

2015
Local Services Plan Guidelines
For Mental Hygiene Services

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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)). The law also requires local governmental units (all counties and New York City) to develop and annually submit a local services plan to each mental hygiene agency. For many years, each state agency conducted its own local planning process which required LGUs to comply with three different sets of planning requirements. In 2008, the three state agencies began collaborating on an integrated and uniform local planning process with a single set of plan guidelines. For the first time, LGUs were able to complete a single integrated local services plan for mental hygiene services that was submitted to all three state agencies. These guidelines represent the seventh consecutive year of an integrated local services planning process.

Mental Hygiene Law also requires that the local services plan establish 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 be formulated from the LGU comprehensive plans (§5.07(b)(1)). Therefore, while mental hygiene priorities may vary from one county to another, there is an expectation that there be considerable alignment of state and local priorities.

B. Mental Hygiene Planning Committee

The Mental Hygiene Planning Committee includes representatives from the three state mental hygiene agencies, the NYS Conference of Local Mental Hygiene Directors ([CLMHD](#)), and several LGUs. It meets regularly to guide the local planning process and to develop resources that support the work of county planners. This collaboration enables LGUs to conduct planning in a more integrated, person-centered fashion that creates system-wide improvements in the quality of services and supports to individuals, families and communities.

In the six 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 in the behavioral health care system, the focus of the planning committee is to ensure that the LGUs continue to provide effective oversight of local behavioral health services for their populations. It is a priority of the committee to provide timely and informed input into state, regional and local 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.

Today, the local services planning process for mental hygiene services is much more dynamic than ever before. With an increased focus on regional planning, LGUs need to be more flexible and strategic in addressing the problems and needs in their communities. The local planning process must now consider regional issues as well as cross-system issues that are 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

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focused and strategic plan guidelines, and a mechanism for more rapid information exchange 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 Directors of Community Service (DCSs) and 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 improve access to and use of county data to support data driven local planning and system management. 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 LGU 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.
- Worked with OMH staff to facilitate county access to the Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) and convened a new user's group in early 2013. Currently 45 counties are utilizing PSYCKES in their local services planning.
- Developed the first iteration of a LGU Data Dashboard to support county access to and use of other data sources in the context of managed care and local/regional planning functions outlined in the CLMHD's white paper. The dashboard was introduced to the DCSs at their fall 2013 membership meeting and released in February 2014.

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. A CPLP Page was developed in CPS in 2009 to provide easy access to these resources, including a County Fiscal Data Dashboard, a County Data Directory, County Planning Tools, and Webinar Archives.

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.

Much of the recent work of the CPLP has been focused on promoting local planning as an active and ongoing process, and not just the development of a required annual document. CPLP efforts 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 high number of new Directors of Community Services and county planners recently, the CPLP will continue to 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.

In 2014, CPLP efforts will focus on providing local planners the opportunity to learn how to use the new Data Dashboard. Through a series of webinars, local planners will have the chance to

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learn about the data available on the dashboard, and hear about how their peers are using this data to effectively steer their planning efforts.

Webinars and training resources developed over the most recent planning cycle included:

- **OMH Data Portal Webinar** - Oriented county planners to planning resources located on the OMH website.
- **New DCS “Boot Camp”** - Introduced new Directors of Community Services to the planning process and planning resources at the April Membership meeting.
- **CPLP Training on LGU Inquiry Reports and Medicaid Data** – Conducted in Syracuse in the spring to show a practical application of these resources for county planning. Training replicated in a subsequent webinar.
- **LGU PSYCKES User Group Webinar** – Showed how PSYCKES Data can enhance the county planner’s ability to access OMH and OASAS Medicaid data and Client Data Inquiry Reports to assist in the local planning process.
- **County Data Dashboard** – Presented jointly with the Data Needs Workgroup at the September CLMHD membership meeting.

C. The Online County Planning System (CPS)

The online County Planning System (CPS) was developed by OASAS to enable counties and their service providers to complete and submit required local planning forms to the state electronically. CPS became a 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 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.

Today, there are more than 2,300 individuals with a CPS user account in one or more of fifteen 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 over 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/>. **NOTE: Anyone interested in establishing a user account in**

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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. Request access to the County Planning System. Once approved, a CPS account can be established using the new OASAS Applications user name and password.

The following table describes the primary CPS user roles and entitlements granted to each.

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 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 Regional Office (DDRO) 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.
Guest Viewer	This role has read-only access to completed plans and most available data resources. These are typically individuals not employed by one of the three state agencies, an LGU, or an OASAS provider agency but have a need to access resources in CPS. They may include researchers, students, consultants, or staff from another state or county agency. The Guest Viewer role is approved by OASAS.
All Roles	All user roles can view and print forms, run special 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 Local Planning, and maintained by staff from the NYS Office of Information Technology Services (ITS) located within OASAS. 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 oasasplanning@oasas.ny.gov or at 518-485-2410.

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Local Services Planning Timeline

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

2015 Local Services Planning Process Timeline	
Ongoing planning and needs assessment conducted by counties and the Mental Hygiene Planning Committee	Year round
Local Services Plan (LSP) Guidelines published; CPS updates available	Monday, March 3
LSP and CPS training for county planners	March/April (TBD)
Due date for completed OASAS provider planning surveys in CPS	Tuesday, April 1
Due date for completed LGU Plans in CPS	Tuesday, June 3
State summary analyses of county and provider plans completed	September 2014
OASAS, OMH, OPWDD Statewide Comprehensive Plans released	November 2014
OASAS, OMH, OWPDD Interim Reports released	March 2015

D. Informing Statewide Comprehensive Planning and Budgeting

Local services plans are central to state comprehensive statewide planning. As noted previously, Mental Hygiene Law requires that OASAS, OMH and OPWDD formulate statewide comprehensive plans in part from local comprehensive plans developed by LGUs. An important outcome 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, 69% of all priorities identified in the local plans addressed needs that crossed multiple disabilities, including 49% that included all three mental hygiene disabilities. This percentage increases every year, suggesting that the integrated mental hygiene planning process and CPS are serving as catalysts for more coordinated, focused and regional planning across multiple systems of care.

The top cross-disability priorities identified in last year's plans included the need for safe and affordable housing, expanding the capacity of local services to provide integrated or coordinated care, supporting reforms such as the Affordable Care Act and Medicaid Redesign while maintaining and strengthening LGU oversight and system management responsibilities, and collaborating with local health departments (LHDs) to support the mental health and substance use disorder related priorities of the NYS Department of Health's (DOH) Prevention Agenda 2013-17. A majority of counties included priorities focused on working with Behavioral Health Organizations (BHOs) and Health Homes on care coordination to ensure that the network meets the behavioral health needs of the county residents.

Medicaid Redesign opportunities and the development of national healthcare reform policies centered on the statewide implementation of an Advanced Primary Care Model (APC) have forced the behavioral healthcare and physical healthcare fields to transform towards combined

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strategies and goals around needed service improvements in community supports, fostering of recovery and resilience, integration of care, quality of treatment, and cost effectiveness.

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, 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 develop policy in a more proactive and effective way than was previously possible. To help ensure that policies supporting 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 important sources of input.

A significant development in the integration of care for individuals with co-occurring substance use and mental health disorders was the formation of the **Behavioral Health Services Advisory Council (BHSAC)**. Changes to Mental Hygiene Law in 2012 established the Council, which replaced the former OASAS Advisory Council on Alcoholism and Substance Abuse and the OMH Mental Health Services Council. The BHSAC advises the two state agencies on matters relating to the provision of behavioral health services. The OASAS and OMH commissioners are non-voting members of the BHSAC. The Chair of the CLMHD serves on the Council. The Governor designated a chair and the 28 members of the BHSAC who were approved by the Senate in 2013. In October 2013, OASAS and OMH staff conducted an orientation for members of the BHSAC, which was followed by the Council's first meeting.

The BHSAC's responsibilities 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 reviews applications seeking OASAS/OMH certification to provide behavioral health services, and reviews all proposed OASAS/OMH rules and regulations prior to enactment.

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CHAPTER II: Planning for Mental Hygiene Services

A. The Context for Planning in an Atmosphere of Change

While each mental hygiene system of care continues to provide quality, individualized services, the agencies recognize the transformational changes that are occurring in the health care system. With the implementation of the Affordable Care Act, The New York State Health Innovation Plan, Medicaid Redesign, Regional Health Improvement Collaboratives (RHICs), Regional Centers of Excellence (RCEs), the integration of behavioral health into the larger health care system, and the movement of behavioral health services from institutional care to community care, OASAS, OMH and OPWDD are working with their state and local partners to implement a more coordinated system of care that addresses the behavioral and physical health care needs of individuals. OASAS and OMH are collaborating with DOH, New York City Department of Health and Mental Hygiene (DOHMH), and CLMHD to integrate services through initiatives like Health Homes, Behavioral Health Organizations (BHOs), and the behavioral health services carve-in to Medicaid managed care.

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's) Strategic Initiative; Managed Behavioral Health Care: BHOs, Health and Recovery Plans (HARPs); the Justice Center and the Protection of People with Special Needs Act. The following is a brief summary of each.

Olmstead Decision

In 1999, the 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 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 to establish the Olmstead Plan Development and Implementation Cabinet to provide guidance and advice to the Governor. The Cabinet published recommendations concerning the implementation and coordination of New York State's Olmstead Plan in October 2013. This report provides the framework for New York to serve people with disabilities in the most integrated setting appropriate to their needs and desires. Through implementation of these recommendations, New York will:

- Assist in transitioning people with disabilities into the community from developmental centers, Intermediate Care Facilities (ICFs), sheltered workshops, psychiatric centers, adult homes, and nursing homes;
- Reform methods of assessment of the needs and wants of people with disabilities;
- Adopt new Olmstead outcome measures for people with disabilities;

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- Enhance integrated housing, employment, and transportation services available to people with disabilities;
- Improve services to children, seniors, and people with disabilities involved with the criminal justice system;
- Remove legal barriers to community integration; and
- Assure continuing accountability for serving people with disabilities in the most integrated setting.

The effective implementation of these recommendations will safeguard the fundamental civil rights of New Yorkers with disabilities to lead integrated lives. All three mental hygiene agencies will work to implement and achieve these goals. For the complete Olmstead plan, please visit: <http://www.governor.ny.gov/olmstead/home>.

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 affect New Yorkers with disabilities include:

- **Health care coverage:** The ACA expands eligibility (to 138% of the FPL¹), prohibits annual coverage limits in health plans and insurance policies, and 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.

Managed Behavioral Health Care: Behavioral Health Organizations (BHOs) and Health and Recovery Plans (HARPs)

In 2011, Governor Cuomo called for “a fundamental restructuring of (the) Medicaid program to achieve measurable improvement in health outcomes, sustainable cost control, and a more efficient administrative structure.” To achieve these goals for individuals with mental health and/or substance use conditions, the Governor appointed a Medicaid Redesign Team (MRT) Behavioral Health Reform Workgroup. The Workgroup developed principles and recommendations for moving behavioral health services into managed care. New York is developing a managed care system for behavioral health that closely follows the MRT guiding principles listed below:

- Coordinated Care
- Integration of physical and behavioral health services
- Recovery oriented services
- Patient/consumer choice
- Protection of continuity of care

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

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- Ensure adequate and comprehensive networks
- Tying payment to outcomes
- Track physical and behavioral health spending separately (firewall)
- Reinvest savings to improve services for behavioral health populations
- Address the unique needs of children, families and older adults

OMH and OASAS are closely collaborating with DOH to implement managed care transition in response to the recommendations and guiding principles set forth by the MRT Behavioral Health Reform Workgroup. To ease the impact of transition, a two-phase transition was planned to take place over a three-year period.

Behavioral Health Organization (BHO) Phase 1

As an initial phase, BHOs were contracted to manage the high cost fee-for-service (FFS) behavioral health services through a concurrent review process for FFS inpatient care and to focus on high-quality engagement post discharge. The purpose of BHO Phase 1 was to assist in transitioning substance use disorder and mental health service systems from a fee-for-service environment to care management.

Phase I began in January 2012 when OASAS and OMH contracted with five BHOs to help prepare the substance use disorder and mental health service systems for the transition from a fee-for-service environment to care management. The BHOs began working with providers and monitoring inpatient behavioral health services for Medicaid-enrolled individuals whose inpatient behavioral health services were not covered by a Medicaid Managed Care plan and who also were not enrolled in Medicare. They began collecting and submitting data; utilizing Medicaid data to inform treatment and care planning; developing and testing metrics for monitoring behavioral health system performance; and identifying improvements in inpatient discharge planning and ambulatory engagement/continuity of care.

The role of the BHOs was refined in 2012 to focus on identifying new approaches and evidence-based practices that would: facilitate the transition from inpatient care to the community; sustain engagement in community-based care; and address co-morbid medical problems and co-occurring substance use and mental health disorders. In addition, the state narrowed the focus of the BHOs to fee-for-service populations with “complex needs” that met certain incident threshold criteria. BHOs would also more actively work with inpatient providers on care coordination, peer and system supports, outreach, and follow-up.

Phase 1 BHOs will phase out by April 2014, while the lessons learned and process improvements achieved by these entities will help inform Phase 2 BHO and the management of integrated behavioral health benefits for Medicaid beneficiaries.

Behavioral Health Managed Care (BHO) Phase 2

Behavioral Health Managed Care Phase 2 will integrate all behavioral health (BH) and physical health (PH) services under the management of risk bearing Qualified Mainstream Managed Care Plans and Health and Recovery Plans (HARPs). The final Phase 2 structure and timing will ultimately depend on federal approval of an amendment to the 1115 waiver.

Contingent upon federal approval, the implementation dates for the final phase in the behavioral health transformation are:

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- January 1, 2015: Adults in NYC (HARP and Qualified Mainstream Managed Care Plans)
- July 1, 2015: Adults in Rest of State (HARP and Qualified Mainstream Managed Care Plans)
- January 1, 2016: Children Statewide

Phase 2 will create a system that provides New Yorkers with fully integrated behavioral health and physical health services offered within a comprehensive, accessible and recovery oriented system. For adults 21 and older, the integration of all Medicaid behavioral health and physical health benefits under managed care will go into effect January 2015 in NYC and July 2015 in the rest of New York State and will be delivered through two BH managed care models:

- **Mainstream Managed Care Organizations (MCOs):** Qualified Mainstream MCOs will manage care for adults including services for mental illness, substance use disorders, physical health and pharmacy.
- **Health and Recovery Plans (HARPs):** HARPs will manage care for adults with significant behavioral health needs. They will facilitate the integration of physical health, mental health, and substance use services for individuals requiring specialized expertise, tools, and protocols, which are not consistently found within most medical plans. In addition to the State Plan Medicaid services offered by mainstream MCOs, qualified Health and Recovery Plans will offer access to an enhanced benefit package comprised of 1915(i)-like Home and Community Based services designed to provide the individual with a specialized scope of support services not currently covered under the State Plan. In order to qualify to deliver BH services, Plans must demonstrate that they have the organizational capacity and culture to ensure the effective management of behavioral health care and facilitate system transformation. All applications will be reviewed against new behavioral health specific administrative, performance, and fiscal standards.

