



Health and Human Services

A close-up photograph of two hands clasped together. The hand on the left is darker-skinned and has a gold ring on the ring finger. The hand on the right is lighter-skinned. The hands are resting on a white, textured surface, possibly a bedsheet or blanket. The lighting is soft and natural.

2016 Local Services Plan Guidelines for Mental Hygiene Services

March 2, 2015

Office of
Mental Health

Office of Alcoholism and
Substance Abuse Services

Office for People With
Developmental Disabilities

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Chapter I: Introduction

A. Integrated Local Mental Hygiene Planning

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. That plan must establish long-range goals and objectives that are 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)).

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 an effort to streamline the local planning process and strengthen the state and local partnership, the three state agencies and the Conference of Local Mental Hygiene Directors ([CLMHD](#)) began collaborating in 2008 on an integrated and uniform local planning process with a single set of plan guidelines. A statewide Mental Hygiene Planning Committee was established which included representation from OASAS, OMH, OPWDD, CLMHD, and several LGUs. 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.

B. Mental Hygiene Planning Committee

The Mental Hygiene Planning Committee meets regularly throughout the year to guide the local planning process and 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. As a result of significant reforms in the primary health and behavioral health care systems, a primary 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 cost effective care and better patient outcomes.

Much of the ongoing activity of the Mental Hygiene Planning Committee is carried out by two very active workgroups. **The Data Workgroup** is focused on improving access to and use of county data to support data driven local planning and system management. The workgroup identifies county data needs and works with state and county agencies to develop resources that are most helpful in carrying out required needs assessment, planning and system management responsibilities. The Data Workgroup consists of Directors of Community Services (DCSs) and planners from several counties and the three state mental hygiene agencies and is chaired by a LGU representative. The workgroup meets monthly throughout the year. During the most recent local planning cycle, the workgroup achieved the following goals:

- Continued development of the LGU Data Dashboard (which was released in February 2014) to support county access to and use of other data sources in the context of managed care and local/regional planning functions.

- Identified updates and improvements to the LGU Data Dashboard portal.
- Collaborated with the Community of Practice for Local Planners (CPLP) Workgroup to deliver several “Dashboard Dialogues” consisting of 30 minute briefings on a relevant data report, analysis or topic.
- Advised State agencies regarding updates to data reporting on their web sites.
- Piloted collection of local forensic data on the number of individuals arrested monthly, and the number of these individuals screening positive for suicide.

The Community of Practice for Local Planners (CPLP) was established in 2009 and is a peer-led state and local partnership that is focused on promoting best planning practices, techniques for assessing local needs, defining outcomes and strategies, and identifying and utilizing available data resources. The CPLP convenes a number of webinars and in-person planning sessions each year that provide county planners with opportunities to learn about new state data systems and resources, local planning requirements, and to share planning practices that help them to perform their planning and system management responsibilities. The goal of the CPLP is to improve the overall quality of local services planning across the state to help ensure that local services are developed and managed in the most rational and effective manner. The group is chaired by a county planner and includes representatives from county and state agencies.

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 is a platform from which counties can access relevant and timely data resources for conducting their needs assessment and planning activities, complete required planning forms, and submit their entire mental hygiene services plan to all three state agencies. Several report features were built into CPS that allow agency staff to query all completed plans on selected information and generate specific reports in a quick and efficient way that results in more timely and accurate summary analyses that inform each agency’s statewide planning process and a variety of policy and program initiatives.

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. OASAS 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.

There are more than 2,300 individuals with a CPS user account in one or more of fifteen separate user roles. **Table 1.1** shows the primary user roles, with each providing 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. Anyone wishing to establish a CPS user account must first contact the OASAS Bureau of State and Local Planning at oasasplanning@oasas.ny.gov or at 518-457-5989. The following table describes the primary CPS user roles and entitlements granted to each.

