Community Health Improvement Plan, as well as the requirements for hospital Community Service Plans. These guidelines reflect the Prevention Agenda 2013-2017 which was developed in conjunction with the agency's new health improvement plan. LHDs and hospitals are being encouraged to collaborate with each other and additional community partners on the development of these documents. DOH believes that collaboration to develop a community health assessment and community health improvement plan will reduce duplication in a more efficient and effective manner.

In the previous Prevention Agenda 2013-2012, LHDs were asked to address at least two of ten priority areas in their plan, including *Promote Mental Health and Prevent Substance Abuse*. Thirteen LHDs developed plans to address this priority area. In the current Prevention Agenda, the list of priority areas to choose from was reduced to five, once again including *Promote Mental Health and Prevent Substance Abuse*. This is a strong indication of the importance of this topic as a public health priority and the need for response strategies to reflect a broad based and collaborative community effort.

DOH, OASAS and OMH staff, along with professionals from the field and other interested stakeholder organizations, including the Conference of Local Mental Hygiene Directors and two Directors of Community Services participated on a workgroup that

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developed specific guidance on this priority area for the LHDs and hospitals that included seven goals and seventeen objectives under three primary focus areas:

- Promote Mental, Emotional and Behavioral (MEB) Well-Being in Communities
- Prevent Substance Abuse and Other Mental Emotional Behavioral Disorders
- Strengthen Infrastructure Across Systems

The objectives outlined in the prevention agenda cover a broad array of issues that many LGUs are already addressing in their plan, and presumably in collaboration with other community partners. A sample of the issues covered include:

- Underage Drinking
- Non-medical Use of Pain Medications
- Suicide Prevention
- Adolescent Depression
- Tobacco Use
- Data Sharing
- Integration of Behavioral Health and Primary Care
- Implementation of Evidence-based Practices
- Cross-training Behavioral Health and Primary Care Professionals

OASAS and OMH each endorsed the Prevention Agenda 2013-2017 and strongly encourage LGUs to proactively reach out to their LHDs to collaborate on the Promote Mental Health and Prevent Substance Abuse priority. While this collaboration is not a requirement, LGUs are asked to report on any collaborative efforts with the LHD regarding this Prevention Agenda and to identify related priorities and strategies included in your plan. Additional information on the [Prevention Agenda 2013-2017](#), including the Community Planning Guidance that was distributed to all LHDs and a detailed report on the *Promote Mental Health and Prevent Substance Abuse* priority that includes all related goals and objectives can be found on the DOH website.

1. Describe the collaborative activities between the LGU and the local health department (LHD) related to the Prevention Agenda 2013-2017. Identify other stakeholder organizations that were also involved in these activities.

2. Identify the specific goals and objectives related to the Prevent Mental Health and Prevent Substance Abuse priority area that are being considered for inclusion in the LHD's Community Health Improvement Plan (e.g., suicide prevention, underage drinking, misuse of prescription drugs).

3. Identify any priority outcomes or strategies included in this year's local services plan that are directly related to the goals and objectives identified under the Promote Mental Health and Prevent Substance Abuse priority area of the Prevention Agenda 2013-2017.

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**Part II: LGU Emergency Management Planning**

**Section A: OASAS Emergency Management Assessment**

In the aftermath of Hurricane Sandy, the Office of Alcoholism and Substance Abuse Services (OASAS) is undertaking an exhaustive review of its certified and funded programs to identify best practices as they relate to emergency management practices in four areas: preparedness, mitigation, response, and recovery.

Dealing with disasters is an ongoing and complex undertaking. Through the implementation of effective preparedness and mitigation BEFORE a disaster or emergency occurs; timely and effective response DURING an actual occurrence; and provision of both short and long term recovery assistance AFTER the occurrence of a disaster, lives can be saved and property damage minimized.

This process is called the Comprehensive Emergency Management Plan. The purpose of the Comprehensive Emergency Management Plan for OASAS and its network of providers is to support the capacity of chemical dependence prevention and treatment programs to provide services to clients and the general public in the event of an emergency and its aftermath.

To aid in the identification of best practices, these guidelines include a survey to be completed by each OASAS prevention and treatment program that will help to:

- determine the extent to which OASAS-certified programs have participated in local disaster planning efforts and/or exercises;
- determine the extent to which OASAS-certified programs have developed a site-specific all hazard plan; and
- assess disaster training needs within the OASAS service system.

All questions regarding the following survey should be directed to Kevin Doherty, OASAS Emergency Manager, at 518-485-1983, or at [KevinDoherty@oasas.ny.gov](mailto:KevinDoherty@oasas.ny.gov).

1. Does your agency's Comprehensive Emergency Management Plan include all of the following: planning, mitigation, response, and recovery contingencies for OASAS providers that are located in your county?  
 a) Yes  
 b) No
  
2. Does your agency have an inventory of contact information (Name/address/phone/email) for OASAS certified or funded programs in your county on a site-by-site basis?  
 a) Yes  
 b) No

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3. How often does your agency meet with OASAS certified or funded programs in your County to discuss emergency management issues?
- a) Monthly
  - b) Quarterly
  - c) Annually
  - d) Other (specify):
  - e) Never
4. Has your agency developed hazard-specific evacuation routes and re-location sites for OASAS certified or funded programs in your county?
- a) Yes
  - b) No

**Section B: OMH Disaster Mental Health Planning Assessment**

The severe weather events of the past several years have wrought considerable devastation over large portions of the state. These large scale disasters have provided ample opportunity to witness the state of readiness in attending to the emotional and mental health needs of the survivors of these traumatic events.

In an effort to gain insight into the state of resources and preparedness across the state OMH is seeking your assistance in providing some basic information on several elements of Disaster Mental Health planning and response.

All questions regarding the following survey should be directed to Steven Moskowitz, OMH Coordinator of Emergency Preparedness and Response at 518-408-2967, or at [steven.moskowitz@omh.ny.gov](mailto:steven.moskowitz@omh.ny.gov).