Stakeholder Engagement

To engage stakeholders in the design and delivery of the behavioral health managed care model, OMH, OASAS, and DOH continue to meet with managed care plans, LGUs, provider associations, families, and consumers regarding this important behavioral health transition from FFS to Medicaid Managed Care. Additionally, OMH, OASAS, and DOH continue to meet with the MRT Behavioral Health Workgroup for input and feedback on the managed care design. All Medicaid Redesign Team (MRT) Behavioral Health Managed Care updates can be found through the [MRT Behavioral Health Reform website](#).

Qualification Process

Before Phase 2 can be fully implemented for adults 21 and older, managed care plans will be required to submit applications to New York State demonstrating that they have the organizational capacity and culture to ensure the delivery of effective behavioral health care and facilitate system transformation. These applications will be reviewed against new behavioral health specific administrative, performance, and fiscal standards. The RFQ will qualify Plans to manage services on their own or in partnership with a BHO.

In December 2013, New York State released a [Request for Information](#) regarding "New York's Request for Qualifications (RFQ) for Behavioral Health Benefit Administration: Managed Care

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Organizations and Health and Recovery Plans." This RFI solicited input concerning New York's draft proposal to manage Medicaid substance use and mental health benefits for adults. The RFI addresses planning and systems oversight under the concept of "Regional Planning Consortia," which would consist of LGUs and other important stakeholders, and require collaboration between MCOs/HARPs and these regional entities. Comments in response to the RFI submitted through January 17, 2014 have been reviewed, and the State plans to release a final RFQ during March 2014.

Children's Service Transition

Currently, pediatric health care services covered under mainstream Plans, including services for children and youth under EPSDT², outpatient, and inpatient behavioral health services are managed by the mainstream Plans. By January 2016, it is proposed that all currently carved-out Medicaid fee-for-service behavioral health services will be included under the MCO benefit package. These services include:

- **OMH:** day treatment, rehabilitation services within community residences, residential treatment facilities, and intensive/ supportive/ blended case management
- **OASAS:** opioid replacement treatment, outpatient chemical dependence rehabilitation, outpatient clinic, methadone maintenance, rehab supports for community residences
- **Office of Children and Family Services (OCFS):** foster care per diem paid to voluntary agencies to manage the health and behavioral health needs of children in foster care
- **OMH Home and Community Based Service (HCBS) Waiver:** individualized care coordination, family support, crisis response, skill building, and respite care
- **OCFS Bridges to Health (B2H) Waiver:** health care integration; family/caregiver supports and services; skill building; day habilitation; special needs community advocacy and support; prevocational services; supported employment; planned respite; crisis avoidance, management and training; immediate crisis response services; intensive in-home supports and services; crisis respite; adaptive and assistive equipment; and accessibility modifications

Planning for the transition of children's Medicaid fee for services behavioral health services is taking place similar to the planning for adult services as outlined above; however, in addition to regular meetings among DOH, OASAS and OMH, discussions also include OCFS. Additionally, a Kids Subcommittee of the MRT Behavioral Health Reform Workgroup, comprised of providers, family members, and other child-specific stakeholder groups, provides guidance and direction to the state agencies regarding the children's managed care design.

Health Homes

New York State is authorized under the federal Patient Protection and Affordable Care Act (ACA) to develop and provide Health Home services for Medicaid recipients with chronic illness. Health Home services support the provision of coordinated, comprehensive medical and behavioral health care to patients with chronic conditions through care coordination and integration that assures access to appropriate services, improves health outcomes, reduces preventable hospitalizations and emergency room visits, promotes use of health information technology (HIT), and avoids unnecessary care. Health Home services include:

² Early Periodic Screening, Diagnosis, and Treatment

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- Comprehensive care management
- Health promotion
- Transitional care including appropriate follow-up from inpatient to other settings
- Patient and family support
- Referral to community and social support services
- Use of health information technology to link services

An individual is eligible for Health Home enrollment if he or she is currently on Medicaid and has: (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.

Comprehensive care management calls for all of an individual's caregivers to communicate with one another to comprehensively address the patient's needs. A care manager is responsible for overseeing and managing this process and assuring the patient has access to all the services necessary to improve health, reduce emergency room visits, and avoid hospitalization. Patient health information is shared among providers to fully address all needs and ensure there is no duplication of services. Health Home services are provided through a network of organizations, including providers, health plans, and community-based organizations that work cooperatively to provide care. As of September 2013, there were 32,661 Medicaid recipients in active care management in a Health Home and another 21,146 engaged in outreach activities with a Health Home provider.

To evaluate the impact and effectiveness of the Health Home implementation the state developed the Health Home Care Management Assessment Reporting Tool (HH-CMART), which collects standardized care management data for members assigned to Health Homes. The data provides DOH with information about care management services to evaluate the volume and type of interventions and the impact care management services have on outcomes for people receiving these services. The data requirements include submission of specified data about care management services provided to members in Health Homes.

Statewide quality measures were developed to address five goal areas of treatment. Substance use disorders are included in the goal to "improve outcomes for persons with substance use and/or mental health disorders." The actual measure addresses follow-up care after a hospitalization for detoxification for alcohol or chemical dependence. For this measure, the state will rely on Medicaid claims data to determine the percentage of discharges for specified alcohol and chemical dependence conditions that are followed up with visits with chemical dependence treatment and other qualified providers within 7 days and within 30 days of detoxification in addition to those who have ongoing visits within 90 days of the discharge.

OASAS and OMH continue to work with DOH on the management and oversight of Health Homes and provider networks across the state. Additional monitoring and evaluation tools are being developed within a larger evaluation plan that includes an external entity, the National Center on Addiction and Substance Abuse (CASA) at Columbia University, conducting in-depth analyses of outcomes for individuals with a substance use disorder engaged in Health Homes.

The Justice Center

In June 2012, the New York State Legislature passed the Protection of People with Special Needs Act. This Act created the Justice Center, a new agency to ensure the safety of

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individuals served in residential and day programs by provider agencies operated, licensed or certified by the state.

The Justice Center opened in June 2013. Its primary focus is the protection of people with special needs, which includes oversight of quality of care in delivery of supports and services within the six state agencies that operate, certify or license residential programs within the Justice Center's jurisdiction. These agencies include: OPWDD, OMH, OCFS, OASAS, DOH, and the State Education Department (SED).

As a law enforcement agency, the Justice Center has primary responsibility for tracking, investigating and prosecuting serious abuse and neglect complaints. It operates a statewide hotline, which is staffed 24-hours a day, seven days a week by trained professionals that receive reports of allegations of abuse, neglect and mistreatment that are promptly investigated. Counties are encouraged to utilize the Justice Center as a secure way to report abuse and use it as a resource to learn more about preventing abuse. To view incident reports and more information on the Justice Center, please visit: <http://www.justicecenter.ny.gov/>.

B. Planning for Addiction Services

OASAS oversees one of the largest addictions service systems in the country that includes a full array of services to address prevention, treatment, and recovery. Treatment services were provided to approximately 245,000 individuals in 2013 through outpatient, crisis, inpatient, residential and opioid treatment services. The prevention system reached over 400,000 individuals through direct service provision. While the OASAS system of care continues to provide quality, individualized services, the agency recognizes the transformational changes occurring in the health care system that were described earlier in this chapter and will continue to collaborate with its state and local partners to implement a more coordinated system of care that addresses the behavioral and physical health care needs of individuals with substance use disorders.

Planning for addiction services in New York State is guided by OASAS' mission *"to improve the lives of New Yorkers by leading a premier system of addiction services through prevention, treatment, recovery."* The OASAS Strategic Framework focuses on priorities that are driven by a data informed and results focused planning process where outcomes are aimed at improving program performance, client results, and return on investment. It allows OASAS to systematically measure progress and make modifications over time to accommodate changing events and circumstances that impact the service system. Each year, these guidelines seek input from counties and providers that inform and support state priorities.

As described in Chapter I of these guidelines, OASAS and the LGUs are required by State Mental Hygiene Law to coordinate and conduct a local services planning process, and that local goals and objectives both inform and are informed by statewide priorities. OASAS recognizes the value of a dynamic local planning process that is participatory, data informed, and focused on outcomes; one that allows the LGU to develop meaningful and realistic strategies, track and measure progress, and ultimately achieve the desired change. It should be a process that can quickly adapt to rapid changes in order to remain a relevant and effective means for influencing not only statewide priorities, but decision-making that impacts local programs and the delivery of care to its citizens.

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The Use of Quality of Life Assessment Tools

Quality of life assessment tools have been used in treatment planning and outcome assessment in primary care and mental health services for many years. More recently, the addiction treatment field began using these tools as a way to address the needs of the whole person rather than just the substance use disorder to improve treatment outcomes. In a planning survey conducted in CPS last year, OASAS treatment programs were asked if they had implemented and currently use a standardized quality of life assessment tool for their participants. Statewide, about 12 percent reported having a standardized tool, ranging from 2 percent in the Western Region to 21 percent in the Northeastern Region.

Of those programs that reported using a standardized tool, 87 percent indicated that all program participants received a quality of life assessment. When those programs were asked about when the quality of life assessment was administered, 94 percent reported administering it at intake and 46 percent at discharge. Nearly half of all respondents reported administering the assessment after three or six months in treatment, and six percent reported administering it after discharge. Of those reporting that they administered the assessment at intake, 57 percent reported administering it at a later time as well.

The information obtained through the survey will help OASAS to more fully assess the readiness of the treatment provider system to participate in the transformation to a Recovery Oriented system of Care (ROSC) and to provide the resources and supports that would most help to achieve that. In addition, OASAS will continue to explore ways to support a provider's capacity to measure its effectiveness in moving towards integrating recovery principles, policies, and practices into their services.

Perception of Care (PoC) Survey System Launched in May, 2013

OASAS developed a new web-based survey application to help treatment and recovery providers regularly obtain feedback from their clients and/or participants on several domains: access; quality; perceived outcome; social connectedness; commitment to change and program recommendation. The new system reflects two of the Institute of Medicine's recommendations for Substance Abuse and Mental Health programs published in 2006: care needs to be patient-centered; and all programs should have an infrastructure for quality improvement including measurement of the processes and outcomes of care. The OASAS Perception of Care (PoC) Survey System will help programs meet CARF and TJC accreditation standards as well as OASAS regulatory requirements for Quality Improvement.

The POC and National Standards of Care

OASAS collaborated with the Nathan Kline Institute for Psychiatric Research to conduct a preliminary psychometric assessment of the survey. They concluded that the OASAS PoC survey provides a superior standard for comparison of programs against national benchmarks, such as the National Quality Forum (NQF) and Affordable Care Act (ACA). It meets all NQF endorsement criteria in its: 1) emphasis on the importance of client-centered measurement and reporting; 2) scientifically validated psychometric properties; 3) user-friendly data retrieval capacity; and 4) benefit to users (consumers, purchasers, providers, and policymakers) to understand results that advance quality improvement and data driven decision making. In addition, it exceeds comparative measures of perception of care, surpassing eleven of the ACA health-quality measures as well.

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System Capabilities

The new system will enable providers to collect, enter and analyze their own client/participant data as part of their program's quality improvement plan in real time. LGUs are able to access provider data within their jurisdiction as well. The survey results can be accessed using graphs and tables, and can be analyzed by client characteristics such as age, race, gender, presence of a co-occurring disorder, and length of stay. Providers with multiple programs will have the capacity to monitor survey administration and results for each of their programs. In addition, providers can monitor change in each program by calendar quarter. Responses to individual items as well as open-ended write-in questions enable providers to identify specific areas for quality improvement. Thus, OASAS programs that administer the survey quarterly can effectively engage in Plan-Do-Study-Act cycles consistent with continuous quality improvement.

The PoC system can be accessed through the OASAS Applications portal at: <https://www.oasas.ny.gov/poc/index.cfm>. The site features two PowerPoint presentations that provide an overview of the system and how to get started, as well as a User Manual and survey tools in English and Spanish. Training is available by contacting Susan.Brandau@oasas.ny.gov.

Prevention Activity and Results Information System (PARIS)

PARIS is a web-based information system that supports the annual planning and approval process, service delivery data reporting, and performance measurement of OASAS-funded prevention providers. The annual work plan approval process - with review by county and OASAS Field Office managers - produces activity data collection templates for the planned services used by providers to report monthly service delivery. PARIS is used to collect data on all funded prevention providers' service activities. A distinguishing feature of PARIS is the integration of the planning and activity reporting functions. Each provider is required to conduct an assessment of community needs, describe the populations affected by risk and protective factors for substance abuse, and then select service approaches for targeted groups of individuals or communities. The OASAS state and county review and approval process supports the coordination of prevention activities in each county and New York City.

These guidelines include a brief prevention workforce survey that OASAS is conducting to provide a better understanding of the characteristics of the prevention workforce. The objective of the survey is to provide information that can be used to plan for the effective use of resources; promote efficient types of prevention services; maximize the impact of the local, state, and federal prevention efforts; and support reliable outcome evaluations.

The Prevention Agenda

In December 2012, the 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. The guidelines reflected the Prevention Agenda 2013-2017, which was developed in conjunction with DOH's new health improvement plan. The Prevention Agenda 2013-2017 is considered the blueprint for local action to improve the health of all New Yorkers in five priority areas. The New York State Health Innovation Plan for 2015 intends on using the Prevention Agenda 2013-2017 as a guide for building healthy communities by strengthening links between primary care, hospitals, LTC providers, LHDs and community stakeholders. LHDs and hospitals were encouraged to

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collaborate with each other and other community partners on the development of the Community Health Improvement Plans (CHIP) and DOH believes that collaboration on a community health assessment and community health improvement plan will reduce duplication of services in a more efficient and effective manner. Each LHD was required to address at least two of the five priority areas.

One of the five priority areas covered under the Prevention Agenda was “**Promote Mental Health and Prevent Substance Abuse.**” OASAS and OMH staff participated in the development of the guidelines for this priority area, which were endorsed by both agencies. In last year’s guidelines, LGUs were encouraged to proactively reach out to their LHD to collaborate on including this priority in their CHIP. The guidelines also asked LGUs to describe those early collaboration efforts and to identify their priorities related to the Prevention Agenda. The following table details the specific focus areas and goals included under the promote mental health and prevent substance abuse priority area.

Prevention Agenda 2013-2017 Focus Areas and Goals Related to the Promote Mental Health and Prevent Substance Abuse Priority Area

<p>Focus Area 1: Promote Mental, Emotional and Behavioral Well-Being in Communities</p> <p>Goal 1.1: Promote mental, emotional and behavioral (MEB) well-being in communities.</p>
<p>Focus Area 2: Prevent Substance Abuse and other Mental Emotional Behavioral Disorders</p> <p>Goal 2.1: Prevent underage drinking, non-medical use of prescription pain relievers drugs by youth, and excessive alcohol consumption by adults.</p> <p>Goal 2.2: Prevent and reduce occurrence of mental, emotional and behavioral disorders among youth and adults.</p> <p>Goal 2.3: Prevent suicides among youth and adults.</p> <p>Goal 2.4: Reduce tobacco use among adults who report poor mental health.</p>
<p>Focus Area 3: Strengthen Infrastructure across Systems</p> <p>Goal 3.1: Support collaboration among leaders, professionals and community members working in MEB health promotion, substance abuse and other MEB disorders and chronic disease prevention, treatment and recovery.</p> <p>Goal 3.2: Strengthen infrastructure for MEB health promotion and MEB disorder prevention.</p>

Because the planning cycles for the local mental hygiene plans and the community health improvement plans do not coincide (MH plans were due in June, while the CHIPs were not due until November), a thorough analysis of all collaborative efforts and mutual priorities will not be possible until this year’s mental hygiene plans are submitted. However, in last year’s plans, nearly all LGUs reported collaborating with their LHD, either as common practice or specifically regarding the Prevention Agenda.