Table 1.1: Primary CPS User Roles and Entitlements

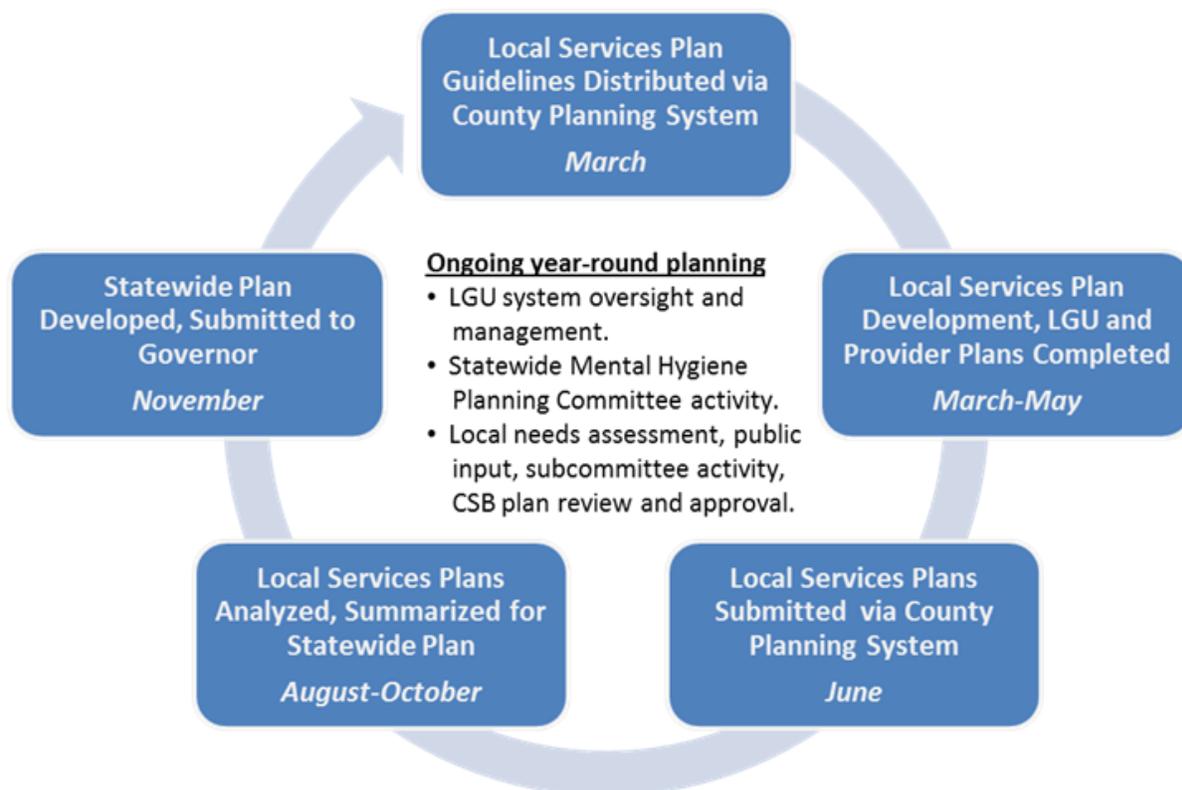
User Role	User Entitlements
Planning Coordinator	This role is identical to the Administrator role and was developed so that state agency staff can communicate with a single individual within a LGU or OASAS provider organization on planning related matters. This will help to eliminate confusion when action is requested, allowing a single point of contact to coordinate an organization's response.
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.

D. The Mental Hygiene Local Services Planning Process

When the mental hygiene local services planning process was fully integrated, a fixed planning cycle was established so that the local planning process could be conducted in an efficient and predictable manner each year. As Figure 1.1 shows, the annual process begins with the distribution of plan guidelines on or about March 1. LGUs are given 90 days to complete their plan and enter it into CPS. Since planning is an ongoing activity that is carried out throughout the year, completing the plan should reflect the results of that year-long activity. After state-wide analyses of all plans submitted are completed, statewide comprehensive plans are produced by the three state agencies incorporating local service goals into their long range agency goals.

Figure 1.1: Mental Hygiene Local Services Planning Process



OASAS routinely uses the local planning process to survey its providers on a variety of topics that help to inform the work that OASAS does. Surveys are typically brief and specific, and providers are given 30 days to complete them in CPS. In recent years, this process and the management tools built into CPS has resulted in an average survey response rate of 95 percent, which has dramatically increased the value and reliability of the data collected. Consistent with State Mental Hygiene Law, the statewide plan then serves as an important source of guidance for the subsequent local services planning process, which begins again the following March.