1. Is your mental health agency/department engaged in planning with your county Emergency Management Agency?
- a) Yes
  - b) No
2. Does your county Comprehensive Emergency Management Plan (CEPM) include a section or annex that speaks directly to mental health concerns of survivors in an emergency?
- a) Yes
  - b) No
3. Are you familiar with the OMH County Disaster Mental Health Planning and Response Guide? (NOTE: The guide is currently being updated and will be available by April 1, 2013. Copies may be requested by contacting the EPR office at the email listed above.)
- a) Yes
  - b) No

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4. Does your county sponsor or support a designated team of responders that are called upon for assistance to the public following a traumatic/disaster event?
- a) Yes  
 b) No (skip to #6)
5. Please indicate the type(s) of DMH team utilized. (check all that apply)
- a) Red Cross DMH team  
 b) OMH curriculum-based DMH team  
 a) CISM Team  
 b) Other (please identify):
6. If there is an OMH psychiatric facility located in your county, are you actively engaged in reviewing and/or drilling emergency planning with that facility?
- a) Yes  
 b) No

**B. Mental Hygiene Priority Outcomes Form**

The Mental Hygiene Priority Outcomes Form was introduced in 2008 as the first fully integrated county planning form. Its purpose is to facilitate a more person-centered planning process that focuses on cross-system collaboration. The form was designed to provide counties with a process for developing priorities in a consistent manner across the three mental hygiene disabilities. It was intended to improve the ability of counties to conduct local planning and develop priorities consistent with state goals and priorities.

Based on feedback from county planners and the work of the Mental Hygiene Planning Committee, this form underwent its first significant modification last year. The form was streamlined to make it more relevant and easier to complete and provided clearer guidance on developing meaningful and realistic priorities, strategies, and performance metrics for measuring progress. Further, the state mental hygiene agencies were looking for priorities that would better inform their respective comprehensive statewide planning efforts.

***Instructions for completing the Priority Outcomes Form***

The Priority Outcomes Form is designed to allow counties to identify forward looking, change-oriented priorities that respond to local needs and are consistent with the goals of the state mental hygiene agencies. County priorities also inform the statewide comprehensive planning efforts of the three state agencies and help to shape policy, programming and funding decisions. For county priorities to be most effective, they need to be clear, focused, and achievable. The following instructions will help counties develop effective priority outcomes statements and associated strategies and metrics.

**Priority Outcome Statement**

The priority outcome statement should be a clear and succinct statement of a desired outcome. It should be focused on a change that is tangible, achievable and within the control of the LGU. It should not be a broad philosophical statement about how things

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should be, nor should it be a statement about ongoing activity that simply maintains the status quo. The following are examples of possible priority outcome statements:

Example #1: Expand access to safe and affordable housing.

Example #2: Enhance the quality of residential treatment services provided to persons served by county's mental hygiene service system.

*Tip: Write a priority statement for a relatively clear and focused outcome rather than an outcome that covers a broad range of issues. For example, do not say "Expand all prevention and treatment services for the general population." It would be more useful to the state agencies to see a priority statement like "Expand residential treatment services to women."*

### **Rationale**

The rationale should be a brief (one to two paragraphs) explanation of the basis for including the priority outcome in the plan. It answers the question "Why is the desired change necessary?" Note: There will be a 200-word limit built into the form for this item. If additional documentation is necessary, it may be attached to this form.

### **Applicable State Agency**

Indicate the state mental hygiene agency to which this priority outcome pertains. If this outcome pertains to more than one agency, check all that apply.

- OASAS
- OMH
- OPWDD

### **A Top Priority**

After all priority outcomes and related strategies have been entered onto the form and you are ready to certify the form for submission, you will need to indicate the top three priorities in your plan. Unlike previous years, you no longer have to identify top priorities for each disability. You only need to identify your top three priorities overall. You will not be able to certify this form until you have indicated the top priorities.

### **Strategy Description**

The strategy description should identify the approach to be taken to help achieve the desired outcome. It answers the question "How will the outcome be achieved?" There is no limit on the number of strategies associated with a priority outcome. The following are examples of strategies associated with the earlier examples of acceptable priority outcome statements:

Example #1: Increase the number of transitional supportive housing beds for individuals leaving treatment.

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Example #2: Increase the number of clinical staff who have been trained in integrated treatment for co-occurring disorders.

*Tip: While a priority outcome statement may be applicable to multiple state agencies, strategies typically (though not always) are applicable to a specific agency. If the strategies for achieving a common priority outcome are different, they should be identified under separate strategies. For example, while safe and affordable housing may be a common outcome for your DD and CD populations, the strategies may be quite different and should be presented separately.*

### **Metric**

A metric is a **meaningful**, **measurable**, and **manageable** target that will demonstrate progress on the associated strategy. It answers the question “How will we know if we are successful?” The best guide to writing realistic and effective metrics is to be sure that it meets the following criteria:

- **Meaningful** – You want to measure something that is directly related to the strategy and, ultimately, achieves the desired outcome. A metric must be important enough to devote resources necessary for collecting and analyzing data and communicating results. It could include such things as people served, staff trained, capacity added, etc.
- **Measurable** – The metric must be quantifiable, typically expressed in terms of an increase or decrease in number or percentage over a specific timeframe.
- **Manageable** – The desired change resulting from the strategy should be within the control of the LGU. It does not mean that the actions of the LGU are solely responsible for accomplishing the strategy, as success may be dependent on collaboration with other partners. For example, do not include strategies that depend solely on state agency actions (e.g., regulatory, funding, or process changes at the state level), but include strategies involving local task forces, workgroups, etc. on which the LGU is a partner.

Metrics are developed primarily as a management tool for the county to monitor the progress of its ongoing planning and system management activities. If the metrics are realistic and well written, they will be a good measure of progress and a good indicator of the possible need to modify the related strategies going forward. The following are examples of metrics associated with the earlier examples of strategies:

Example #1: Add 20 new supportive living beds in the county over the next two years.