An analysis of priorities included in those plans showed that 37 LGUs (65%) included one or more priorities that were in alignment with the Prevention Agenda. Whether those priorities are also included in the LHD CHIPs is currently being determined and will be reported at a later date.

Preliminary data from DOH shows that 29 counties included promote mental health and prevent substance abuse as one of their priorities. Most of the goals identified under this priority were in

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Focus Area #2: Prevent Substance Abuse and other Mental Emotional Behavioral Disorders and focus Area #3: Strengthen Infrastructure across Systems.

Close collaboration among DOH, OASAS, OMH, and the Mental Hygiene Planning Committee and will focus on identifying the evidence-based practices that can be implemented to address the priorities and to measure outcomes over the course of the current Prevention Agenda.

C. Planning for Mental Health Services

The forces of change in Medicaid Redesign, mental health parity, managed behavioral health, the Olmstead Plan and Regional Centers of Excellence continue to drive the transformation of the public mental health system, and it is critical that local stakeholders be informed and engaged in ongoing planning. With so many large scale reforms converging, there are numerous opportunities to serve and support the recovery and resiliency of adults, children, and families impacted by mental illness. Below are a number of recent and ongoing initiatives that will drive, and are driven by local and statewide planning efforts in the public mental health system.

Regional Centers of Excellence and Managed Behavioral Healthcare

With the release of the OMH Regional Centers of Excellence (RCE) Plan, the extensive community outreach and stakeholder engagement during a Statewide Listening Tour and the Regional Centers of Excellence Teams advisory process, a significant amount of planning is already underway for the transformation of the public mental health system in the coming years.

Under the RCE Plan, state-operated services will be transformed by using the assets of our State workforce and savings associated with rebalancing our institutional footprint to develop and enhance community-based services in geographically distinct areas of each region. These Centers will be designed to diagnose and treat the most severe or complex forms of mental illness and offer expanded and improved ambulatory services. Strong university affiliations, based upon collaborations that promote research and result in the quick dissemination of evidence-based treatments will support these RCEs. Each will be the axis of a hub of ambulatory community-based services for treating individuals upon discharge and for persons in the community actively engaged in their recovery.

Five RCE Advisory Teams were convened in each OMH region of the State in order to identify those services and supports necessary to help reduce inpatient admissions and lengths of stay, and to optimize community living for adults with serious mental illness and children with serious emotional disturbance. Some of the commonly identified areas for each region were mobile intervention and community support teams, flexible housing models, crisis and respite beds, recovery center and family resource center expansion, mental health urgent care, home and community based waiver expansion, transportation supports, and greater integration of peers and families into all service models.

At the same time that the RCE planning proceeds, work continues on the Medicaid Redesign Team's recommendation to carefully and responsibly transform the current fee-for-service system to Medicaid managed care for enrolled individuals with substance use disorder and mental health treatment needs. The primary vehicles for managing behavioral health under managed care will be the integration of nearly all behavioral health services into mainstream managed care plans, and the use of Health and Recovery Plans (HARPs), which are distinctly

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qualified, specialized and integrated managed care products, for individuals with significant behavioral health needs.

HARPs will have an enhanced benefit package with a focus on care coordination and accessing community and social supports- including many of the critical services and supports identified by the RCE Teams in their advisory reports to the Commissioner. This new product will enable individuals to receive their healthcare in a fully coordinated manner and benefit from more effective care management, increased communication among providers, more seamless referrals and better access to a broader array of supports and services that support person-centered community living.

Health homes will also support the goal to better integrate and manage behavioral health services and supports under managed care by convening all of the systems important to an individuals' health and recovery, coordinating care, and ensuring smooth transitions through the range of behavioral and physical health services.

Integrated Behavioral Health and Physical Health Care

Under managed behavioral healthcare, HARPs, and Health Homes, New York has the opportunity to move toward 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.

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.

Project TEACH: Primary care physicians (PCPs) are often the first place where families seek help for, or information about emotional or behavioral concerns with their children. OMH has funded Project TEACH (Training and Education for the Advancement of Children's Health) to support the critical role that primary care physicians play in the early identification and treatment of social-emotional disturbances in children by providing the following services to PCPs throughout the State: consultation from child and adolescent psychiatrists, education and

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training on children's mental health, and referral and linkage services for the children and adolescents they serve.

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, and initiatives including:

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 concept that a systemic approach can comprehensively address suicide risk.

Although New York State has the lowest suicide rate per 100,000 in population, more can be done to prevent the loss of life. The Office of Mental Health has a wide variety of clinically appropriate suicide prevention activities in place which strongly promote community involvement. For more information go to http://www.omh.ny.gov/omhweb/suicide_prevention/

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.

Early Childhood Initiatives: OMH has developed a number of initiatives that help establish supports for young children's social-emotional development across a wide range of settings. One such initiative is funding for **ParentCorps**, a culturally-informed, family-centered evidence based, preventive intervention designed to foster healthy development and school success among young children (ages 3 – 6) living in low-income communities. Through this effort, OMH is better able to align and mobilize resources from various service systems to intervene early and make an important public health impact.

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:

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Peer Specialist Certification: OMH is developing a certification process for persons who provide peer support services. This process was undertaken to align with services under Medicaid Managed Care and the proposed HARP waiver. Additionally this will provide the benefit of improving the knowledge and experience base for peers who work in the public mental health system. Individuals will be required to have general qualifications, training in core competencies, and practical experience applying their knowledge in a supervised environment. Formal training in the competency areas can be done online through the Academy of Peer Services (APS) or through various other programs that currently provide this training. Peers trained outside of the Academy will be required to pass a test on the core competencies to ensure that all Certified Peer Specialist have the required basic knowledge. Individuals who meet all the requirements for certification will be granted a certificate for a set period; in order to renew the certification individuals will need to participate in continuing education. OMH plans to initiate the Certified Peer Specialist program in 2014.

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.

New York Employment Services System: OMH has led 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.

Improving Work and Employment Retention Skills: In 2002, OMH commissioned a study by the Educational Development Center, Inc. to assist in the planning of services to youth in transition. The study highlighted the need to more adequately facilitate the transition to adulthood and independent living, for children and adolescents who need services beyond age 18. Although more attention to vocational, educational, and life skill development is needed in order to build resiliency, self-sufficiency, recovery and a sense of hope, OMH has a good start in this area. Since 1999, OMH has funded sixteen innovative vocational programs for youth in locations throughout the State, including two Residential Treatment Facilities. These programs are demonstrating that young adults with serious emotional disturbance are able to fully and actively participate in career planning, skill development, and hold down jobs.

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. OMH has supported the development of 16 Recovery Centers (serving 20 counties plus New York City) and continues its commitment to the development of additional Centers in the future.

Accountability and Ensuring High Quality of Care

OMH maintains a strong emphasis on continuous quality improvement efforts, from a clinical and a systems perspective, through the use of data and information to measure outcomes and support the implementation of evidence-based treatments.

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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.

Health Information Exchange: OMH is working with DOH to connect OMH providers to information hubs in their region of the State. These Regional Health Information Organizations (RHIOs) collect health record data from the healthcare providers in their area, and, with patient consent, allow this information to be shared securely with other providers. Both individuals and their providers, when securely connected to the health exchange will have complete, accurate, and private access to the information carefully gathered by each one of the specialists the individual has visited. Fewer mistakes will be made, fewer tests repeated, and money and time will be saved on administrative details. Most importantly, the individual and doctor will have more time together to discuss treatment options and recovery.

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, ensuring accountability, and promoting recovery-oriented outcomes.

MyPSYCKES: MyPSYCKES is an innovative Web-based portfolio of reports and tools developed by New York State Office of Mental Health to promote active participation by consumers in their treatment and recovery. MyPSYCKES includes three major components: the My Treatment Data portal, which allows Medicaid beneficiaries to view and comment on their treatment history; a Learning Center, which provides access to educational materials and recovery tools; and CommonGround, a shared decision-making tool.

D. Planning for Developmental Disability Services

Consistent with major policy initiatives across the state, OPWDD is developing its own plan for system transformation in partnership with the federal Centers for Medicare and Medicaid Services (CMS) and the NYS Department of Health. It is based on furthering its mission and vision for individuals with developmental disabilities. Achieving the primary outcomes of person-centered supports: home of choice, employment and meaningful activities, good health, and positive relationships for the people we support are the continuing goals, and OPWDD is adopting the most effective methodologies and tools to accomplish them.

In 2011, OPWDD (in collaboration with the New York State Department of Health) began developing the People First Waiver: a 1915(b)/(c) Medicaid waiver that would help integrate long-term care services with behavioral and physical health services. The People First Waiver, along with OPWDD's transformational agenda, is the vehicle for implementing the following system reform goals:

- Making the system more person-centered

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- Restructuring to provide more integrated, holistic support
- Establishing transparent and sustainable funding
- Measuring quality of the system based on individual outcomes
- Serving people in the most integrated setting

System Transformation

Large-scale transitions are being planned for OPWDD that require an alignment of agency values and policies. To support the creation of a new agency culture, OPWDD has undertaken several initiatives that change how OPWDD interacts with its employees and the model of care for individuals in our service delivery system. These include health and safety reforms, the adoption of the National Alliance for Direct Support Professionals' Code of Ethics as well as establishing core competencies for Direct Support Professionals (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 creating consistent and efficient practices to support improved service delivery.

People First Waiver and DISCOs

OPWDD continues a dialogue with the Center for Medicare and Medicaid Services (CMS) to define the system reforms embodied in the forthcoming People First Waiver agreements. 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 initial two year period of managed care, slated to begin in fall 2014, individuals will voluntarily opt to enroll in a DISCO. As part of the application process to become a DISCO, each organization will be required to describe how they will:

- Provide person-centered planning; promote living and active engagement in the 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.

The DISCOs are still being developed and finalized. OPWDD has submitted its 1915(c) amendment and 1915(b) application for waivers to the Centers for Medicare and Medicaid Services (CMS) and pending approval, will be moving forward with the waiver plan within the next year. To accommodate the terms of the waiver, the NYS legislature has passed legislation that authorizes the delivery of specialized developmental disabilities services through a managed care structure. Weekly discussions with CMS are ongoing related to deliverables per the Transformation Agreement, the 1915(c) waiver amendment and reforming OPWDD's rate methodology. Following the finalization of the rate methodology, negotiations will continue to determine the final provisions within the 1915(c) and 1915(b) waivers.

To confirm that OPWDD is prepared for this transition into managed care, there have been meetings and plans developed around communications, logistics and quality assurance. OPWDD is also examining the possibility of providing support for DISCO start-up costs via a

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grant program that will use Balancing Incentive Program (BIP) funds to subsidize the pilot program. To prepare for evaluation beginning in fall 2014, OPWDD is developing care coordination guidance, continuing to test the new Coordinated Assessment System (CAS) via case study agencies, and defining quality improvement review processes.

Rate Rationalization Discussions

A new rate setting methodology was submitted to CMS for approval to comprehensively identify suitable and appropriate rates for providers billing for services. The proposed methodology recognizes a direct care staff hour as the core of new, standardized rates. The first services to use the new methodology will be voluntary operated intermediate care facility (ICF/DD) services, residential habilitation (supervised and supportive IRAs) and group day habilitation. New rates will be phased in over time, but the timeline for implementation is not yet determined.

Developmental Center Closures

In line with OPWDD's long-standing commitment to downsizing and closing institutions and achieving full community integration, in July 2013 OPWDD announced plans to close four institutional campuses over the next four years:

- The Oswald D. Heck Developmental Center in Schenectady, by March 31, 2015
- The Brooklyn Developmental Center in Brooklyn, by December 31, 2015
- The Broome Developmental Center in Binghamton, by March 31, 2016
- The Bernard M. Fineson Developmental Center in Queens, by March 31, 2017

Services and supports provided to individuals who reside in these four campus based facilities will transition to the community by the above dates, including services in specialized units such as those supporting individuals with autism, individuals with multiple disabilities, and those supported in Intensive Treatment units. The individual, his or her family, clinicians, and staff who support the individual will work together to develop a plan to provide appropriate services and supports in a community-based setting. Individuals will be encouraged to self-direct their services and plans will be developed that recognize the individuals' strengths, needs and goals.

OPWDD has set the closure date for each institution based on the planning processes already in place, and the date by which all individuals are anticipated to be successfully assisted in moving into the community. Individuals who continue to need more intensive treatment will receive necessary services in the setting most appropriate for them, with the goal of a community placement as soon as it is clinically appropriate.

OPWDD will retain a total institutional capacity of approximately 150. This capacity will be reserved for individuals with developmental disabilities who are court-mandated to OPWDD and those with intensive short-term behavioral needs that require stabilization in a focused, intensive treatment setting in order to achieve a successful return to a community-based setting.

Integrated Housing Options

When transitioning to the community, one specific type of residential setting will not meet the needs of all people with developmental disabilities. OPWDD is creating a continuum of housing options based on the support needs of individuals, personal resources and available government subsidies.

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OPWDD is increasing integrated housing options by taking significant steps, including: (1) maintaining existing partners in the housing industry; (2) cultivating new partners; and (3) collaborating with the CMS-Housing Technical Assistance group to build an infrastructure for non-certified/non-traditional housing. The following chart articulates OPWDD’s six goals and accompanying strategies for implementing an integrated housing platform in NYS.

Integrated Housing Platform

Expand the inventory of housing alternatives	<ul style="list-style-type: none"> • Increase rental subsidy opportunities • Provide incentives for developers to build integrated units for individuals with DD • Expand partnerships with the state and federal housing agencies
Increase access to rental subsidies	<ul style="list-style-type: none"> • Partner with state and local agencies to prioritize rental subsidy needs of people with DD • Track the distribution of housing choice vouchers for people with DD • Pursue and develop funding sources to expand rental assistance
Educate individuals with DD and other stakeholders about independent living options	<ul style="list-style-type: none"> • Implement a communications, advocacy, outreach and education plan • Build capacity of agencies to assist people with DD in making informed choices • Host forums on housing currently available to people with DD • Create DVDs and webinars for statewide access and distribution
Improve cross system collaboration so individuals can access supports and services more efficiently	<ul style="list-style-type: none"> • Align the work of OPWDD’s Office of Home & Community Living to support the following NYS initiatives: MFP Demonstration, BIP, 1915 b/c waiver applications, residential transitions and expansion of supportive housing, supportive employment services, and increasing self-direction.
Create sustainable living environments by funding housing supports	<ul style="list-style-type: none"> • Increase funding for environmental modifications • Continue the down payment assistance program • Create consistent funding for home repairs for homeowners
Improve housing alternatives for people with developmental disabilities	<ul style="list-style-type: none"> • Create a systemic infrastructure that puts people first and is based on self-direction • Work with the Interagency Housing Council to ensure cross systems collaboration

To advance the goals of the Integrated Housing Platform, OPWDD has partnered with the CMS Housing Capacity Building Initiative for Community Living Project Team to facilitate regional trainings entitled, “Accessing Housing Resources for People with Disabilities Transitioning from Institutions to the Community.” The first two regional trainings were held in Long Island and Batavia, New York.