Mental Hygiene 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.

Table 1.2: 2016 Local Services Planning Process Timeline

Process Step	Date
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 2, 2015
LSP and CPS training for county planners	March/April (TBD)
Due date for completed OASAS provider planning surveys in CPS	Wednesday, April 1
Due date for completed LGU Plans in CPS	Tuesday, June 2
State summary analyses of county and provider plans completed	September 2015
OASAS, OMH, OPWDD Statewide Comprehensive Plans released	November 2015
OASAS, OMH, OWPDD Interim Reports released	March 2016

E. Informing Statewide Comprehensive Planning

After the Affordable Care Act was signed into law in 2010, New York State established the Medicaid Redesign Team in 2011, which sparked the creation of Behavioral Health Organizations (BHOs), Health Homes, Managed Care Organizations (MCOs), Health and Recovery Plans (HARPs), and the Delivery System Reform Incentive Payment (DSRIP) Program. These initiatives are laying the groundwork for system transformation from a fee-to-service chronic care model to a community based Medicaid Managed Care model. Population Health Improvement Programs (PHIPs) with the support of Regional Planning Consortiums (RPCs) and other state initiatives driven by the Prevention Agenda 2013-2017 and the State Health Innovation Plan (SHIP), will assist New York State in delivering a community based, recovery-oriented system of care for both primary and behavioral health.

Additional changes to New York State Mental Hygiene Law in 2012 established the ***Behavioral Health Services Advisory Council (BHSAC)***. The Council, which replaces the former OASAS Advisory Council on Alcoholism and Substance Abuse and the OMH Mental Health Services Council is another example of the focus on integration of care for individuals with co-occurring substance use and mental health disorders. 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 and 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.

County governments and behavioral health care providers have also been engaging in integrated planning, assessment and readiness activities in order to be prepared for the overarching shift of institutional care to community care and from a fee-for-service model to a managed care model.

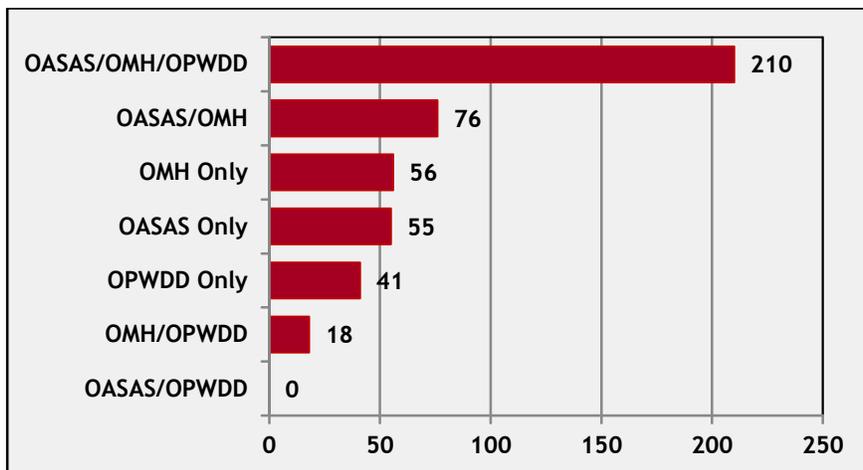
Addressing the needs of individuals with multiple disabilities who need services from more than one system is also clearly reflected in the local services plans of the LGUs. Last year, 67% of all local priorities identified in the county plans addressed needs that crossed multiple disabilities,

including 46% that applied to all three mental hygiene disabilities. The cross-disability priorities most frequently included in local plans focused on care coordination and collaboration across multiple systems, particularly integrating behavioral health services and coordinating behavioral health care with primary health care. Another top priority area was addressing the need for safe and affordable supported housing for persons receiving care for one or more mental hygiene disability. Collaboration with Local Health Departments (LHDs) to support the priorities related to mental health and substance use disorders under the New York State Department of Health's (DOH's) Prevention Agenda 2013-17 also continues to be a priority area addressed by a majority of LGUs.