Example #2: Increase the number of CD and MH clinical staff trained through the online Focus on Integrated Treatment (FIT) modules by 10 percent (from X to Y) by the end of 2014.

### **C. OASAS Outcomes Management Survey**

Since 2007, OASAS has been committed to using and promoting outcomes management (also referred to as performance management) as a tool to improve client level outcomes and communicate results. Since 2009, the counties and OASAS

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providers have been surveyed on outcomes management so that we could monitor progress in the utilization of outcomes management practices in the field and better understand and assist in those efforts.

The use of outcomes management is becoming increasingly important as behavioral health care is integrated into the larger health care system where performance measures are utilized to assess treatment outcomes and, in turn, provider performance. In using outcomes management as a tool to improve client level outcomes and overall program performance, programs are able to communicate their strengths in a language shared by other providers within the healthcare system. OASAS encourages providers' use of outcomes management to both improve individual, patient level outcomes, as well as overall program and system level outcomes that are relevant in the larger arena of healthcare.

We are administering this annual survey to continue to encourage and measure the use of outcomes management within the field of substance abuse treatment. The following are all the questions included in the Outcomes Management Survey to be completed by LGUs in CPS. All questions regarding this survey should be directed to Constance Burke at 518-485-0501 or at [constanceburke@oasas.ny.gov](mailto:constanceburke@oasas.ny.gov).

1. Does your county agency have an active [outcomes management](#) program in place?  
 a) Yes  
 b) No (skip 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 (skip to END)
  
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 (skip to #6)  
 b) IPMES (skip to #6)  
 c) Other Data Source (please specify):  (answer #5a)  
 d) None (skip to #6)

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- 5a. Does your county agency collect, maintain and analyze data using an electronic database system?
- a) Yes (answer #5b)
- b) No (skip to #6)
- 5b. What system does your county agency use to maintain and analyze this data?
- a) Celerity
- b) Foothold
- c) Self Developed (specify software used: e.g., Microsoft Access, Excel, SPSS):
- d) Other (please specify):
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

**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.

**D. 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

## **2014 Local Services Plan Guidelines For Mental Hygiene Services**

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 Service 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 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.

**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.

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**E. 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. If no changes will be made to an existing agreement, the county should simply recertify the form in CPS.

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

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:

- A. 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;
- B. 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;

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- C. 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;
- D. 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
- E. 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.

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**F. 2014 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 2014 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 2014 local services planning process.***

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**G. 2014 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:

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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:

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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:

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**H. 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: \_\_\_\_\_

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*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.*

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**I. Community Services Board Roster (Counties Outside NYS)**

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: \_\_\_\_\_

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*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.*

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**J. 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.***

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**K. 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.***

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**L. 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.***

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**M. 2014 DDRO Plan Approval**

**LGU: \_\_\_\_\_**

On behalf of the Commissioner of the New York State Office for People With Developmental Disabilities, I, as Director of the Developmental Disabilities Regional Office (DDRO), assure and certify that the development and content of the Local Services 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.

DDRO 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 Developmental Disabilities Regional Office (DDRO), assure and certify that the development and content of the Local Services 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.

DDRO Director Name: \_\_\_\_\_ Date: \_\_\_\_\_

Exceptions:

Parts of Plan applicable to OPWDD Not Approved:

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## **2014 Local Services Plan Guidelines For Mental Hygiene Services**

### **CHAPTER IV: OASAS Provider Plan Guidance and Forms**

The local services planning process for addiction services relies on the partnership between OASAS, the local governmental unit (LGU), and OASAS funded and certified providers. The involvement of providers and other stakeholders in the local planning process is necessary to ensure that community needs are adequately identified, prioritized, and addressed in the most effective and efficient way.

Providers are expected to participate in the local services planning process and to comply with these plan guidelines. Each provider must have at least one person with access to the OASAS online County Planning System (CPS) in order to complete the required planning forms that help to support various OASAS initiatives. Please refer to Chapter I of these guidelines for additional information about CPS and the appropriate user roles for provider staff.

This year, providers are once again being asked to complete a small number of planning surveys that provide OASAS with important information in support of a variety of programming, planning and administrative projects. Some surveys are repeated in order to show changes over time, while other surveys are new. In every case, the information being requested is information not otherwise collected through existing data reporting systems. Some surveys are to be completed at the provider level on behalf of the entire agency, while other surveys are to be completed at the program level. In all cases, the provider should make sure that the surveys are completed by staff who are in a position to provide accurate and reliable information, or who can coordinate with appropriate staff within the agency to obtain the information.

All provider surveys must be completed in CPS no later than **Monday, April 1, 2013**. Each survey includes the name and contact information of the OASAS staff person responsible for that survey and who can answer any questions you might have about the survey. Each survey in CPS also contains a link back to the relevant section of the plan guidelines associated with that survey.

Each of the following surveys includes a brief description of its purpose and the intended use of the data collected. All questions included in the survey (including skip patterns and follow-up questions built into the CPS version) and definitions of certain terms used in the survey are shown.

#### **A. Health Coordination Survey (Treatment Providers)**

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)

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- Non-Medically Supervised Chemical Dependence Outpatient Services (Part 821)
- Chemical Dependence Outpatient and Opioid Treatment Programs (Part 822)

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.ny.gov/regs/>

The **Health Coordination Survey** 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.

All questions on this form should be answered as they pertain to each program operated by this agency. The responses to this survey should be coordinated to ensure accuracy of responses across all programs within the agency. Any questions related to this survey should be directed to Nora Yates by phone at 518-485-1224, or at [NoraYates@oasas.ny.gov](mailto:NoraYates@oasas.ny.gov).