OPWDD continues to pursue funding to develop and grow the supportive housing inventory in NYS. Meetings are being held with NYSHCR to define and refine OPWDD’s specific role in the supportive housing industry. Voluntary providers are increasing the number of proposals submitted to OPWDD for support of their application for the NYSHCR Unified Funding RFP. To

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date, OPWDD received 13 new proposals for supportive housing opportunities in the 2013 round of funding.

In addition, the partnership between the State of New York Mortgage Agency (SONYMA) and the Home of Your Own (HOYO) program has grown from a total of \$19.8 million to \$25 million in loans for individuals with developmental disabilities in four years.

OPWDD continues to play a vital role in the Governor's Supportive Housing Development Program to expand rental assistance. Under the Medicaid Redesign Team Program, 61 individuals will move to a less restrictive residential setting, including at least 21 supportive housing opportunities through Consolidated Supports and Services (CSS) and Individual Supports and Services (ISS) options.

Competitive Employment and Workshop Conversion

Employment, whether supported or competitive, is an important way to include individuals in the community and promote independence. A draft competitive employment plan was submitted to CMS on October 1, 2013. It includes information on how OPWDD will encourage businesses to hire people with developmental disabilities, increase opportunities for high school students to transition to employment, and improve the quality of supported employment services. From April through October, 2013, 273 new people were engaged in supported employment.

OPWDD will encourage growth in supported employment throughout the next few years by working collaboratively with the Adult Career and Continuing Education Services-Vocational Rehabilitation (ACCES-VR) and the New York State Commission for the Blind (NYSCB), and by creating a career planning service called Pathway to Employment, a person-centered, comprehensive career planning and support service that will be available by May. It is a focused and time limited service that engages participants in identifying career directions, provides instruction and training in pre-employment skills, and develops a plan for achieving integrated employment with rates exceeding the minimum wage. There are plans to improve job retention by creating financial incentives for providers to deliver supported employment, including a new supported employment billing and fee structure that more accurately reflects the cost of supported employment. In December 2014, OPWDD will release an annual report on its website on provider outcomes for supported employment.

As of July 1, 2013, OPWDD ended new enrollments in sheltered workshops. Plans are underway to convert sheltered workshops into alternative business models that create integrated employment opportunities for people with disabilities. Based on assessment scores, OPWDD estimates that 50 percent of workshop participants could successfully transition to competitive employment over six years. OPWDD will be proposing a multi-year strategy to identify and support workshop participants who are interested in competitive employment. Understanding that competitive employment is not appropriate for everyone, OPWDD is also supporting other options such as community habilitation, day habilitation, and consolidated supports and services (CSS) to support volunteer, recreation, senior center, or other community activities for people who are of retirement age. For the full employment plan, please visit:

http://www.opwdd.ny.gov/opwdd_services_supports/employment_for_people_with_disabilities/draft-plan-increase-employment-opps.

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Crisis Intervention and START

OPWDD is developing an initiative to address the need for community-based crisis prevention and intervention services to individuals with developmental disabilities and co-occurring behavioral health needs. OPWDD's goal is the establishment of an evidence-based model for crisis prevention and response that enhances partnerships with mental health support and treatment settings and programs.

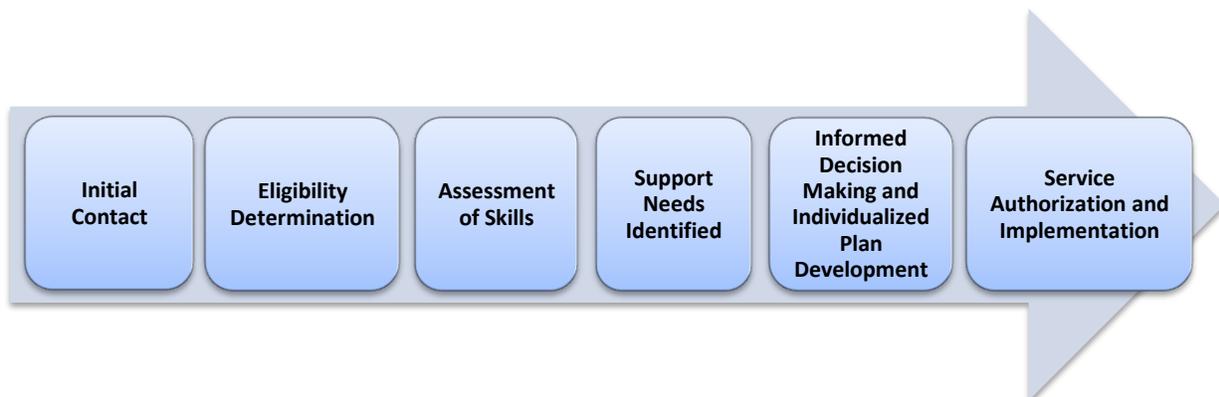
OPWDD partnered with leaders at the Center for START (Systemic, Therapeutic, Assessment, Respite and Treatment) Services in July 2012 to develop a START model in New York State. The model uses a cost-effective, best-practices approach that allows for maximum use of waiver eligible services and results in improved crisis prevention and intervention. NY START will be implemented statewide via a regional rollout over the next four to five years. Upon regional implementation of NY START, the program will establish linkage agreements between developmental disability and mental health agencies/providers to provide crisis prevention and response services. NY START will also develop site-based and in-home therapeutic respite services for planned and emergency use.

NY START Services will be operated by a community provider in Region 1 (Finger Lakes and Western NY) and operated by OPWDD in Region 3 (Capital District, Taconic, and Hudson Valley), with an expected launch date of January 2014. Following the full implementation, OPWDD will use data from Regions 1 and 3 to next develop and implement NY START in Region 4. OPWDD is committed to seeing the START services initiative to the point of statewide implementation, affirming the delivery of START services as a key component to community integration.

The Front Door

OPWDD launched a major initiative designed to provide a consistent, person-focused experience for individuals seeking services. The purpose of the Front Door is to promote self-determination and choice, ensure supports are provided in the most integrated setting possible, and provide increased opportunities and supports for employment. Since June 2013, more than 8,000 individuals have been assisted through the Front Door. OPWDD is currently in the process of assessing people's experience with the Front Door to ensure customer satisfaction and the smooth functioning of the process.

The Front Door process consists of six elements representing an individual's path to OPWDD services from their initial point of contact through service implementation.



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As shown, the Front Door uses a “no-wrong-door” or “single point of entry” approach so individuals have the same experience no matter where they start their inquiry. Staff and the individual review information about the person’s interests, skills, needs and goals in order to determine his or her eligibility for services and, if eligible, to identify the nature of supports needed. OPWDD staff explains potential service options and how they can meet the individual’s needs. The service coordinator helps the person develop an ISP to request the supports and providers that will best meet his or her needs. OPWDD reviews the service request, including the individual’s level of need and cost, and when authorized, services begin. As services are implemented, there are ongoing quality assessments to measure individual satisfaction, personal outcome attainment, and the effectiveness and efficiency of the provider(s).

Each OPWDD Regional Office has at least one Front Door Team. Front Door Team members have knowledge and expertise in intake, enrollment, self-direction, employment, housing, service planning, budgets/funding, billing, and the wide array of non-OPWDD services available to the individual.

As of June 2013, new people seeking services began using the Front Door process. This included young adults transitioning from public and residential schools. Eventually all individuals seeking services will go through the Front Door process, as well as those who experience a change in support needs or request a modification to their services.

Self-Direction

Self-direction offers individuals with disabilities and their circles of support more autonomy and decision-making authority over some or all of their supports and services. Self-direction is an alternative to provider managed programs where individuals are able to design and choose the habilitative services that best meet their needs and the staff who will support them.

To increase self-directed services statewide, OPWDD developed new processes at the Front Door to ensure that individuals, their family members, and other advocates as appropriate, are aware of all support options available and are educated about the option to self-direct services. Additionally, the Front Door processes help individuals to better understand what outcomes they are seeking from their services so they can make informed choices and receive the appropriate level of support. OPWDD has held 267 training sessions for 4,440 individuals with developmental disabilities and their family members to educate them about self-direction. By the end of 2013, 2,203 people self-direct their services statewide.

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CHAPTER III: County Plan Guidance and Forms

The mental hygiene local services planning process is expected 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. Mental Hygiene Priority Outcomes Form

The Mental Hygiene Priority Outcomes Form was introduced in 2008 as the first fully integrated county mental hygiene 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 two years ago. The form was streamlined to facilitate the development of more meaningful and realistic priorities, strategies, and performance metrics. It was also believed that the improved form and guidelines would better inform the state agency comprehensive statewide planning efforts. This year, some minor changes are being made to the form that will enhance the state's ability to categorize and analyze county priorities.

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 promote a convention for developing and writing effective priority outcome 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. The key word is "change." Avoid statements that focus on "maintaining" or "continuing" activity

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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 meaningful to split that priority outcome into separate priority statements, like "Expand residential treatment services to women," and "Expand primary prevention services into all school districts in the county."

Rationale

The rationale should be a brief (one to two paragraphs) explanation for including the priority outcome in the plan. The rationale helps to answer the question, "Why is the desired change necessary?" Include data that documents the need for pursuing this priority outcome. Note: There is a 200-word limit built into the form for this item.

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. Note: If there are no strategies that apply to a specific state agency, do not indicate that the priority outcome is applicable to that agency.

- OASAS
- OMH
- OPWDD

Priority Focus

For each applicable state agency checked above, indicate the option that most accurately describes the focus of this priority. Priorities that overlap into two or more focus categories can be further categorized by checking multiple options under the primary focus category selected.

OASAS Priority Focus: (check one)

- Service Capacity Expansion (check all that apply)
 - Crisis Services
 - Inpatient Treatment
 - Outpatient (non-opioid) Treatment
 - Opioid Treatment
 - Intensive Residential Treatment
 - Community Residential Treatment

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- Supportive Living Treatment
 - Prevention Services
 - Housing
 - Other Recovery Support Services
 - Services for a Target Population (specify population): _____
 - Other (specify): _____
- Service Improvement/Enhancement (check all that apply)
- Implement/Expand Best/Promising Practices
 - Implement/Expand Recovery Supports
 - Recruit/Retain Workforce
 - Train Workforce
 - Improve Outreach to a Target Population (specify population): _____
 - Other (specify): _____
- Service Coordination/Integration (check all that apply)
- Coordinate Care with MH, DD, and/or Primary Health Services
 - Coordinate Care with Recovery Support Services
 - Coordinate Care with Other Service Systems
 - Integrate Care with MH, DD, and/or Primary Health Services
 - Integrate Care with Recovery Support Services
 - Integrate Care with Other Service Systems
 - Cross-train Clinical Staff on Co-occurring Disorders
 - Other (specify): _____
- Service System Planning/Management (check all that apply)
- Engage/Expand Stakeholder Involvement in Planning
 - Conduct Strategic Planning Process
 - Conduct Needs Assessment
 - Develop Data Resources/Performance Measures
 - Seek New Funding Sources
 - Improve System Management/Oversight
 - Collaborate with BHO/Health Home/Others on Care Management/Oversight
 - Other (specify): _____
- Workforce Development (check all that apply)
- Recruit/Retain Workforce
 - Train Workforce (Cultural Competency)
 - Train Workforce (Treating Co-occurring Disorders)
 - Train Workforce (Evidence-based Practices)
 - Train Workforce (General/Other Topic Areas)
 - Improve Workforce Salaries/Benefits
 - Other (specify): _____

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OMH Priority Focus: (check one)

- Service Capacity Expansion/Add New Service
- Service Improvement/Enhancement
- Increase Access to Services
- Service Coordination/Integration
- Service System Planning/Management
- Workforce Development
- Outreach/Education
- Other (specify): _____

OPWDD Priority Focus: (check one)

- Housing (check all that apply)
 - Group Homes
 - Supported Housing
 - Home Ownership
 - Family Care/Shared Living
 - Rental Subsidies
 - Respite
 - Nursing Home Transition and Diversion
 - Institutional Transition
 - Other (specify): _____

- Employment (check all that apply)
 - Supported Employment
 - Competitive Employment
 - Workshop Conversion
 - Pre-vocational Services
 - Day Habilitation
 - Volunteering
 - Transition Services (School to Adult Services)
 - Other (specify): _____

- Health (check all that apply)
 - Crisis Intervention
 - Clinical Services
 - Emergency Preparedness
 - First Responder Training
 - Chronic Disease Prevention
 - Incident Management
 - Reproductive Health
 - Other (specify): _____

- Relationship Development and Community Supports (check all that apply)
 - Family Support Services
 - Faith-based Initiatives

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- Community Habilitation
- Direct Support Workforce
- Clinical Workforce
- Public Education and Training
- Other (specify): _____

- Putting People First (check all that apply)
 - Self-direction
 - Access to Services/Front Door
 - Managed Care Transition
 - Other (specify): _____

- Infrastructure (check all that apply)
 - Cross-system Collaboration
 - Funding Systems
 - Communications
 - Quality Improvement
 - Other (specify): _____

Rank Order Top Priorities

Not all priorities are of equal value. When the state agencies analyze individual county priorities, or priorities on a regional or statewide basis, there has to be a way to provide relative weight to them. 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 rank order the top five priorities in your plan. You do not have to rank priorities by disability. If the plan contains fewer than six priorities, all priorities will be rank ordered. You will not be able to certify this form until you have rank ordered your 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.

Example #2: Increase the number of clinical staff 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.

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Metrics

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% (from X to Y) by the end of 2014.

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

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

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

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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. Currently, there are three counties with an approved Outpatient Sub-County Service Plan.

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.

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

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

In 2004, OASAS asked that these arrangements be formally documented in the plan of each county involved in the collaboration, for two very important reasons. First, it establishes such arrangements as official policy in a public planning document. Second, it provides OASAS with the basis for applying the need methodology at a geographic level other than the standard

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county level. Today, there are 14 counties that have entered into five separate Community Residence Multi-County Collaborative Agreements.

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;
- 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.

D. County Needs Assessment Survey

The current OASAS treatment need methodology was implemented in 2003 and has undergone periodic adjustments over the past decade. Considering the evolution of the substance use

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disorder treatment system during that time and the dramatic changes underway today, the entire methodology is now under review. As OASAS considers the development of a new methodology for estimating specific treatment service needs at the county, region and state levels, counties are being asked to complete this survey to inform the state about: 1) how local service needs are determined, 2) how accessible services are or should be, 3) the extent to which local treatment needs are being met and where service gaps may exist, and 4) existing barriers to accessing treatment. All questions regarding this survey should be directed to Jean Audet at 518-485-2410 or at Jean.Audet@oasas.ny.gov.

1. **Resources for Identifying Service Needs:** How important is each of the following resources in identifying substance use disorder problems and service needs in your county?