Local health departments, local mental hygiene departments and behavioral health providers are striving to work together in implementing State and federal initiatives to integrate behavioral and physical health care by promoting mental health and preventing substance abuse through more efficient and cost-effective services based on improved performance outcomes.

As **Figure 1.2** shows, 210 county priorities in 2014 were associated with all three disabilities, with another 76 that were associated with OMH and OASAS. These numbers reflect the high degree to which priorities are intended to address needs that require a more comprehensive cross-system approach.

Figure 1.2: 2015 Local Services Plan Priorities by Disability Agency (N=456)



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. 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.

CHAPTER II: Planning for Mental Hygiene Services

A. Transformation of Care: The Integration of Behavioral and Physical Health Care

While each mental hygiene system of care continues to provide quality, individualized services, the State Department of Mental Hygiene agencies recognize the transformational changes that are occurring in the health care system. As the public health care and behavioral health care systems continue to transition and integrate, OASAS, OMH and OPWDD are working with their state and local partners to implement a more coordinated system of care that addresses the needs of all individuals.

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. Included in this chapter is a summary of the federal and statewide initiatives taking place and how local services interact with those initiatives.

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 Federal Poverty Level (FPL); approximately \$30,000 per year for a family of four), 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 created a temporary 90% federal match for states to provide health homes for individuals with chronic conditions and extended the Money Follows the Person (MFP) Rebalancing Demonstration through September 30, 2016.

Medicaid Redesign

The Medicaid Redesign Team (MRT) has been at the forefront of leading change and advancing the State toward the seamless integration of health and mental healthcare for beneficiaries of Medicaid. A cornerstone of healthcare transformation in the State public mental health system, Medicaid Redesign aligns with research findings demonstrating that outcomes improve and healthcare dollars are saved when integrated care approaches are implemented effectively whether in primary care settings, behavioral health settings or health homes.

Governor Cuomo established the MRT in 2011 and charged it with finding ways to reduce costs and increase quality and efficiency in the Medicaid program. Because of the special needs of the behavioral health population, a Behavioral Health Workgroup was created. The charge of the Behavioral Health Workgroup was to help establish a framework for the transition to care

management for all New Yorkers with mental illnesses and substance use disorders. The goals of the transition are to improve patient outcomes, reduce inpatient hospitalizations and create a comprehensive, accessible and recovery oriented system that enables individuals to thrive in the community.

The final report produced by the MRT Team has provided New York State with a blueprint and action plan for reforming Medicaid services and optimizing health system performance through alignment with what the Institute of Healthcare Improvement calls the triple aim: improving the patient experience of care (including quality and satisfaction), improving the health of populations, and reducing the per person cost of healthcare. Overall, the design and operational components of the newly configured behavioral health system for Medicaid beneficiaries address the State's advancement of the MRT vision and goals, including:

- Improved access to appropriate behavioral and physical healthcare services for individuals with mental illnesses and/or substance use disorders.
- Better management of total medical costs for individuals diagnosed with co-occurring behavioral and physical health conditions.
- Improved health outcomes and increased satisfaction among individuals engaged in care.
- Transformation of the behavioral health system from one dominated by inpatient care to one based in ambulatory and community care.
- Enhanced service delivery system that supports employment, success in school, housing stability and social integration.

Medicaid Managed Care

The first phase of the transition to behavioral health managed care began in 2012 when OASAS and OMH selected five BHOs to monitor Medicaid fee for service behavioral health inpatient admissions. This first phase led to the development of behavioral health managed care requirements, including contract requirements for managed care plans, eligibility for specialized services, performance metrics and evaluation, use of peer services and interface with Health Home implementation.

The Medicaid managed care program design takes a multi-pronged approach to raise expectations and improve the behavioral and physical healthcare outcomes for all members. Key elements of the design include:

- Providing all Medicaid State Plan services for physical health, behavioral health, pharmacy, and long-term care.
- Expanding and enhancing network capacity and the array of evidence-based treatment and support services accessible in the community so they facilitate recovery for adults and resiliency for children.
- Clearly specifying the expectation that the behavioral health benefit will result in high-quality care that has a positive impact on member outcomes.
- Requiring routine screening of members in primary care settings to identify unmet behavioral health needs and expedited, effectively made referrals to behavioral health services.
- Requiring routine screening of members in behavioral health settings to identify unmet medical needs and expedited, effectively made referrals to appropriate physical services.