1. What is the overall average fringe benefit rate paid to employees by this agency? This number must be entered in number format as a percentage of salary, without the percent sign (example: 25.0).
2. How are **health coordination** services provided to patients in each program operated by your agency? (check all that apply)

Program	Paid Staff	Contracted Services	In-kind Services
a) PRU #1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) PRU #2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) PRU #3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. Please provide the following information for each PRU where those staff services are provided. If multiple paid staff provide these services at a single program, provide the total hours worked and the total annual salary and fringe benefits for each individual. For salary, use number format without a dollar sign comma (example: 45000).

Program	Health Coordinator #1				Health Coordinator #2			
	Services Provided		Hours per Week	Annual Salary	Services Provided		Hours per Week	Annual Salary
	On-site	Off-site	Worked as a Health Coordinator	(in dollars)	On-site	Off-site	Worked as a Health Coordinator	(in dollars)
a) PRU #1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
b) PRU #2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>

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4. Please provide the following information for each PRU where those contracted services are provided. If multiple contracted individuals provide these services at a single program, provide the total hours worked per week and the total dollars paid per year. For dollars paid, use number format without a dollar sign comma (example: 45000).

Program	Service Provided		Hours per Week	Dollars
	On-site	Off-site	Worked as a Health Coordinator	Paid Per Year
a) PRU #1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
b) PRU #2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>

**B. Outcomes Management Survey (All Providers)**

The use of outcomes management is becoming increasingly important as behavioral health care is integrated into the larger health care system where performance measures are utilized to assess treatment outcomes and, in turn, provider performance. In using [outcomes management](#) (also referred to as performance management) as a tool to improve client level outcomes and overall program performance, organizations are able to communicate their strengths in a language shared by other organizations within the healthcare system.

OASAS encourages use of outcomes management to both improve individual, patient level outcomes, as well as overall program and system level outcomes that are relevant in the larger arena of healthcare. This annual survey is being administered to continue to encourage and measure the use of outcomes management within the field of substance abuse treatment. All questions regarding this survey should be directed to Constance Burke at 518-485-0501 or at [ConstanceBurke@oasas.ny.gov](mailto:ConstanceBurke@oasas.ny.gov).

- Does this agency have an active outcomes management program in place?
  - a) Yes
  - b) No (skip to #3)
- 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
- Does this agency set outcomes/[performance targets](#) based on client and/or program level data?
  - a) Yes
  - b) No (skip to END)
- 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

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5. Which of the following data sources does this agency use to track progress toward performance targets? (check all that apply)
- a) Scorecard (skip to #6)
  - b) IPMES (skip to #6)
  - c) STAR-QI (skip to #6)
  - d) Focus Groups (answer #5a)
  - e) Client Surveys (answer #5a)
  - f) Other Data Source (please specify):  (answer #5a)
  - g) None (skip to #6)
- 5a. Is this data collected, maintained and analyzed using an electronic database system?
- a) Yes (answer #5b)
  - b) No (skip to #6)
- 5b. What system does this agency use to maintain and analyze this data?
- a) Celerity
  - b) Foothold
  - c) Self Developed (specify software used; e.g., Microsoft Access, Excel, SPSS):
  - 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

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### **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.

### **C. Clinical Supervision Survey (Treatment Programs)**

The goal of clinical supervision is to continuously improve client care and support ongoing staff development. The implementation of a strong clinical supervision program aids in enhanced staff understanding of clinical situations, prevention of escalating clinical crises, and better assessment, case conceptualization, treatment strategies and discharge planning. It also provides a vehicle by which directives are followed and helps facilitate the implementation of evidence-based practices.

Since May of 2012, OASAS has been in the process of developing a “Community of Learning” for its constituency of clinical supervisors with the intention that this initiative will result in a coalition and support system which allows participants to share information and resources. It will also enable OASAS to hear and respond to areas of concern, interest and ongoing assessment, collect data through ongoing surveys, and establish clinical supervision as a fundamental and foundational element of “best practice.” Clinical supervisors will be contacted in the near future with more information on how they can become involved in the important development of this new community and how OASAS can offer technical assistance and support for this endeavor.

To ensure that the agency has the most up-to-date information, all treatment programs are being asked to complete the following brief survey and provide the contact information for each clinical supervisor in the program. In addition to developing learning communities, this information will facilitate communication on training opportunities, topics and resources relevant to clinicians, and clinical guidance issued by OASAS so that clinical supervisors can better perform their essential role in assuring quality treatment to clients.

The following are all the questions included in the Clinical Supervision Survey to be completed by all treatment programs in CPS. All questions related to this survey should be directed to Pat Lincourt at 518-457-1011, or at [PatLincourt@oasas.ny.gov](mailto:PatLincourt@oasas.ny.gov).

For each clinical supervisor employed by this program, please enter his/her name and email address. If this person serves as the program’s clinical lead staff for women’s or adolescent services, indicate so by checking the appropriate box to the right.

		<u>This Person is Clinical Lead for</u>	
Name	Email Address	Women's Services	Adolescent Services
+ <input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>

+ Note: If you need to enter contact information for additional clinical supervisors, click on the + sign next to the first supervisor’s name and a new row will open for you to enter the additional information. Continue to click on the + sign to open up additional rows, if necessary.

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### **D. Recovery Oriented System of Care (ROSC) Survey (Treatment Programs)**

Recovery is a process of change in which an individual, family member, or family moves from impairment to an enduring and holistic focus on self awareness, understanding of others, and an improved quality of life. SAMHSA defines a Recovery-Oriented Systems of Care (ROSC) as a *“coordinated network of community-based services and supports that is person-centered and builds on the strengths and resilience of individuals, families, and communities to achieve abstinence and improved health, wellness, and quality of life for those with or at risk of alcohol and drug problems.”*

OASAS is developing a ROSC that recognizes and integrates the emerging consensus that substance use disorder is a chronic condition and that individuals can recover but may need long-term supports. Some of the strategies that OASAS employs to support recovery from addiction include the development of Recovery Community Centers (RCCs); recovery coach training; supportive housing; and the development of a web-based perception of care system to help both treatment and recovery providers assess if they are meeting their client’s and/or participants’ needs and expectations.