Needs Assessment Resources	Very Important	Somewhat Important	Not Very Important	Resource Not Used
Public forums or hearings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Focus groups on specific topics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Advisory group/task force/coalition reports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CSB/sub-committee/provider meetings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Population surveys	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Patient satisfaction/perception of care surveys	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Provider surveys	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Provider waiting lists	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OASAS client data/LGU Inquiry Reports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OASAS treatment need methodology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medicaid data	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other secondary data (e.g., census, health stats)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify): <input style="width: 50px;" type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. **Service Areas:** From a service planning perspective, indicate whether each service listed below should be considered primarily a county or regional resource (i.e. should the service be available in every county or should it be accessible within a multi-county service area?) If you indicate that the service should be a regional resource, identify the counties that you believe fall within your county's service area for that particular service.

Service	County Resource	Regional Resource	Counties in service area
Medically Managed Detoxification	<input type="checkbox"/>	<input type="checkbox"/>	_____
Medically Supervised Withdrawal Inpatient	<input type="checkbox"/>	<input type="checkbox"/>	_____
Medically Supervised Withdrawal Outpatient	<input type="checkbox"/>	<input type="checkbox"/>	_____
Medically Monitored Withdrawal	<input type="checkbox"/>	<input type="checkbox"/>	_____
Inpatient Rehabilitation Treatment	<input type="checkbox"/>	<input type="checkbox"/>	_____
Outpatient Treatment (non-opioid)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Opioid Treatment	<input type="checkbox"/>	<input type="checkbox"/>	_____
Intensive Residential Treatment	<input type="checkbox"/>	<input type="checkbox"/>	_____
Community Residential Treatment	<input type="checkbox"/>	<input type="checkbox"/>	_____
Supportive Living Facility	<input type="checkbox"/>	<input type="checkbox"/>	_____
Primary Prevention	<input type="checkbox"/>	<input type="checkbox"/>	_____
Prevention Counseling	<input type="checkbox"/>	<input type="checkbox"/>	_____
Housing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Recovery Supports	<input type="checkbox"/>	<input type="checkbox"/>	_____

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3. **Assessment of Service Capacity Within County or Region:** For each service listed below, indicate whether there is sufficient or insufficient capacity available within your county or region to meet the needs of the residents of your county. (NOTE: If you indicated above that the service should be considered a regional resource, assess available capacity for that service on a regional level.) If you indicate that the capacity within your county is insufficient, indicate whether filling the service gap represents a high, moderate, or low priority. (NOTE: When determining priority level, assess each service relative to all other services.)

Service	Sufficient Capacity	Insufficient or unavailable capacity		
		High Priority	Moderate Priority	Low Priority
Medically Managed Detoxification	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medically Supervised Withdrawal Inpatient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medically Supervised Withdrawal Outpatient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medically Monitored Withdrawal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inpatient Rehabilitation Treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Outpatient Treatment (non-opioid)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Opioid Treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intensive Residential Treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Community Residential Treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Supportive Living Facility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Primary Prevention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prevention Counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Housing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recovery Supports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. **Access to Services by Population Group:** For each population group listed below, indicate the extent to which you believe it has access to needed services. If you indicate that access is insufficient, indicate whether filling the service gap for that population is a high, moderate, or low priority, and identify the services that are lacking for that population within your county or region. (NOTE: When determining priority level, assess each service relative to all other services.)

Population Group	Sufficient Access	Insufficient Access			Services that are lacking
		High Priority	Moderate Priority	Low Priority	
General Population	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Men	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Women	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Women with Children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Adolescents (under age 18)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Young Adults (age 18 to 24)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seniors (60+)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Persons with Co-occurring Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Veterans	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
LGBT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other (specify): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other (specify): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

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5. **Barriers to Accessing Treatment:** How significant would you say each of the following barriers to treatment are for the residents in your county?

Barriers to Treatment	Significant Barrier	Moderate Barrier	Minor Barrier	Not a Barrier
Not enough service capacity in county	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appropriate services not available in county	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Waiting time to get admitted to treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Individuals not being referred to treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insufficient case management/care coordination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lack of insurance coverage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insurance/managed care restrictions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Restrictive government regulations/policies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insufficient childcare services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insufficient transportation services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insufficient culturally competent clinical staff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stigma, cultural/language barriers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify): <input style="width: 50px; height: 15px;" type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify): <input style="width: 50px; height: 15px;" type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

The following question pertains to the OMH State psychiatric inpatient transformation and Regional Centers of Excellence. All questions regarding this question should be directed to Jeremy Darman at 518-474-4403 or at Jeremy.Darman@omh.ny.gov.

6. **Local needs to support State psychiatric inpatient transformation and Regional Centers of Excellence:** What types of services and/or supports does your locality need to assist in reducing avoidable admissions and reduce length of stay in inpatient psychiatric facilities (Article 28, 31, and State-operated)?

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E. 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 2015 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 2015 local services planning process.

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F. Multiple Disabilities Consideration Form

LGU: _____

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

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

Yes No

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

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

Yes No

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

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

Yes No

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

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G. 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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H. 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.

**2015 Local Services Plan Guidelines
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I. 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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J. 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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K. 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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L. DDRO 2015 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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CHAPTER IV: OASAS Provider Plan Guidance and Forms

The local services planning process for addiction services relies on the partnership between OASAS, the LGUs, 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 limited 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 not 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 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 **Tuesday, April 1, 2014**. Each survey includes the name and contact information of the OASAS staff person responsible for that survey and who can answer any questions you have about it. 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)
- 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 in the Official Compilation of the

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Codes, Rules and Regulations of the State of New York. For additional information, 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 Matt Kawola by phone at 518-457-6129, or by e-mail at Matt.Kawola@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: 20.0).

2. How are **health coordination** services provided to patients in each program operated by your agency? (check all that apply)

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

3. Please provide the following information for each PRU where those paid staff and in-kind services are provided. If multiple individuals provide these services at a single program, provide the total hours worked and the hourly pay rate for each individual. For hourly pay rate, use number format without a dollar sign (example: 35.00).

PRU	Program Name	Services Provided		Hours/Week Worked as a Health Coordinator	Hourly Rate (dollars)
		On-site	Off-site		
a) PRU #1	Program Name #1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
b) PRU #2	Program Name #1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
c) PRU #3	Program Name #1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
d) PRU #3	Program Name #1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>

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 average hourly rate paid. For dollars paid, use number format without a dollar sign comma (example: 35.00).

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PRU	Program Name	Service Provided		Hours per Week	Hourly Rate (dollars)
		On-site	Off-site	Worked as a Health Coordinator	
a) PRU #1	Program Name #1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
b) PRU #2	Program Name #2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
c) PRU #3	Program Name #3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>

End of survey. Thank you for your cooperation.

B. 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 repeating the Drug Use Trend Survey to monitor regional and statewide trends in drug use behavior. A detailed analysis of last year's survey is available on the CPS County Data Page [CPS County Data Page](#).

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 Jean.Audet@oasas.ny.gov.

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. Synthetic Marijuana	<input type="checkbox"/>				
f. Heroin	<input type="checkbox"/>				
g. Other Synthetic Opiates (specify): <input type="text"/>	<input type="checkbox"/>				
h. Tranquilizers/Sedatives (specify): <input type="text"/>	<input type="checkbox"/>				
i. Amphetamines/Other Stimulants	<input type="checkbox"/>				
j. Cocaine	<input type="checkbox"/>				
k. Crack	<input type="checkbox"/>				
l. MDMA (Ecstasy and Molly)	<input type="checkbox"/>				
m. Methamphetamine	<input type="checkbox"/>				
n. PCP	<input type="checkbox"/>				
o. LSD	<input type="checkbox"/>				
p. Other Hallucinogens (specify): <input type="text"/>	<input type="checkbox"/>				
q. Inhalants (specify): <input type="text"/>	<input type="checkbox"/>				
r. Bath Salts	<input type="checkbox"/>				
s. Anabolic Steroids	<input type="checkbox"/>				
t. Other Substance (specify): <input type="text"/>	<input type="checkbox"/>				

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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. Synthetic Marijuana	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Heroin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Other Synthetic Opiates (specify): <input style="width: 50px;" type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Tranquilizers/Sedatives (specify): <input style="width: 50px;" type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Amphetamines/Other Stimulants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Cocaine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Crack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. MDMA (Ecstasy and Molly)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. Methamphetamine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n. PCP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o. LSD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p. Other Hallucinogens (specify): <input style="width: 50px;" type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
q. Inhalants (specify): <input style="width: 50px;" type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
r. Bath Salts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
s. Anabolic Steroids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
t. Other Substance (specify): <input style="width: 50px;" type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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)

End of survey. Thank you for your cooperation.

Terms Defined for the Drug Use Trends 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 Percocet, Percodan, Vicodin, OxyContin, Codeine, Demerol, Dilaudid, Morphine, Non-prescription Methadone, other drugs derived from opium.

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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*)

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

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. (NOTE: Recent state and federal controls placed on the sale and possession of bath salts and its component chemicals have significantly curtailed the availability of bath salts and its component ingredients.) 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 Lightning, 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*)

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C. Hepatitis C Virus (HCV) Practices Survey (Treatment Programs)

OASAS is conducting this survey of current practices surrounding hepatitis C virus (HCV) screening and testing to help address gaps in service and create a network of care for HCV patients. All questions related to this survey should be directed to Steven Kipnis, M.D. at Steven.Kipnis@oasas.ny.gov.

1. In the past year, has this program tested any clients for HCV infection? (check all that apply)
 - a) Yes, program staff directly provide HCV testing for clients. (skip to 2)
 - b) No, an outside provider/program comes to this clinic and directly provides HCV testing.
 - c) No, this program refers its clients to an outside agency for HCV testing.
 - d) No, this program does not offer HCV testing for clients at this time.
 - e) Don't know. (skip to 8)

- 1a. Why has this program not directly tested participants for HCV infection? (check all that apply)
 - a) This program is not set up to test.
 - b) Clients have been tested at a different site.
 - c) This program does not serve a population at risk for hepatitis C.
 - d) This program cannot pay for clinical evaluation and treatment.
 - e) This program cannot pay for test.
 - f) This program does not have testers who are trained in hepatitis C testing.
 - g) This program refers its clients to an outside agency for HCV testing.
 - h) An outside provider comes in and provides HCV testing for our clients on site.
 - i) Other (specify):
 - j) Don't know

(skip to 8)

2. Which of the following tests does this program provide? (check all that apply)
 - a) Hepatitis C antibody test. (NOTE: Antibody testing is the first test performed to see if the person has ever been exposed to the hepatitis C virus. It can be done with a blood draw or a finger stick.)
 - b) Hepatitis C rapid antibody testing (e.g.; OraQuick®).
 - c) Hepatitis C PCR or RNA test. (NOTE: This is a confirmatory test performed after a person tests positive for the hepatitis C antibody, and determines if the person currently has hepatitis C virus in the blood.)
 - d) Don't know

3. Does this program have a written policy for providing reflex RNA testing for clients who test positive for the HCV antibody? (NOTE: Reflex testing is when a laboratory automatically performs the RNA confirmatory test after a positive initial antibody test. This eliminates the extra step of collecting a second blood sample from a participant who tests positive at the initial screen for HCV antibodies.)
 - a) Yes
 - b) No

4. Approximately what percent of this program's clients receive their HCV test results?
 - a) 0 to 25%
 - b) 26% to 50%
 - c) 51% to 75%
 - d) 76% to 100%
 - e) Don't know

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5. Does this program have a standard written procedure to check the prior chart of a client that leaves and then re-enrolls in this program for a previous HCV antibody or RNA confirmatory test before they are re-tested?
- a) Yes, we have a written procedure.
 - b) No, we do not have a specific written procedure but we regularly check the clients' prior charts for previous test results.
 - c) No, we do not have a specific written procedure and we do not regularly check for previous test results.
 - d) Don't know
6. If a client is uninsured or their insurance doesn't cover the HCV test (antibody or RNA), what is this program's policy for covering the cost of services?
- a) Client must pay the full amount.
 - b) Client is charged a reduced amount (sliding scale fees).
 - c) This program provides the test at no cost to client.
 - d) Client is referred to an assistance program.
 - e) This program has no payment policy.
 - f) Don't know.
 - g) Other (explain):
7. Select the procedures that are routinely conducted at this program with clients who are confirmed RNA positive (currently have HCV infection, not just exposed to the virus). (check all that apply)
- a) Hepatitis B vaccine, if susceptible. (skip to 8)
 - b) Hepatitis A vaccine, if susceptible. (skip to 8)
 - c) Medical care on site, including management and potential treatment of HCV.
 - d) Mental health evaluation. (skip to 8)
 - e) Alcohol counseling. (skip to 8)
 - f) Refer to outside medical provider for management and potential treatment of HCV. (skip to 8)
 - g) None, this program does not provide any of the above services for clients who are confirmed RNA positive. (skip to 8)
- 7a. Approximately what percent of this program's hepatitis C RNA-positive clients were clinically evaluated for treatment in the last year?
- a) 0 to 25%
 - b) 26% to 50%
 - c) 51% to 75%
 - d) 76% to 100%
 - e) Don't know
- 7b. Approximately what percent of this program's RNA-positive clients were treated with antivirals in the past year at this program?
- a) 0 to 25%
 - b) 26% to 50%
 - c) 51% to 75%
 - d) 76% to 100%
 - e) Don't know

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8. Approximately what percent of all of this program's clients received an HCV antibody test in the past year? (Please include all HCV tests this program's clients received, whether they were provided directly by the program or by an outside program or via referral. To get this number, you may need to look in charts, your patient billing system, or Electronic Health Record.)
- a) 0 to 25%
 - b) 26% to 50%
 - c) 51% to 75%
 - d) 76% to 100%
 - e) Don't know
9. Approximately what percent of this program's clients who tested positive for the HCV antibody received a RNA confirmatory test in the last year? (The RNA confirmatory test is the test given after a positive antibody test to see if the person currently has the HCV virus.)
- a) 0 to 25%
 - b) 26% to 50%
 - c) 51% to 75%
 - d) 76% to 100%
 - e) Don't know
10. Approximately what percent of this program's clients have chronic (current) HCV infection? (Insert percentage between 0 and 100)
- %
11. Approximately what percent of this program's clients are uninsured?
- a) 0 to 25%
 - b) 26% to 50%
 - c) 51% to 75%
 - d) 76% to 100%
 - e) Don't know
12. Approximately what percent of this program's clients are covered by public insurance (including Medicaid or Medicare)?
- a) 0 to 25%
 - b) 26% to 50%
 - c) 51% to 75%
 - d) 76% to 100%
 - e) Don't know
13. Does this program provide a linkage to care for HCV? (Linkage to care requires active facilitation of booking appointments, accompaniment to appointments, and/or following up with future medical appointments.)
- a) Yes
 - b) No
14. What are the barriers this program experiences to making effective linkages with other agencies to provide its participants with HCV-related services that this program cannot provide directly? (Check all that apply)
- a) Time
 - b) Unaware of where to refer clients.
 - c) Can't find providers that speak the client's language.
 - d) Insurance coverage limitations of population.
 - e) Lack of protocol for referrals or linkages.