- Stipulating data integration and predictive modeling approaches to identify individuals who are at high risk for, or have intensive and costly service needs, and facilitating program evaluation across systems.
- Instituting utilization management, medical management, and quality management protocols and other administrative methods to ensure that behavioral health service delivery, and associated financial and clinical outcomes, are appropriately managed.
- DOH, in conjunction with OMH and OASAS, will pre-approve MCO behavioral health services criteria and practice guidelines for utilization review, prior authorization, and levels of care.
- Each MCO will be required to use an OASAS-approved substance use disorder level-of-care tool for all substance use disorder level-of-care decisions (to include, but may not be limited to, the agency's placement criteria system known as the Level of Care for Alcohol and Drug Treatment Referral (LOCADTR)).
- Utilizing specialized case management and care coordination protocols to improve the engagement of each person in care, promote self-care, and enhance cross-system coordination—including participation in health home innovations—for people at risk for or experiencing intensive and costly service needs.
- Facilitating system transformation through the provision of comprehensive and ongoing education, training and technical assistance programs for members, behavioral and physical health providers, and MCO staff.
- Developing a transition plan that delineates key milestones and time lines for transitioning behavioral services from fee-for-service to MCOs.
- HARPs having responsibility for providing specialized services for adult Medicaid beneficiaries with significant behavioral health needs based on clinical/functional impairment eligibility requirements. The HARP benefits package will include rehabilitation, crisis intervention, educational and employment support, and peer and self-directed services; modeled under the Home and Community Based Services (HCBS) waiver. These services will be available to beneficiaries based their detailed plan of care, which will be informed by a full functional assessment. Qualified HARPs will rely upon specialized medical and social necessity/utilization review approaches and beneficiaries will have care management through a Health Home.

In 2013, a new design for managed behavioral health care was introduced and whereby all Medicaid behavioral health and physical health benefits for adults 21 and older will be delivered through two behavioral health managed care models:

- **Qualified Mainstream Managed Care Organizations (MCOs):** For all adults served in mainstream MCOs throughout the State, the qualified MCO will integrate all Medicaid State Plan covered services for mental illness, substance use disorders and physical health conditions.
- **Health and Recovery Plans (HARPs):** HARPs are described as a “distinctly qualified, specialized and integrated managed care product for individuals with significant behavioral health needs.” Individuals must meet HARP eligibility criteria to enroll in the program. In addition to the State Plan Medicaid services offered by mainstream MCOs, qualified HARPs will offer access to an enhanced benefit package comprised of Home and Community Based Services (HARP HCBS) designed to provide the individual with a specialized scope of support services not currently covered under the State Plan, including rehabilitation, crisis intervention, educational and employment support, and peer and self-directed services.

The MRT Children's Behavioral Health Team designed a separate framework for children's behavioral health and physical health services under managed care, in recognition of the additional complexity of systems accessed by children and families, and of the nature and span of some children's behavioral health problems. OASAS, OMH, DOH, and the Office of Children and Family Services (OCFS) are collaborating on the design of the new system.

Implementation of the management of behavioral health benefits and of HARPs is scheduled to begin the enrollment process in April 2015 for New York City plans and October 2015 for plans in the rest of New York State. Implementation is beginning with the distribution of HARP passive enrollment letters in April 2015 for New York City, followed by enrollment and management of benefits beginning in July 2015; this same two-phase implementation is planned for Rest of State in October 2015 and January 2016 for adults. Children's enrollment in managed care is still targeted for January 2016. The State agencies are working with plans to ensure that they are ready to implement the requirements included in the request for proposals. Additional information about this [timeline](#) can be found on the DOH website.

The state agencies have also worked with stakeholders to support this transition through several major initiatives including: Home and Community Based Services (HCBS) and Residential Redesign. The State agencies released a [manual describing new HCBSs](#) that will be included as a benefit through the HARP.