The RCC is a place where people can participate in supportive services to meet their needs. Services at the RCC may include a range of emotional, informational, and social supports for individuals and their families<sup>2</sup>. OASAS supports three RCCs in Rochester, Delaware and Otsego counties, and Brooklyn.

OASAS administers a four-year \$13 million federally funded *Access to Recovery (ATR) grant* in three locations: Brooklyn, Rochester and Delaware/Otsego counties. A combination of 75 recovery care management and recovery support services providers achieved the grant’s enrollment target of 2,995 for its second year of implementation and is on track to achieve its Year Three enrollment target of 3,561. Since its inception, OASAS has engaged over 4,287 ATR participants and provided recovery support services as per individualized participant recovery plans.

OASAS believes that safe, affordable housing and employment, in combination with a personal recovery plan, are essential for successful long-term recovery. Individuals and families who are homeless, or at high risk of becoming homeless, are the priority target population for Permanent Supportive Housing (PSH) services. These services include rental subsidies up to United States Department of Housing and Urban Development (HUD) Fair Market Rental (FMR) rates, case management services, job development and employment support services, and clinical supervision.

OASAS is also exploring ways to support a provider’s capacity to measure its effectiveness in moving towards integrating recovery principles policies and practices into their services.

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<sup>2</sup> For additional information about family supports, see [Strengthening Families Program \(SFP\)](#), a 14-session, science-based parenting skills, children's life skills, and family life skills training program specifically designed for high-risk families, or [Celebrating Families](#), a National Association for Children of Alcoholics (NACoA) evidence based cognitive behavioral, support group model written for families in which there is a high risk for domestic violence, child abuse, or neglect as a result of a parent’s problem with alcohol or other drugs.

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The purpose of this survey is for OASAS to assess the readiness of the treatment provider system to participate in the transformation to a Recovery Oriented System of Care and to identify for OASAS the supports that are needed to achieve that transformation. OASAS is reviewing potential ROSC indicators, drawn from the Client Data System and responses to this survey, as a means for assessing the extent to which an individual program is moving towards becoming a recovery-oriented system of care and what supports they need. Potentially, this will help the entire OASAS system move towards a more Recovery Oriented System of Care. All questions related to this survey should be directed to Marialice Ryan at 518-485-0506 or at [MarialiceRyan@oasas.ny.gov](mailto:MarialiceRyan@oasas.ny.gov).

1. Is this program a member of a local, county, or Regional ROSC Task Force or workgroup?  
 a) Yes  
 b) No
  
2. Which of the following ROSC components does this program currently have in place (check all that apply):  
 a) Policy and procedures to address recovery services  
 b) Recovery services that are integrated into your program's written mission, vision and purpose statements  
 c) A Board of Directors that includes representation from members of the recovering community  
 d) Written [Recovery Plans](#) are developed with the individual in addition to individualized treatment plans  
 e) Staff trained on [recovery support services](#)  
 f) Staff trained on [Peer Recovery Coaching](#)  
 g) Staff trained on the [evidence-based practice 12-step facilitation skills](#)  
 h) The hosting or implementation of mutual aid/self-help meetings on-site  
 i) Actively linking participants with community recovery linkages such as; [recovery coaches](#), peer specialists, and recovery support services  
 j) Linking participants with transportation services contacts  
 k) Linking participants with housing services contacts  
 l) Program has developed a provider service agreement or MOU with a Recovery Community Center  
 m) Program has an active alumni association that regularly convenes  
 n) Program has integrated a particular focus on recovery services within its annual Quality Improvement Plan  
 o) Program conducts [Telephone Recovery Support](#)  
 p) Program provides treatment and recovery services with participant's [family](#) members  
 q) The Program routinely conducts follow-up with participants that have completed the program to assess recovery needs; status in recovery
  
3. Has this program implemented and sustained a standardized tool to assess your participant's quality of life?  
 a) Yes  
 b) No (skip to #7)
  
4. Which quality of life assessment tool does this program use?

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5. Do all participants in this program receive a quality of life assessment?  
 a) Yes  
 b) No (skip to #7)
6. When is the [quality of life assessment tool](#) is administered? (check all that apply)  
 a) At assessment/intake  
 b) After 3 months  
 c) After 6 months  
 d) During discharge  
 e) During post-treatment follow-up
7. Has this program implemented and sustained a process to routinely obtain participant feedback on program services?  
 a) Yes  
 b) No (skip to #12)
8. What tool and/or process does this program utilize? (check all that apply)  
 a) Perception of care survey  
 b) Client satisfaction survey  
 c) Participant focus groups  
 d) Other (specify):
9. Does this program provide participants with a summary of their feedback?  
 a) Yes  
 b) No
10. Does this program have a process to act upon participant feedback?  
 a) Yes  
 b) No
11. Does this program include current participants and/or alumni or persons in recovery within the program's change team or quality improvement team to act upon participant feedback?  
 a) Yes  
 b) No
12. Is this program interested in having an assessment conducted of its integration of recovery policies and practices, capacity, or readiness?  
 a) Yes  
 b) No
13. What support would this program need from OASAS to move more toward integration of recovery policies and practices?

**Terms Defined for this Survey**

**Recovery Plan** is developed, implemented, evaluated and revised by the client (not the treatment professional). This plan is based on a partnership between professional and a recovering individual. It has a broad scope, encompassing such domains as physical health, education, employment, finances, legal, family, social life, intimate relationships and spirituality. Additionally, this plan speaks to the resolution of AOD problems, includes long-term recovery goals and

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smaller action steps that denote progress toward those goals. The plan draws upon the strength and strategies from the collective experience of others in recovery.

**Recovery Support Services** - Persons in recovery have identified several primary issues need to be addressed during recovery, including: family/parenting issues, health, education, employment, and housing.

**Peer Recovery Coaching** assists and guides people across a span of religious, spiritual and secular frameworks with a self-directed plan for engagement and recovery initiation, stabilization and recovery maintenance.