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f) Other (specify):

15. Which of the following services might be helpful to improve HCV testing at this program? (Check all that apply)

- a) RNA testing.
- b) Training and/or Grand Rounds.
- c) Financial support to provide on-site testing.
- d) Financial/linkage support to provide peer health navigators/care coordinators.
- e) Other (specify):

End of survey. Thank you for your cooperation.

D. Buprenorphine Prescribing in a Managed Care Environment Survey (Treatment Programs)

OASAS supports patient centered care and the use of addiction medications when appropriate. This survey is being conducted to assess current buprenorphine prescribing experiences in a managed care environment to help inform the development of policy and practice standards. All questions related to this survey should be directed to Steven Kipnis, M.D. at Steven.Kipnis@oasas.ny.gov.

1. Does this program's physician write prescriptions for buprenorphine to any of its patients?
 - a) Yes
 - b) No

2. Does this program utilize "doctors orders" for prescribing buprenorphine?
 - a) Yes
 - b) No

3. Is prior authorization by insurance companies/payers required before this program can prescribe buprenorphine to its patients?
 - a) Yes, all of this program's payers require prior authorization
 - b) Yes, at least one of this program's payers require prior authorization
 - c) No (skip to 10; if "No" to #1 and #2, skip to end)

4. How long does the insurance company/payer authorization decision generally take?
 - a) Same day
 - b) 24 hours
 - c) 48 hours
 - d) Longer than 48 hours

5. Has this program ever had an authorization for buprenorphine denied by a payer?
 - a) Yes, always
 - b) Yes, sometimes
 - c) No (skip to 10)

6. What justifications were given for denying authorization to prescribe buprenorphine?

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7. Did this program ever appeal a denial to prescribe buprenorphine?
 a) Yes
 b) No (skip to 10)

8. Has an appeal ever resulted in a reversal of a denial to prescribe buprenorphine?
 a) Yes, always
 b) Yes, sometimes
 c) No (skip to 10)

9. How long does a decision on an appeal generally take?
 a) 24 hours
 b) 48 hours
 c) Longer than 48 hours

10. Has the approved duration of a buprenorphine prescription ever been limited (i.e. approving only for detox, not for maintenance)?
 a) Yes
 b) No

11. Has an insurance company/payer ever restricted a buprenorphine formulation (i.e. tablet, film)?
 a) Yes
 b) No

12. Has an insurance company/payer ever restricted a buprenorphine dosage?
 a) Yes
 b) No

13. Are there additional experiences with insurance companies/payers regarding buprenorphine prescribing practices that you would like to make OASAS aware?

End of survey. Thank you for your cooperation.

E. Prevention Provider Workforce Survey (Prevention Providers)

OASAS estimates that the number of staff delivering prevention services at funded agencies has decreased by about 40% over the last five years. This survey will provide a better understanding of the characteristics of the prevention workforce in order to plan for the effective use of resources; promote efficient types of prevention services; maximize the impact of the local, state, and federal prevention efforts; and support reliable outcome evaluations. The goal of the survey is to develop general guidance and best-practice tips for prevention providers.

Unless otherwise stated, “staff” refers to those individuals who are [1] at least partially supported by OASAS funds and [2] provide direct services to the actual activity participants. When answering these questions, staff and volunteers should be categorized as working in either primary prevention services only, other prevention services only, or splitting their time between primary and other prevention services.

All questions related to this survey should be directed to Newton Walker at 518-485-7438 or at Newton.Walker@oasas.ny.gov.

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1. How many full-time and part-time staff currently provide direct care services in your OASAS-funded prevention programs and how many do you anticipate providing direct care services during the next fiscal year (July 2014 – June 2015)?

Paid Staff	Current Fiscal Year (7/13-6/14)			Next Fiscal Year (7/14-6/15)		
	Primary Prevention Only	Other Prevention Only	Primary and Other Prevention	Primary Prevention Only	Other Prevention Only	Primary and Other Prevention
a) Full-time	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
b) Part-time	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

2. Of the number of current staff indicated in #1 above, indicate how long they have been employed by this organization?

	Primary Prevention Only	Other Prevention Only	Primary and Other Prevention
a) At least 7 years	<input type="text"/>	<input type="text"/>	<input type="text"/>
b) At least 3 but less than 7 years	<input type="text"/>	<input type="text"/>	<input type="text"/>
c) At least 1 but less than 3 years	<input type="text"/>	<input type="text"/>	<input type="text"/>
d) Less than 1 year	<input type="text"/>	<input type="text"/>	<input type="text"/>

3. Of the number of current staff indicated in #1 above, indicate the number that has achieved each level of education?

	Primary Prevention Only	Other Prevention Only	Primary and Other Prevention
a) Ph.D. or M.D.	<input type="text"/>	<input type="text"/>	<input type="text"/>
b) Masters Degree	<input type="text"/>	<input type="text"/>	<input type="text"/>
c) Bachelors Degree	<input type="text"/>	<input type="text"/>	<input type="text"/>
d) Associates Degree	<input type="text"/>	<input type="text"/>	<input type="text"/>
e) Some Post-High School Education	<input type="text"/>	<input type="text"/>	<input type="text"/>
f) High School or GED Graduate	<input type="text"/>	<input type="text"/>	<input type="text"/>
g) Less than High School Graduate	<input type="text"/>	<input type="text"/>	<input type="text"/>

4. Of the number of current staff indicated in #1 above, indicate the numbers that possess each of the following prevention or treatment credentials?

	Primary Prevention Only	Other Prevention Only	Primary and Other Prevention
a) Credentialed Prevention Professional (CPP)	<input type="text"/>	<input type="text"/>	<input type="text"/>
b) Credentialed Prevention Specialist (CPS)	<input type="text"/>	<input type="text"/>	<input type="text"/>
c) Credentialed Problem Gambling Counselor (CPGC)	<input type="text"/>	<input type="text"/>	<input type="text"/>
d) Credentialed Alcoholism and Substance Abuse Counselor (CASAC)	<input type="text"/>	<input type="text"/>	<input type="text"/>

5. How many full-time and part-time volunteers currently provide direct care services in your OASAS-funded prevention programs and how many do you anticipate providing direct care services during the next fiscal year (July 2014 – June 2015)?

Volunteers	Current Fiscal Year (7/13-6/14)			Next Fiscal Year (7/14-6/15)		
	Primary Prevention Only	Other Prevention Only	Primary and Other Prevention	Primary Prevention Only	Other Prevention Only	Primary and Other Prevention
a) Full-time	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
b) Part-time	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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6. Does this program collaborate with the following groups in the delivery of prevention services? With how many formal community coalitions and other organizations (e.g., Men's or Women's Clubs, PTA, special interest groups, etc.) does this program collaborate?

	<u>Yes</u>	<u>No</u>	<u>Number of Organizations</u>
a) Community Coalitions	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 50px; height: 20px;" type="text"/>
b) Other Community Organizations	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 50px; height: 20px;" type="text"/>

End of survey. Thank you for your cooperation.

Term Defined for the Prevention Provider Workforce Survey

Community Coalitions – A community coalition is a group of stakeholders who represent diverse organizations and community constituents who agree to work together to achieve a common goal to reduce alcohol use and abuse, other substance abuse, and problem gambling behaviors in their community. A viable coalition should meet regularly with an agenda and recorded minutes of each meeting, have an organizational structure, and operate under written by-laws.

F. Evidence-Based and Best Practice Interventions Survey (Treatment Programs)

It is an ongoing priority of OASAS to strengthen the field of prevention, treatment, and recovery by supporting the adoption of administrative, clinical, and programmatic practices that are supported by evidence and science-based research. To understand the extent to which evidence-based practices (EBPs) and established best practices are being utilized by OASAS-certified and funded treatment providers, the cooperation of all program units is being sought through the completion of an Evidence-Based Practices Survey as part of the 2015 local services planning process. In addition, to better understand how to increase the capacity of addiction outpatient programs to provide integrated clinical care for individuals with co-occurring substance use and mental disorders, OASAS has continued its collaboration with the Center for Excellence in Integrated Care (CEIC) to include survey questions specific to integrated care and the use of evidence-based practices in those settings. Those EBPs are ideally tailored to meet the needs of patients with co-occurring disorders with the intent of improving their health and well-being.

The New York State Health Foundation, in collaboration with OASAS and OMH, established the CEIC to function in partnership with other interested constituencies to increase the capacity of New York State's addiction and mental health outpatient clinics to provide integrated clinical care for people with co-occurring conditions. That would include but not be limited to the implementation and use of selected EBPs for integrated treatment.

This year's survey is a follow-up to the evidence-based practices surveys that were completed by treatment programs in 2008, 2010, and 2012. Those bi-annual EBP surveys provided OASAS with baseline and comparative data about programs' adoption of EBPs and their implementation stage. The primary objectives of this year's survey are to contrast and compare current responses with the three prior surveys, as well as identify trends that indicate, and are supportive of, programs' implementing and sustaining evidence-based practices. For selected EBPs, if you indicate that implementation in your program is at least at the **implementation stage**, which would include those EBPs tailored for individuals presenting with co-occurring disorders, you will be prompted to answer additional follow-up questions. Therefore, it is very important that this survey be completed by either the program director or the clinical director responsible for the treatment practices used by the program. In addition, OASAS staff may

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contact a sample of programs to obtain additional detail about the implementation process for the specific EBPs identified.

For the purposes of this survey, the following terms should be used to evaluate and assess the program's stage of implementation of the EBP and/or best practice, (Fixsen, Naoom, Blasé, & Wallace, 2007). When considering the appropriate stage of implementation, it is important to remember that a decision to adopt a particular innovation cannot be considered implementation of that innovation.

For each of the practices or approaches below, please indicate the stage of implementation within this program. If this program has not yet considered implementation of a particular practice, you must indicate "Not Applicable." Sections C, E and G are specific to practices for persons with co-occurring psychiatric conditions. These are person-centered approaches for improving access to treatment that have been demonstrated to be effective for this population. If you move your cursor over a term or phrase that is hyperlinked, you will see a definition. Additional information about this survey, including helpful links and the complete glossary of terms and phrases used in this survey are also included in the local services plan guidelines and are accessible through the link above. All questions related to the completion of this survey should be directed to Ms. Pat Lincourt at 518-457-1011 or Pat.Lincourt@oasas.ny.gov.

	Implementation Stage					Not Applicable
	Exploration	Installation	Implementation	Innovation	Sustainability	
A. Screening and Assessment:						
1) Screening for Co-Occurring Disorders	<input type="checkbox"/>					
2) Assessment for Co-Occurring Disorders	<input type="checkbox"/>					
3) CRAFFT (Screening Tool)	<input type="checkbox"/>					
4) GAIN (Global Appraisal of Individual Needs)	<input type="checkbox"/>					
5) GAIN – SS (Global Appraisal of Individual Needs –Short Screen)	<input type="checkbox"/>					
6) Other (Specify): <input style="width: 50px;" type="text"/>	<input type="checkbox"/>					
B. Clinical Practices and Interventions:						
1) Motivational Interviewing (MI)	<input type="checkbox"/>					
2) Cognitive-Behavioral Therapy (CBT)	<input type="checkbox"/>					
3) Contingency Management (CM)	<input type="checkbox"/>					
4) Behavioral Couples Therapy (BCT)	<input type="checkbox"/>					
5) Brief Intervention Therapy	<input type="checkbox"/>					
6) Twelve-Step Facilitation (TSF)	<input type="checkbox"/>					
7) Anger Management	<input type="checkbox"/>					
8) Relapse Prevention	<input type="checkbox"/>					
9) Trauma-Related Counseling	<input type="checkbox"/>					
10) Matrix Model	<input type="checkbox"/>					
11) Rational Emotive Behavioral Therapy/REBT	<input type="checkbox"/>					
12) Other (Specify): <input style="width: 50px;" type="text"/>	<input type="checkbox"/>					
C. Clinical Practices and Interventions Specific to Treating Patients with Co-occurring Disorders:						
1) Motivational Interviewing (MI)	<input type="checkbox"/>					
2) Cognitive-Behavioral Therapy (CBT)	<input type="checkbox"/>					
3) Contingency Management (CM)	<input type="checkbox"/>					

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- | | | | | | | |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 4) Behavioral Couples Therapy (BCT) | <input type="checkbox"/> |
| 5) <u>Mutual Self-Help Groups</u> | <input type="checkbox"/> |
| 6) Other (Specify): <input style="width: 40px;" type="text"/> | <input type="checkbox"/> |

D. Evidence-based Practices Specific to Adolescents:

- | | | | | | | |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1) Motivational Enhancement Therapy/
Cognitive Behavioral Therapy (MET/CBT) | <input type="checkbox"/> |
| 2) Adolescent Community Reinforcement
Approach (ACRA) | <input type="checkbox"/> |
| 3) Assertive Continuing Care (ACC) | <input type="checkbox"/> |
| 4) Multidimensional Family Therapy (MDFT) | <input type="checkbox"/> |
| 5) Functional Family Therapy (FFT) | <input type="checkbox"/> |
| 6) The Seven Challenges | <input type="checkbox"/> |

E. Achieving Integrated Care/Services for Treating Patients with Co-occurring Disorders:

- | | | | | | | |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1) <u>Achieving Integrated Care/Services</u> | <input type="checkbox"/> |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|

F. Medication Assisted Therapy (Pharmacotherapy):

- | | | | | | | |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1) <u>Buprenorphine</u>
<u>(Subutex®/Suboxone®)</u> | <input type="checkbox"/> |
| 2) <u>Methadone</u> | <input type="checkbox"/> |
| 3) <u>Naltrexone (oral) and</u>
<u>Vivitrol® (injectible Naltrexone)</u> | <input type="checkbox"/> |
| 4) <u>Acamprosate (Campral®)</u> | <input type="checkbox"/> |
| 5) <u>Nicotine Replacement Therapies</u> | <input type="checkbox"/> |
| 6) <u>Disulfiram/Antabuse</u> | <input type="checkbox"/> |
| 7) Other (Specify): <input style="width: 40px;" type="text"/> | <input type="checkbox"/> |

G. Psychotropic Medication for Treating Patients:

- | | | | | | | |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1) <u>Psychotropic Medication for Treating</u>
<u>Patients with Co-occurring Disorders</u> | <input type="checkbox"/> |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|

H. Process Improvement Administrative Practices:

- | | | | | | | |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1) <u>Process Improvement</u> | <input type="checkbox"/> |
| 2) Other Process Improvement Practice
(Specify): <input style="width: 40px;" type="text"/> | <input type="checkbox"/> |

Follow-up Questions to “Screening for Co-Occurring Disorders” (Question A1)

A1a. Does this program have a documented implementation plan for **Screening for Co-Occurring Disorders**?

Yes
 No

A1b. Does this program have written policy and procedures related to the implementation of this EBP?

Yes
 No

A1c. Has this program received staff training by an OASAS-approved education and training provider on this screening process/instrument?

Yes
 No

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A1d. Are positive screen findings incorporated into the treatment plans?

- Yes
 No

A1e. Does this program have documented service agreements (e.g., a Memorandum of Understanding, contract, etc.) with Mental Health service providers?

- Yes
 No

Follow-up Questions to "Assessment for Co-Occurring Disorders" (Question A2)

A2a. Is there a distinct section in the assessment tool that identifies the presence of a mental health condition?