Community based programs that submit an application may be designated by the State as providers of these services and may contract with managed care plans for reimbursement. The State envisions a robust network of providers that offer these rehabilitative services designed to engage individuals with high functional needs in meaningful community activity to avoid hospitalizations and thrive in the community. These services are designed to promote successful recovery and long term support for recovery.

Health Homes

The New York State Health Home Program was launched in 2012. Health Home services support the provision of coordinated, comprehensive medical and behavioral health care to patients with chronic conditions through care coordination and integration. They assure access to appropriate services, improve health outcomes, reduce preventable hospitalizations and emergency room visits, promote the use of health information technology (HIT), and avoid unnecessary care.

Health Home services include:

- 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 multiple chronic conditions, including a substance use disorder, a serious persistent mental illness, or a single qualifying condition such as HIV/AIDS. OASAS and OMH continue to work with DOH on the management and oversight of Health Homes and provider networks across the state. The state agencies are developing monitoring instruments and a plan to evaluate Health

Home performance to facilitate the re-designation of currently authorized Health Homes. Additional monitoring and evaluation tools are being developed within a larger evaluation plan that includes in-depth analyses of outcomes for individuals with a substance use disorder engaged in Health Homes conducted by the National Center on Addiction and Substance Abuse at Columbia University (CASAColumbia).

OASAS and OMH are also engaged with DOH in the development of Health Homes designed to meet the unique needs of children. While children who meet the Health Home eligibility requirements have been eligible for Health Home enrollment since 2012, it has been the intent of the State to work with existing Health Homes and other providers to tailor New York State's Health Home Model to better serve children and to recognize the important differences in the approach to care management and planning for children and adults. The agencies developed and released a Health Home application for children, which are due March 2, 2015. OASAS and OMH, in partnership with DOH, the Aids Institute, and OCFS, will review the applications and designate Health Homes particularly suited to serve children. Enrollment of children is expected to begin in October 2015.

Health Home Plus

Health Home Plus (HH+) is an intensive Health Home Care Management service established for defined populations with serious mental illness who are enrolled in a Health Home. In order to ensure their intensive needs are met, Health Homes must assure HH+ members receive treatment in keeping with requirements for caseload ratios, reporting, and minimum levels of staff experience and education, formerly required under Office of Mental Health Intensive Case Management (ICM) level of care. Providers will be appropriately reimbursed for management and oversight of this population.

This population currently includes only people on court ordered Assisted Outpatient Treatment (AOT) status who are not being served by Assertive Community Treatment (ACT) teams. In the future this rate may expand to include individuals with serious mental illness who meet additional criteria.

Integrated Licensure Regulations

On December 31, 2014, regulations were adopted establishing standards applicable to programs licensed or certified by OMH, DOH, or OASAS, which want to add to existing program services provided under the licensure or certification of one or both of the other agencies. The regulations promote increased access to physical and behavioral health services at a single site and foster delivery of integrated services.

These regulations were developed utilizing the principles of the OMH/OASAS/DOH Integrated Licensure Pilot Project that was implemented by seven providers across 15 clinic sites across the State. These principles are: (1) to allow a provider to deliver the desired range of cross-agency clinic services at a single site under a single license; (2) the provider would need to possess licenses within their network from at least 2 of the 3 participating State agencies; (3) the site's current license would serve as the "host;" and (4) the desired "add-on" services would be requested via the State agency currently with primary oversight responsibility for such services.

The State Health Innovation Plan (SHIP)

The [State Health Innovation Plan \(SHIP\)](#) is the State's strategic roadmap to achieving the Triple Aim (better care, better population health & lower costs). The SHIP outlines a multi-faceted approach that builds on the work of the MRT, the Prevention Agenda and other ongoing initiatives. The SHIP works towards the development and implementation of innovative service delivery and payment models, which help give access to integrated care delivery systems.

The SHIP identified five strategic pillars as the foundation for New York's efforts to achieve the Triple Aim:

- 1) Improving access to care for all New Yorkers, without disparity;
- 2) Integrating care to meet consumer needs seamlessly;
- 3) Making health care cost and quality transparent to enhance consumer decision making;
- 4) Paying for value, not volume; and
- 5) Promoting population health.

The SHIP also identified three enablers:

- 1) Workforce strategy;
- 2) Health information technology; and
- 3) Performance evaluation and measurement.