**Evidence-based practices 12-step facilitation skills** is a twelve-step facilitation therapy (TSF) is a manual-guided therapy based upon the 12-step model outlined in the Alcoholics Anonymous ‘Big Book.’ The intervention focuses on the patient’s acceptance of his/her alcohol use as a disease, using 12-step tools, and connecting with recovering persons in the fellowship. The manual-guided version was evaluated in comparison with MET and CBT in Project MATCH NIAAA Project MATCH Study and produced favorable outcomes on abstinence, treatment retention, and other life dimensions. More recently, it also has been shown to be effective with cocaine abusers who are concurrently alcoholic.

**Recovery Coach** is a trained staff or volunteer with recovery experience. The Recovery Coach helps remove personal and environmental obstacles to recovery and links the recovering person to the recovery community, acting as a personal guide and mentor in the management of personal and family recovery.

**Telephone Recovery Supports** are services provided by telephone after a person has completed treatment.

**Quality of Life Assessment Tool** refers to the use of an approved federal, national or state measurement tool that is comparable to the World Health Organization’s Quality of Life ([WHOQOL](#)) assessment tool or the [SF-36](#) tool or the OASAS Recovery Center’s [GPRA](#) tool.

### **E. Drug Use Trends Survey (Prevention and Treatment Programs)**

OASAS relies on several different strategies to assess community and statewide drug use problems, such as conducting large-scale population surveys and monitoring a variety of indirect indicator databases. The knowledge and perceptions of experts and key informants in the community have also proven to be a credible and valuable source of information. An important component of a comprehensive effort to monitor and characterize drug use trends is the observations of informed professionals working in chemical dependence prevention and treatment programs. This year, OASAS is reintroducing the Drug Use Trend Survey that provided valuable regional trend data in previous plan submissions.

It is very important that the responses to these questions reflect the impressions of the direct care staff based on face to face contact with clients and interactions with other service systems. All questions regarding this survey should be directed to Jean Audet at 518-485-2410 or at [JeanAudet@oasas.ny.gov](mailto:JeanAudet@oasas.ny.gov).

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1. Indicate the extent to which you believe the use of each of the following substances is a problem within the community you serve? Where asked, please identify the specific drug(s).

Substance	Serious Problem	Moderate Problem	Minor Problem	Not a Problem	Don't Know
a. Alcohol (among minors)	<input type="checkbox"/>				
b. Smoked Tobacco (among minors)	<input type="checkbox"/>				
c. Smokeless Tobacco (among minors)	<input type="checkbox"/>				
d. Marijuana/Hashish	<input type="checkbox"/>				
e. <a href="#">Synthetic Marijuana</a>	<input type="checkbox"/>				
f. <a href="#">Heroin</a>	<input type="checkbox"/>				
g. <a href="#">Other Synthetic Opiates</a> (specify): <input type="text"/>	<input type="checkbox"/>				
h. <a href="#">Tranquilizers/Sedatives</a> (specify): <input type="text"/>	<input type="checkbox"/>				
i. <a href="#">Amphetamines/Other Stimulants</a>	<input type="checkbox"/>				
j. <a href="#">Cocaine</a>	<input type="checkbox"/>				
k. <a href="#">Crack</a>	<input type="checkbox"/>				
l. <a href="#">Ecstasy (MDMA)</a>	<input type="checkbox"/>				
m. <a href="#">Methamphetamine</a>	<input type="checkbox"/>				
n. <a href="#">PCP</a>	<input type="checkbox"/>				
o. <a href="#">LSD</a>	<input type="checkbox"/>				
p. <a href="#">Other Hallucinogens</a> (specify): <input type="text"/>	<input type="checkbox"/>				
q. <a href="#">Inhalants</a> (specify): <input type="text"/>	<input type="checkbox"/>				
r. <a href="#">Bath Salts</a>	<input type="checkbox"/>				
s. <a href="#">Anabolic Steroids</a>	<input type="checkbox"/>				
t. Other Substance (specify): <input type="text"/>	<input type="checkbox"/>				

2. Indicate the extent to which the use of each of the following substances has changed **IN THE PAST 12 MONTHS** within the community you serve? Where asked, please identify the specific drug(s).

Substance	Increased	Decreased	No Change	Don't Know
a. Alcohol (among minors)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Smoked Tobacco (among minors)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Smokeless Tobacco (among minors)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Marijuana/Hashish	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. <a href="#">Synthetic Marijuana</a>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. <a href="#">Heroin</a>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. <a href="#">Other Synthetic Opiates</a> (specify): <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. <a href="#">Tranquilizers/Sedatives</a> (specify): <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. <a href="#">Amphetamines/Other Stimulants</a>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. <a href="#">Cocaine</a>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. <a href="#">Crack</a>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. <a href="#">Ecstasy (MDMA)</a>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. <a href="#">Methamphetamine</a>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n. <a href="#">PCP</a>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o. <a href="#">LSD</a>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p. <a href="#">Other Hallucinogens</a> (specify): <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
q. <a href="#">Inhalants</a> (specify): <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
r. <a href="#">Bath Salts</a>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
s. <a href="#">Anabolic Steroids</a>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
t. Other Substance (specify): <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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3. Describe any changes that you've seen **IN THE PAST 12 MONTHS** in the populations using the substances listed above, the patterns of their use, or other health-related consequences within the community you serve. (please be as specific and detailed as necessary)

4. Identify any new substances or combination of substances that are being used within the community you serve that you did not see last year. (please be as specific and detailed as necessary)

**Terms Defined for this Survey**

**Synthetic Marijuana** – K2 or “Spice” is a mixture of herbs and spices that is typically sprayed with a synthetic compound chemically similar to THC, the psychoactive ingredients in marijuana. K2 is commonly purchased in head shops, tobacco shops, various retail outlets, and over the Internet. It is often marketed as incense or “fake weed” and labeled “not for human consumption.” Street names: Bliss, Black Mamba, Bombay Blue, Fake Weed, Genie, Spice, Zohai, Yucatan Fire, Skunk, Moon Rocks. (*Drug Enforcement Administration; National Institutes of Health*)

**Heroin** - an addictive drug that is processed from morphine and usually appears as a white or brown powder or as a black, sticky substance. It is injected, snorted, or smoked. Street Names: Smack, H, ska, junk. (*National Institutes of Health*)

**Other Opiates/Synthetics** - includes the misuse, abuse or diversion to non-intended users of Percocets, Percodan, Vicodin, OxyContin, Codeine, Demerol, Dilaudid, Morphine, Non-prescription Methadone, , other drugs derived from opium.