- Yes
 No

A2b. Does a formal mental health assessment, if necessary, typically occur for each patient?

- Yes
 No

A2c. Is there a licensed or certified health professional on staff that can conduct the mental health assessment?

- Yes
 No

A2d. Does the mental health assessment typically lead to the formulation and recording of a mental health diagnosis in the clinical record?

- Yes
 No

A2e. Are changes in mental health status routinely documented in the clinical record during the course of treatment?

- Yes
 No

A2f. Is the interaction of the patient's mental health condition with his or her substance use documented in the assessment?

- Yes
 No

A2g. Does this program provide feedback to staff for the purpose of improving the proficiency of their skills used in **assessing** patients who have a co-occurring mental health condition?

- Yes
 No

A2h. Are there Quality Assurance systems in place to monitor the Assessment of Mental Health Conditions?

- Yes
 No

Follow-up Questions to "Motivational Interviewing" (Question B1)

B1a. Does this program have a documented implementation plan for **Motivational Interviewing**?

- Yes
 No

B1b. Has staff from this program received training on **Motivational Interviewing**?

- Yes
 No

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B1c. Has this program revised its assessment and treatment plan instruments to reflect the integration of **Motivational Interviewing**?

- Yes
 No

B1d. Does this program provide periodic observation of staff utilizing **Motivational Interviewing**?

- Yes
 No

If "Yes" to B1d:

B1e. Does this program provide feedback to staff for the purpose of improving the proficiency of their skills used in **Motivational Interviewing**?

- Yes
 No

Follow-up Questions to "Cognitive-Behavioral Therapy" (Question B2)

B2a. Does this program have a documented implementation plan for **Cognitive-Behavioral Therapy**?

- Yes
 No

B2b. Has staff from this program received training on **Cognitive-Behavioral Therapy**?

- Yes
 No

B2c. Has this program revised its assessment and treatment plan instruments to reflect the integration of **Cognitive-Behavioral Therapy**?

- Yes
 No

B2d. Does this program provide periodic observation of staff utilizing **Cognitive-Behavioral Therapy**?

- Yes
 No

If "Yes" to B2d:

B2e. Does this program provide feedback to staff for the purpose of improving the proficiency of their skills used in **Cognitive-Behavioral Therapy**?

- Yes
 No

Follow-up Questions to "Motivational Interviewing (COD)" (Question C1)

C1a. Does this program utilize **motivational interviewing** to help patients resolve ambivalence about engaging in mental health treatment or taking psychotropic medication for their mental disorder?

- Yes
 No

C1b. Does this program have a documented implementation plan for the utilization of **motivational interviewing** for patients who have a co-occurring mental health condition?

- Yes
 No

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- C1c. Has staff from this program received training on applying **motivational interviewing** with patients to address their co-occurring mental health condition or the interaction between their mental health and substance use issues?
 Yes
 No
- C1d. Do the assessment and treatment plan sections of COD patients' clinical record reflect the use of **motivational Interviewing**?
 Yes
 No
- C1e. Does this program provide feedback to staff to improve their skills in applying **motivational Interviewing** with patients who have a co-occurring mental health condition?
 Yes
 No
- C1f. Are there Quality Assurance systems to monitor the use of **motivational interviewing** with co-occurring patients?
 Yes
 No

Follow-up Questions to "Cognitive Behavioral Therapy (COD)" (Question C2)

- C2a. Does this program utilize **cognitive-behavioral therapy** to treat a variety of mental health problems including for example, distortions in thinking or psychiatric symptoms, mood, anxiety, depression, personality, or psychotic disorders?
 Yes
 No
- C2b. Does this program have a documented implementation plan for **cognitive-behavioral therapy** that is to be applied with patients who have a co-occurring mental health condition?
 Yes
 No
- C2c. Has staff from this program received training on the application of **cognitive-behavioral therapy** with patients who have a co-occurring mental health condition?
 Yes
 No
- C2d. Do the assessment and treatment plan sections of COD patients' clinical record reflect the use of **cognitive-behavioral therapy**?
 Yes
 No
- C2e. Does this program provide feedback to staff to improve their skills in providing **cognitive-behavioral therapy** to patients who have a co-occurring mental health condition?
 Yes
 No
- C2f. Are there opportunities to document patient feedback about this treatment approach in the clinical record?
 Yes
 No
- C2g. Are there Quality Assurance systems in place to monitor the use of **Cognitive Behavioral Therapy**?
 Yes
 No

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Follow-up Questions to “Contingency Management (COD)” (Question C3)

- C3a. Does this program utilize **Contingency Management** techniques for patients with a co-occurring mental health condition to encourage participation in treatment or compliance with psychotropic medication?
- Yes
 No
- C3b. Does this program have a documented implementation plan for **Contingency Management** that is to be applied with patients that have a co-occurring mental health condition?
- Yes
 No
- C3c. Has staff from this program received training on the application of **Contingency Management** with patients that have a co-occurring mental health condition?
- Yes
 No
- C3d. Do treatment plan instruments of COD patients reflect the integration of **Contingency Management**?
- Yes
 No
- C3e. Does this program provide feedback to staff to improve their skills in **Contingency Management** with patients that have a co-occurring mental health condition?
- Yes
 No
- C3f. Are there Quality Assurance systems to monitor the use of **Contingency Management** for co-occurring patients?
- Yes
 No

Follow-up Questions to “Mutual Self-Help Groups (COD)” (Question C5)

- C5a. Are there mutual self-help groups facilitated **on-site** for substance abuse such as NA/AA that welcome people with a co-occurring mental health condition?
- Yes
 No
- C5b. Are there mutual self-help groups facilitated **off-site** for substance abuse such as NA/AA to which clinicians typically refer that welcome patients with a co-occurring mental health condition?
- Yes
 No
- C5c. Are there mutual self-help groups facilitated **on-site** for co-occurring disorders such as Double Trouble in Recovery (DTR) or Dual Recovery Anonymous (DRA)?
- Yes
 No
- C5d. Are there mutual self-help groups facilitated **off-site** for co-occurring disorders (e.g. DTR, DRA) to which clinicians typically refer co-occurring patients during the course of treatment?
- Yes
 No

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- C5e. Does the program maintain the involvement of alumni with co-occurring conditions to facilitate peer support onsite or ensure connections to peer recovery supports in the community?
- Yes
 No

Follow-up Questions to “Achieving Integrated Care/Services (COD)” (Question E1)

- E1a. Does the agency join together with an external consortium to create a program that will serve the population of patients with both conditions?
- Yes
 No
- E1b. Do treatment staff use a program model (e.g., Relapse Prevention or Assertive Community Treatment) that integrates care?
- Yes
 No
- E1c. Do treatment staff coordinate a variety of substance use and mental health efforts in an individual treatment plan and deliver care that integrates the needed services?
- Yes
 No
- E1d. Do treatment staff consult with mental health specialists and integrate that consultation into the care provided?
- Yes
 No
- E1e. Do two or more treatment staff work together to provide substance abuse and mental health services to the same patient?
- Yes
 No
- E1f. Do treatment staff deliver a variety of substance abuse and mental health services to the same individual?
- Yes
 No

Follow-up Questions to “Medication Assisted Therapies” (Questions F1 through F7)

- Fa. Are at least half of this program’s clinical staff trained in **Medication Assisted Therapy**?
- Yes
 No
- Fb. For each patient, is the appropriateness for **Medication Assisted Therapy** incorporated into the assessment process and assessment instrument?
- Yes
 No
- Fc. Are there ongoing mechanisms to monitor medication response and potential side-effects?
- Yes
 No

Follow-up to Question F1 (Buprenorphine):

- F1a. Does this program’s attending physician have a license to prescribe Buprenorphine?
- Yes
 No

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If “No” to F1a:

- F1b. Has this program’s attending physician applied for a license to prescribe Buprenorphine?
 Yes
 No

Follow-up to Question F2 (Methadone):

- F2a. Does this program’s attending physician have a license to prescribe Methadone?
 Yes
 No

If “No” to F2a:

- F2b. Has this program’s attending physician applied for a license to prescribe Methadone?
 Yes
 No

Follow-up Questions to “Psychotropic Medications (COD)” (Question G1)

- G1a. Does this program have documented policies and procedures to evaluate and monitor patients’ need for **psychotropic medications**?
 Yes
 No
- G1b. For each patient, is the need for **psychotropic medication** routinely determined as part of the comprehensive assessment?
 Yes
 No
- G1c. Is at least half the program’s clinical staff cross-trained on **psychotropic medications** and their interaction with substance use and addictive medications (e.g. benzodiazepines)?
 Yes
 No
- G1d. Are there Quality Assurance systems in place to monitor the use of **psychotropic medications**?
 Yes
 No
- G1e. Is there a person on staff who is licensed or certified (e.g. psychiatrist) to prescribe **psychotropic medications**?
 Yes
 No

If “No” to G1e:

- G1f. Does this program have access to a psychiatrist or another qualified health professional (e.g. nurse practitioner) on or off-site (e.g. part-time consultant) who can prescribe medication?
 Yes
 No

Follow-up Questions to “Process Improvement” (Question H1)

- H1a. Does this program have a “Change Team”?
 Yes
 No

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If “Yes” to H1a:

Does the change team include the following?

H1b. Executive Sponsor

Yes

No

H1c. Change Leader

Yes

No

H1d. Data Coordinator

Yes

No

H1e. Does this program routinely collect data regarding retention and engagement rates?

Yes

No

H1d. Does the program use **Plan-Do-Study-Act** cycles to test improvements specific to Process Improvement?

Yes

No

Terms Defined for the Evidence-Based and Best Practice Interventions Survey

Stages of Implementation (Fixsen, Naoom, Blasé, & Wallace, 2007):

Exploration Stage: The exploration stage involves information collection, analysis, and its dissemination. Frequently there will be a need to formulate an implementation team. Information sharing in various formats is essential to increasing awareness of innovations and can prompt program professionals and other staff to consider the need to make changes in current practices and services that will anticipate and support the subsequent introduction of a new practice.

Installation Stage: The installation stage ideally begins with the decision to implement an innovation and ends when the innovation is initially used with the first individual or program cohort. Starting or adopting any innovation requires time and resources, and the lack of planning for those costs and program changes can interfere with attempted implementation of an EBP.

Implementation Stage: During the initial implementation stage, program staff and others involved in the innovation must learn how to carry out and relate to the new practice(s) and intervention processes. It is called the initial implementation stage to acknowledge that staff, supervisors, and administrators in the provider organization are not always likely to be adept in their new roles and/or tasks at the beginning of the implementation process. Full implementation of an innovation is reached when at least 50% of the currently employed staff/clinicians concurrently perform the new practice/intervention and its functions/activities acceptably. The achievement of full implementation in your program should also include measurable fidelity to the original innovation, in the replication of the EBP or best practice intervention.

Innovation Stage: Efficacious and useful innovation(s) normally happens only after full implementation has occurred. Generally, that involves learning the intervention, learning how to do it with fidelity, maintaining the intervention long enough to learn the nuances of its applications/tasks, and then strategically planning to improve the intervention via adaptations that would be applicable to your programs' uniqueness. Nonetheless, innovation and change should be based on data obtained from attempts to implement the EBP and its interventions with fidelity. As a result, adaptations in the innovation stage are based on solid data that demonstrate improved benefits and better outcomes.

Sustainability Stage: Sustainable and effective implementation efforts are firmly rooted in the activities

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that occur during the exploration stage and must be integrated into every stage of the implementation process. Sustainability is achieved when the program has, (1) developed and maintained ongoing quality assurance systems and measures, and (2) maintained continued fidelity of the EBP or best practice intervention.

I. Screening and Assessment:

Screening for Co-Occurring Disorders: Screening for co-occurring disorders is a formal process of administering a formal tool to determine whether an individual warrants further attention for a particular mental health disorder. The screening process and its instruments generally include dichotomous questions, which ask for a “yes/no” response to questions like, “Does the individual being screened show signs of a possible mental health problem that requires a comprehensive mental health assessment by a licensed practitioner.” An example of a valid screening instrument for co-occurring disorders is the Modified Mini Screen (MMS).

The MMS is a 22-item scale designed to identify individuals in need of a complete mental health assessment in the domains of Mood Disorders, Anxiety Disorders, and Psychotic Disorders. The questions are common to many screening, diagnostic and assessment tools, including the Diagnostic and Statistical Manual IV (DSM-IV), the Structured Clinical Interview for Diagnosis (SCID) and the Mini International Neuropsychiatric Interview (MINI).

Assessment for Co-Occurring Disorders: Consists of gathering key information and engaging in a process with the patient that enables the counselor to understand the patient's co-occurring disorder, readiness for change, problem areas, co-occurring disorders diagnosis(es), disabilities, and strengths. Information should be gathered on 12 domains: presenting problem(s), current symptoms & functioning, background, individual history, substance use, mental health, medical history, mental status examination, patient perception(s), cultural and linguistic considerations, supports & strengths, and diagnostic impressions on 5 DSM-IV Axes.

II. Clinical Practices and Interventions:

Motivational Interviewing (MI): A patient-centered approach for initiating behavior change by helping individuals resolve ambivalence about engaging in treatment and stopping drug use. It helps an individual develop a schema about the positive and negative effects of drug use to facilitate readiness for treatment and drug use reduction and/or cessation. MI techniques include reflective listening, delivering individual feedback, summarizing, decisional balancing, and developing change plans.

Cognitive-Behavioral Therapy (CBT): A short-term, focused approach to helping drug dependent individuals become abstinent from cocaine and other drugs. CBT posits that the same learning processes involved in the acquisition of drug using behavior can be used to help individuals reduce their drug use and become abstinent. Two critical components include an individual functional analysis of the role substances play in an individual's life and teaching individuals positive coping skills.

Contingency Management (CM): Sometimes called Motivational Incentives, CM is based upon principles of behavior modification. The intervention involves the opportunities for selected patients to earn immediate tangible rewards once they demonstrate achievement of concrete targeted behaviors such as the submission of negative urine toxicology. The process is for the individual to initially receive some form of extrinsic motivation to cease drug use and then develop over time internal motivation to reach their targeted goals as stated on their treatment plan.

Behavioral Couples Therapy (BCT): Is a structured, skill- based intervention designed to build support for abstinence and to improve relationship functioning among married or cohabitating partners seeking help for addiction once a domestic violence assessment has been completed. The theoretical rationale for the effects of BCT on chemical dependency is that certain dyadic interactions function as inadvertent reinforcement triggers for the use of substances. BCT involves teaching and promoting methods to

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resolve problems and conflicts appropriately as they arise and encourages participation in relationship enhancement exercises.

Brief Intervention Therapy: A short-term intervention, usually one to five sessions, for substance abusers who are not yet dependent. The intervention generally focuses on solutions to the individual's problems rather than on causes of the problems, or emotional responses to the problems. The therapist uses respectful curiosity to invite the individual to explore and envision their preferred future and then develop a plan to work towards attaining that vision in small incremental steps. The rationale is that if an individual has the capacity to identify/describe something as a problem, that individual also has the capacity to identify/describe how their life could be improved, to include, articulating what are the necessary resources to make that change happen.

Twelve-Step Facilitation (TSF): Twelve-Step Facilitation (TSF) consists of a brief, structured, and manual-driven approach to facilitating early recovery from alcohol abuse/alcoholism and other drug abuse/addiction. It is intended to be implemented on an individual basis in 12 to 15 sessions and is based in behavioral, spiritual, and cognitive principles that form the core of 12-step fellowships such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA). It is suitable for problem drinkers and other drug users and for those who are alcohol or other drug dependent. (NIDA, 2003)

Anger Management: Generally, anger is a feeling or emotion that ranges from mild irritation to intense rage. Substance use, abuse, and dependence often coexist with anger and violence. Anger and its related behaviors can have a causal role in the initiation of drug and alcohol use, relapse, and can be a consequence of substance abuse/dependence. In addition, individuals who experience traumatic events often experience anger. Ideal objectives of anger management are to: (1) learn to manage anger effectively, (2) stop violence/threat of violence, and (3) the development of self-management skills.

Relapse Prevention: Relapse is the act of taking a drink or drug after being clean and sober, and is generally caused by a combination of factors. It helps to view relapse as a process that begins well in advance of that act of using alcohol and drugs. Relapse prevention is the pedagogy of educating people in recovery on how to identify the warning signs and behavioral cues that may lead to a lapse in their abstinence, and the development of strategies that would enable taking positive steps to stay clean and sober.

Trauma-Related Counseling: Trauma-related counseling includes screening and a trauma-informed system of services that have been assessed and developed with regard to how trauma may have played a part in the lives of patients requesting substance use and mental health treatment services, (SAMHSA webpage <http://www.samhsa.gov/nctic/trauma.asp#care>) In addition, trauma-informed services are designed to consider and adjust to potential vulnerabilities a traumatized patient may have, taking into consideration service delivery constructs and approaches that will be supportive and not continue, or re-traumatize the patient, (Harris, M., & Fallot, R.D., 2001). For informational and educational purposes only, the following are a few examples of some trauma-specific interventions that have been used extensively in public system settings. Moreover, additional information regarding trauma-informed care can be obtained at the National Center for Trauma-Informed Care. (<http://www.samhsa.gov/nctic/>)

- [Addiction and Trauma Recovery Integration Model \(ATRIUM\)](#)
- [Essence of Being Real](#)
- [Risking Connection](#)
- [Sanctuary Model](#)
- [Seeking Safety](#)
- [Trauma, Addictions, Mental Health, and Recovery \(TAMAR\) Model](#)
- [Trauma Affect Regulation: Guide for Education and Therapy \(TARGET\)](#)
- [Trauma Recovery and Empowerment Model \(TREM and M-TREM\)](#)

Matrix Model: The Matrix Model is a multi-element collection of therapeutic strategies that complement each other and combine to produce an integrated outpatient treatment experience. It is a set of evidence-based practices delivered in a clinically coordinated manner as a "program." The therapist fosters a

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positive relationship with the patient and uses that relationship to reinforce positive behavior change. The Model and its strategies are derived from clinical research literature that includes cognitive behavioral therapy, research on relapse prevention, motivational interviewing strategies, psycho-educational information, and 12-Step program involvement. Guiding principles of the Model are:

- Establishing a positive and collaborative relationship with the client
- Creating explicit structure and expectations
- Teaching psycho-educational information, i.e., brain chemistry and other relevant research findings
- Application of cognitive-behavioral concepts
- Positively reinforcing desired behavioral change
- Educating family members regarding the expected course of recovery
- Introducing and encouraging self-help participation
- Monitoring drug use through the use of urinalyses

Additional information regarding the Matrix Model can be obtained at NREPP SAMHSA's National Registry of Evidence-Based Programs and Practices. <http://nrepp.samhsa.gov/ViewIntervention.aspx?id=87>

Rational Emotive Behavioral Therapy (REBT): Rational emotive behavior therapy is a comprehensive, humanistic, and action-oriented approach to emotional growth. REBT is a philosophically and empirically based psychotherapy which focuses on resolving emotional and behavioral problems and disturbances. REBT emphasizes individuals' capacity for creating emotions; the ability to change and overcome the past by focusing on the present; and the power to choose and implement satisfying alternatives to current ineffective behavior patterns.

III. Clinical Practices and Interventions Specific to Treating Patients with Co-Occurring Disorders:

Motivational Interviewing (MI): A client-centered method for enhancing intrinsic motivation to change by exploring and resolving client ambivalence. For example, does this program utilize motivational interviewing to help patients with co-occurring disorders resolve ambivalence about engaging in mental health treatment or taking psychotropic medication for their mental disorder?

Cognitive–Behavioral Therapy (CBT): A therapeutic approach that seeks to modify negative or self-defeating thoughts and behavior. Cognitive–Behavioral Therapy is aimed at both thought and behavior change—that is, coping by thinking differently, and coping by acting differently. In the context of co-occurring disorders or conditions, does this program utilize cognitive behavioral approaches to address distortions in thinking or psychiatric symptoms?

Contingency Management (CM): An approach to treatment that maintains that the form or frequency of behavior can be altered through a planned and organized system of positive and negative consequences. The key concept in contingency management is frequent monitoring and the provision of tangible, positive reinforcement whenever a patient demonstrates specific targeted behavior as per their treatment plan goals. The objective is to encourage and reward pro-recovery behaviors and attitudes for patients in treatment or considering behavior change in relation to their mental health in the context of co-occurring disorders (or conditions). Target behaviors for mental health treatment would include (1) treatment attendance, (2) medication compliance, and (3) treatment goal accomplishments.

Behavioral Couples Therapy (BCT): A structured, skill-based intervention designed to build support and to improve relationship functioning among married or cohabitating partners once a domestic violence assessment has been completed. BCT involves teaching and promoting methods to resolve problems and conflicts appropriately as they arise and encourages participation in relationship enhancement exercises. The purpose of BCT is to restore a better level of functioning in couples who experience relationship distress. The reasons for distress can include a broad spectrum of issues such as domestic violence, alcoholism, depression, anxiety, and schizophrenia. The focus of BCT is to identify the presence of dissatisfaction in the relationship, and to devise and implement a treatment plan with objectives designed to improve the presenting symptoms and restore the relationship to a better and healthier level

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of functioning.

Mutual Self-Help Groups: Mutual support is a process by which people who share their experience, strength and hope about dual recovery voluntarily come together to help each other address common problems. This peer-to-peer approach offers social, emotional, or instrumental support that is mutually provided by persons with similar [mental health](#) conditions. Examples may include many [mental health consumer non-profits](#) and social groups such as Double Trouble in Recovery, Dual Diagnosis Anonymous, Dual Disorders Anonymous, and Dual Recovery Anonymous.

IV. Achieving Integrated Care/Services for Treating Patients with Co-occurring Disorders:

Achieving Integrated Care/Services: Integrated Care/Services involves the *joint* provision of both mental health and addiction care and services. A patient receives care at a single agency from a single *cross-trained* staff member or a treatment team who assess both conditions, develops a single treatment plan to address both conditions, and combines interventions for both conditions *into a single or series of session(s) or interaction(s)*. Care for both disorders may also be coordinated across agencies. There is no one-way of providing integrated care/services; rather there exist a variety of techniques or methods for supplying integrated services to patients. All of these recognize the equal importance of both the mental health and substance abuse problems and the need for treatment to address both conditions.

V. Medication Assisted Therapy (Pharmacotherapy):

Buprenorphine: Is a partial opiate agonist (with agonist and antagonist properties). Buprenorphine behaves like a full agonist (activates the opiate receptor) at low dose and behaves like an agonist or antagonist (blocks the opiate receptor) at high dose. It can be used for detoxification from opiates or for maintenance treatment; however, the individual should always be linked to chemical dependence treatment. There are two forms of the medication, available in 2 mg and 8 mg sublingual tablets, (under the tongue):

- **Subutex®** – Buprenorphine alone
- **Suboxone®** – Buprenorphine combined with Naloxone in a 4:1 ratio. This combination form prevents intravenous use of the tablet after crushing, in which the user would get an antagonist effect of the Naloxone, or at the least, a diminished opiate effect.
- Doses for opioid dependence range from 2 mg to 32 mg.

Methadone: Methadone treatment provides services to persons dependent on opiates, such as heroin and morphine, so that they may develop productive lifestyles. These programs offer methadone as part of a range of medical procedures and services. Included in these services are supportive counseling, medical care, and other individualized services. Medically supervised withdrawal is a short-term (up to 30 days) or long-term (not more than 180 days) medical treatment protocol that utilizes methadone to alleviate withdrawal symptoms caused by the continued use of opiates. This protocol will be included in the array of services available in methadone programs.

Naltrexone (Oral) and Vivitrol® (Injectible Naltrexone): Is a narcotic antagonist that blocks the pleasurable effects of alcohol, reduces alcohol cravings after establishing abstinence, and can be utilized alone for long-term treatment of individuals with opioid addiction. Naltrexone is used for alcohol dependent individuals and can be used after medically supervised withdrawal from an opioid to prevent drug relapse in selected and well-motivated individuals.

Acamprosate (Campral®): Enhances abstinence and reduces drinking days through its effect on the neurotransmitters GABA and glutamate. Although its mode of action has not been clearly established, it may work by reducing symptoms of protracted abstinence such as insomnia, anxiety, and restlessness. Treatment usually starts between 2 to 7 days after the individual ceases alcohol consumption, and the medication does not have hepatic metabolism, which is an advantage in individuals who have inflamed livers due to alcohol use.

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Nicotine Replacement Therapies: Designed to support the goal of tobacco abstinence and decrease withdrawal symptoms. A variety of products have been developed which include nicotine gum, nicotine transdermal patches, nicotine inhaler, nicotine spray, and nicotine lozenges.

- **Nicotine Transdermal Patch** - All patches deliver slow release of nicotine per hour. Temperature and circulation affect delivery.
- **Nicotine Lozenge** - Lozenges come in 2 mg and 4 mg doses with the recommended number being about nine (9) lozenges per day, in the first 6 weeks, with tapering thereafter.
- **Nicotine Gum** - available in 2 mg and 4 mg pieces (.86 mg absorbed from the 2 mg piece and 1.2 mg absorbed from the 4 mg piece). The "Park and Chew" technique is used and is affected by chewing rate and pH of the saliva.
- **Nicotine Inhaler** - Cigarette holder shape with replaceable cartridges each containing 10mg nicotine and 1 mg menthol (400 puffs per cartridge and 80 puffs equal one cigarette). One can use 4 to 6 inhalers per day and the delivery is affected by puff rate, temperature, and saliva pH.
- **Nicotine Spray** - One inhalation in each nostril equals a total dose of 1mg nicotine. The average use is 13- to 20 doses per day.
- **Chantix (Varenicline)** - Chantix comes in two doses: 0.5 mg and 1.0 mg. A steady-state level is usually achieved in about four days and is not affected by food or time of day dosing. Ninety-two (92%) percent of the medication is excreted unchanged in the urine, making this a safe medication for individuals with liver disease as there is no significant liver metabolism.
- **Bupropion (Zyban/Wellbutrin)** – Bupropion should be started when the individual is still smoking. Individuals should set a target quit date generally in the second week of treatment. Individuals can receive 150 mg/per day for the first three days, followed by a dose increase in most individuals to 150 mg twice a day (300 mg/day), no sooner than 3 days after beginning therapy. Treatment duration ranges from 7 to 12 weeks, longer in some cases.

Disulfiram/Antabuse®: Disulfiram (or antabuse) produces an unpleasant flushing reaction whenever the individual drinks alcohol, thus it produces a disincentive to drinking and provides some external controls on drinking behavior. It has been shown to be most effective when given in a monitored fashion, such as at a treatment program or by a spouse.

VI. Psychotropic Medication for Treating Patients:

Psychotropic Medications: Pharmacological interventions that can be prescribed for symptoms and behavior associated with mental disorders (or conditions).

VII. Process Improvement Administrative Practices:

Process Improvement: A practice that involves increasing treatment access and retention for individuals by making organizational changes that impact four treatment aims: (1) decrease wait times; (2) decrease no-shows; (3) increase admission rates; and (4) increase continuation and rates of treatment engagement. Five principles guide organizational improvement; (1) understand and involve the customer (e.g., conduct a walk-through to understand the individual perspective); (2) fix key problems; (3) use an internal and powerful change leader; (4) get ideas from outside the organization and/or field; and (5) use rapid cycle testing to make changes using a PDSA Cycle paradigm, i.e., Plan-Do-Study-Act.

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G. 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 2015 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 2015 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, and must be at least 5 years longer than the term of the bond. Projects under \$500,000 are generally considered too small to warrant the cost of bond issuance.

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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 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.

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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 **2015 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.

- **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.

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- **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.

Expiration of Schedule C Application: The Schedule C application will expire 24 months from the OASAS Field Office approval date unless the project has moved to the funding stage. If the application expires prior to satisfying the need and the project has not moved to the funding stage a new Schedule C application must be submitted for approval by OASAS Field Office in order for the application to remain active.

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

**2015 Local Services Plan Guidelines
For Mental Hygiene Services**

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

Project Site		
Provider Name:	Provider Number:	PRU:
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)		
7. Complete if the project is for an EXISTING certified site:		
a) The site is: <input type="checkbox"/> Leased <input type="checkbox"/> Owned <input type="checkbox"/> Provided as a gift		
b) If leased, is the lease an arms-length lease? <input type="checkbox"/> Yes <input type="checkbox"/> No		
c) If leased, what is the annual rent? \$_____		
d) If owned, are there any liens on the site? <input type="checkbox"/> Yes <input type="checkbox"/> No		
e) If YES, what is the current market value of the site? \$_____		
f) If YES, what is the total balance of all liens on the site? \$_____		
g) Are you the sole occupant of the site? <input type="checkbox"/> Yes <input type="checkbox"/> No		
8. Complete if the project is for a NEW site:		
a) Has a probable site been identified? <input type="checkbox"/> Yes <input type="checkbox"/> No		
b) How do you expect to acquire the site? <input type="checkbox"/> Lease <input type="checkbox"/> Purchase <input type="checkbox"/> Other (attach explanation)		
c) Have you obtained an option on the site? <input type="checkbox"/> Yes <input type="checkbox"/> No		
d) If an appraisal or fair market rental study of the proposed site has been completed, forward a copy to the field office.		
9. If a feasibility study has been completed for the project, forward a copy to the field office.		
10. Planned project financing:		
a) Provider funds: \$_____		
b) Commercial loans/debt: \$_____		
c) Grants (other than OASAS): \$_____		
d) OASAS: \$_____		
11. Has this financing plan been adopted by the governing authority? <input type="checkbox"/> Yes <input type="checkbox"/> No		
NOTE: The Schedule C application will expire 24 months from the OASAS Field Office approval date unless the project has moved to the funding stage. If the application expires prior to satisfying the need and the project has not moved to the funding stage a new Schedule C application must be submitted for approval by OASAS Field Office in order for the application to remain active.		
<u>Provider Official</u>		
Name: _____ Title: _____ Date: _____		
FOR OASAS USE ONLY		
OASAS Field Office Approval of Need (Funding is to be determined)	Signature (Statewide Field Office Director or Designee)	Date Approved