**Tranquilizers/Sedatives-**. includes the misuse, abuse or diversion to non-intended users of prescription drugs such as Xanax, Valium, Tuinal, Seconal or Phenobarbital.

**Amphetamines/Other Stimulants** - includes the misuse, abuse or diversion to non-intended users of prescription drugs such as Adderall, Dexedrine, Ritalin, etc., and other stimulants not included elsewhere.

**Cocaine** - an intense, euphoria-producing stimulant drug with strong addictive potential. It is usually distributed as a white, crystalline powder and can be snorted, injected or smoked. Street names: Coca, Coke, Crack, Flake, Blow, Snow, Soda Cot. (*Drug Enforcement Administration; National Institutes of Health*)

**Crack** - cocaine hydrochloride powder that has been processed to form a rock crystal that is then usually smoked. (*National Institutes of Health*)

**Ecstasy (MDMA)** - a synthetic drug that has stimulant and psychoactive properties. It is taken orally as a capsule or tablet. Street names: XTC, X, Adam, hug, beans, love drug. (*National Institutes of Health*)

**Methamphetamine** - a very addictive stimulant that is closely related to amphetamine. It is long lasting and toxic to dopamine nerve terminals in the central nervous system. It is a white, odorless, bitter-tasting powder taken orally or by snorting or injecting, or a rock "crystal" that is heated and smoked. Street names: speed, meth, chalk, ice, crystal, glass, crank, tweek. (*National Institutes of Health*)

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**PCP** - a synthetic drug sold as tablets, capsules, or white or colored powder. It can be snorted, smoked, or eaten. Developed in the 1950s as an IV anesthetic, PCP was never approved for human use because of problems during clinical studies, including intensely negative psychological effects. Street names: angel dust, ozone, wack, rocket fuel. (*National Institutes of Health*)

**LSD** – Lysergic Acid Diethylamide is a potent hallucinogen that has a high potential for abuse that is sold on the street in tablets, capsules, and occasionally in liquid form and is often added to absorbent paper, such as blotter paper, and divided into small decorated squares, with each square representing one dose. Street names: Acid, Blotter Acid, Dots, Mellow Yellow, Window Pane. (*Drug Enforcement Administration*)

**Other Hallucinogens (psychedelics)** - includes any of a group of substances that alter consciousness. (e.g., mescaline, magic mushrooms).

**Inhalants** - breathable chemical vapors that users intentionally inhale because of the chemicals' mind-altering effects. The substances inhaled are often common household products that contain volatile solvents, aerosols, or gases. Street names: whippets, poppers, snappers. (*National Institutes of Health*)

**Bath Salts** - a synthetic stimulant sold legally online and in drug paraphernalia stores under a variety of “brand” names, and as different products, such as plant feeder or insect repellent. Street names: Bliss, Bloom, Blue Silk, Cloud Nine, Drone, Energy-1, Hurricane Charlie, Ivory Wave, Lunar Wave, Meow Meow, Ocean Burst, Ocean Snow, Pure Ivory, Purple Wave, Red Dove, Scarface, Snow Leopard, Stardust, Vanilla Sky, White Dove, White Knight, White Lightening, Zoom. (*Drug Enforcement Administration; National Institutes of Health*)

**Anabolic Steroids** - synthetic substances similar to the male sex hormone testosterone. They are taken orally or are injected. Some people, especially athletes, abuse anabolic steroids to build muscle and enhance performance. Street names: Juice, gym candy, pumpers, stackers. (*National Institutes of Health*)

### **F. Emergency Management Assessment Survey (All Programs)**

In the aftermath of Hurricane Sandy, the Office of Alcoholism and Substance Abuse Services (OASAS) is undertaking an exhaustive review of its certified and funded programs to identify best practices as they relate to emergency management practices in four areas: preparedness, mitigation, response, and recovery.

Dealing with disasters is an ongoing and complex undertaking. Through the implementation of effective preparedness and mitigation BEFORE a disaster or emergency occurs; timely and effective response DURING an actual occurrence; and provision of both short and long term recovery assistance AFTER the occurrence of a disaster, lives can be saved and property damage minimized.

This process is called the Comprehensive Emergency Management Plan. The purpose of the Comprehensive Emergency Management Plan for OASAS and its network of providers is to support the capacity of prevention and treatment programs to provide services to clients and the general public in the event of an emergency and its aftermath. The purpose of this survey is to aid in identifying best practices and to help OASAS:

- determine the extent to which OASAS-certified programs have participated in local disaster planning efforts and/or exercises;

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- determine the extent to which OASAS-certified programs have developed a site-specific all hazard plan; and
- assess disaster training needs within the OASAS service system.

All questions regarding the following survey should be directed to Kevin Doherty, OASAS Emergency Manager, at (518) 485-1983, or at [KevinDoherty@oasas.ny.gov](mailto:KevinDoherty@oasas.ny.gov).

1. Does this program have a designated Emergency Manager?
  - a) Yes
  - b) No (skip to #3)
2. Please provide the following information on this program's Emergency Manager. (NOTE: Include a cell phone number at which the Emergency Manager can be reached at or away from the site)

Name:

Site Address:

Cell Phone Number:

Email Address:

3. Does this program have a written Emergency Management Plan?
  - a) Yes
  - b) No (skip to #8)
4. Does this program work with the local government (county, municipality, etc.) to develop, update, review and/or test your comprehensive emergency plan?
  - a) Yes
  - b) No

5. What county/municipality does this program work with on your Emergency Management Plan?

6. When was the Emergency Management Plan last reviewed and updated?  
Month:  Year:

7. Indicate whether each of the following elements are included in this program's Emergency Management Plan.

	<u>Yes</u>	<u>No</u>
a) Emergency Phone Numbers	<input type="checkbox"/>	<input type="checkbox"/>
b) Phone number of the State Emergency Operation Center	<input type="checkbox"/>	<input type="checkbox"/>
c) List of staff trained in first aid, CPR, AED, etc.	<input type="checkbox"/>	<input type="checkbox"/>
d) Procedure for developing client roster and a means for accounting for all clients	<input type="checkbox"/>	<input type="checkbox"/>
e) Procedures for special needs clients	<input type="checkbox"/>	<input type="checkbox"/>
f) Procedures for notification of next of kin	<input type="checkbox"/>	<input type="checkbox"/>
g) Chain of authority (site responsibilities in event of emergency)	<input type="checkbox"/>	<input type="checkbox"/>
h) Orientation of clients/patients to emergency procedures	<input type="checkbox"/>	<input type="checkbox"/>
i) Procedures for communicating with off-duty staff, including call-in procedures	<input type="checkbox"/>	<input type="checkbox"/>
j) Emergency supplies to have on stock	<input type="checkbox"/>	<input type="checkbox"/>
k) Secondary gathering sites	<input type="checkbox"/>	<input type="checkbox"/>
l) Policy on moving medications	<input type="checkbox"/>	<input type="checkbox"/>
m) Procedure for safe-keeping/back-up of records and computer files	<input type="checkbox"/>	<input type="checkbox"/>

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- |   |                          |                          |
|---|--------------------------|--------------------------|
| n) Extra keys, records, files, supplies, and vehicles at other sites  | <input type="checkbox"/> | <input type="checkbox"/> |
| o) Record of disaster/emergency response training provided to staff   | <input type="checkbox"/> | <input type="checkbox"/> |
| p) Evacuation procedures  | <input type="checkbox"/> | <input type="checkbox"/> |
| q) Contingency plans for each of the following emergencies/disasters: |                          |                          |
| 1) Fire   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) Power Outage/Failure   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) Disruption in transportation                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| 4) Presence of Hazardous Materials                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 5) Terrorism  | <input type="checkbox"/> | <input type="checkbox"/> |
| 6) Bio-Chemical/Radiological Attack                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 7) Disruption in food, water and/or medical supplies                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 8) Loss of phone service/Internet                                     | <input type="checkbox"/> | <input type="checkbox"/> |
- 
8. How often does your agency convene agency-level emergency management staff meetings?
- a) At Least twice annually
- b) Annually
- a) Less than annually
- b) Never
- 
9. How often does staff from your agency attend county-level emergency management meetings?
- a) At Least twice annually
- b) Annually
- a) Less than annually
- b) Never
- 
10. How often does staff from your agency attend state-level emergency management meetings?
- a) At Least twice annually
- b) Annually
- a) Less than annually
- b) Never
- 
11. How often does your agency participate in mock emergency drills?
- a) At Least twice annually
- b) Annually
- a) Less than annually
- b) Never
- 
7. Does this program site have a back-up electrical generator in case there is a power outage?
- a) Yes
- b) No
- 
8. If this program has a back-up electrical generator, how frequently is it tested for proper maintenance?
- a) At least monthly
- b) At least quarterly
- c) At least annually
- d) Less than annually
- e) Don't know

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**Capital Funding Request Form - Schedule C**

***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 the 2014 planning cycle, 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 the 2014 planning cycle, 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, un-grandfather programs to meet current space regulations, 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 program relocation or reconstruction.

Mental Health 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,

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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. 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. Upon obtaining a fully executed capital contract approval, project obligations and expenditures can commence. Only approved expenditures made during the capital contract period will be eligible for reimbursement.

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

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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 **2014 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.
- 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.

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- **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.



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**Schedule C – OASAS Capital Project Funding Request Form (Page 2)**

Project Site		
Provider Name:	Provider Number:	PRU:
<p>6. Provide a detailed statement of need for the proposed project that addresses programmatic, physical plant and financial need, as appropriate: (provide attachment, if necessary)</p>          		
<p>7. Complete if the project is for an EXISTING certified site:</p> <p>a) The site is:      <input type="checkbox"/> Leased      <input type="checkbox"/> Owned      <input type="checkbox"/> Provided as a gift</p> <p>b) If leased, is the lease an arms-length lease?      <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>c) If leased, what is the annual rent?      \$_____</p> <p>d) If owned, are there any liens on the site?      <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>    e) If YES, what is the current market value of the site?      \$_____</p> <p>    f) If YES, what is the total balance of all liens on the site?      \$_____</p> <p>g) Are you the sole occupant of the site?      <input type="checkbox"/> Yes    <input type="checkbox"/> No</p>		
<p>8. Complete if the project is for a NEW site:</p> <p>a) Has a probable site been identified?      <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>b) How do you expect to acquire the site?      <input type="checkbox"/> Lease      <input type="checkbox"/> Purchase      <input type="checkbox"/> Other (attach explanation)</p> <p>c) Have you obtained an option on the site?      <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>d) If an appraisal or fair market rental study of the proposed site has been completed, forward a copy to the field office.</p>		
<p>9. If a feasibility study has been completed for the project, forward a copy to the field office.</p>		
<p>10. Planned project financing:</p> <p>a) Provider funds:      \$</p> <p>b) Commercial loans/debt:      \$</p> <p>c) Grants (other than OASAS):      \$</p> <p>d) OASAS:      \$_____</p>		
<p>11. Has this financing plan been adopted by the governing authority?      <input type="checkbox"/> Yes    <input type="checkbox"/> No</p>		
<p><u>Provider Official</u></p> <p>Name: _____ Title: _____ Date: _____</p>		