Recently, New York State, in coordination with Health Research Inc. was awarded a four year, \$100 million State Innovations Model (SIM) Testing Grant. The grant, given by the Centers for Medicare and Medicaid Innovation, will integrate care and services by improving access to primary care and will also integrate primary care into long-term care, behavioral health, specialty care and community supports.

The Population Health Improvement Programs (PHIPs)

One of the most recent tools introduced to the population health and behavioral health planning sphere is the *Population Health Improvement Program* which was introduced through the 2014-2015 State Budget and is still in the development phase. The Population Health Improvement Program (PHIP) will promote the Triple Aim of better care, better population health and lower health care costs through regional efforts that reflect local needs, assets and capabilities. PHIP contractors will each work in one of several regions that together will serve the entire State. PHIP contractors will provide a neutral forum for identifying, sharing, disseminating and helping implement best practices and strategies to promote population health and reduce health care disparities in their respective regions. In particular, PHIP contractors will help support and advance ongoing activities related to the New York State Prevention Agenda 2013-2017 and the NYS Health Innovation Plan and incorporate strategies to reduce health and health care disparities.

Each PHIP contractor will plan, facilitate, and coordinate many different activities required for the promotion of healthy communities and the successful transformation of the health and care system in the region to achieve the Triple Aim, and make activities and findings transparent to the public. PHIP contractors will be expected to integrate and coordinate activities with regional health and human services planning agencies including, but not limited to, local public health departments, health care providers and payers, local departments of mental hygiene services,

regional health information organizations, area agencies on aging, social services agencies, and behavioral health regional planning consortiums.

The Delivery System Reform Incentive Payment (DSRIP) Program

[DSRIP](#) is a \$6.42 billion, five-year initiative that seeks to transform, through strategic incentive payments, the healthcare delivery system in New York State to one driven by clinical and population-level health outcomes. The statewide goal of DSRIP is to reduce avoidable hospitalization by 25% over five years, but DSRIP will be implemented through regional networks of providers called “Performing Provider Systems” (PPS) that will develop regional goals and plans to which they will be held accountable for performance payments.

DSRIP’s overarching strategy is to integrate hospitals and community-based providers into robust networks of person-centered care that reduce avoidable inpatient stays while shifting the emphasis to ambulatory and community-based care, wellness, and recovery. Projects are organized into three domains (System Transformation, Clinical Improvement, and Population Health) and numerous strategy areas that are designed to drive the transformation of hospital systems, in particular, toward more broad-based networks of community services and supports.

DSRIP represents an important opportunity for counties and local service providers to better serve their populations. The PPS community needs assessments have identified health and service delivery priorities for their catchment areas which will inform county priorities. When carrying out local services planning, LGUs should take into account the PPS network(s) and projects in their area, particularly as they impact the three disabilities areas that they oversee. More immediately, many LGUs will already be participating in one or more of the PPS networks, many of them as safety net providers, while others will have opportunities to clinically (or in other ways) link up with networks. Many PPS will develop networks that go beyond county borders. This is an opportunity for providers who serve individuals receiving services across counties or boroughs. Local LGUs will need to work collectively across counties and take a more regional approach as DSRIP and similar health care reform initiatives roll out.

Regional Planning Consortiums

The goals of Health Homes, integrated Medicaid managed care, DSRIP, and the Prevention Agenda call for sweeping transformation of the healthcare system. While the overarching goals are broad, the success of these healthcare reform initiatives will be contingent upon collaboration and planning at the community level and the performance metrics can be directly linked to issues and solutions in the community.

At the local level, the County Mental Hygiene Departments/LGUs prioritize, plan for, fund and oversee services in their counties across the mental health, substance abuse and developmental disability systems. The LGUs have a legal mandate under Article 41 MHL to assure that under the goals of the annual Local Services Plan (LSP):

- 1) the needs of all population groups (MH/SA/DD) are adequately addressed,
- 2) that the Local Services Plan is integrated and coordinated with other community OMH/OASAS and OPWDD programs, and
- 3) that the LGUs make policy and exercise general supervisory authority over local services and facilities including responsibility for proper performance of services.

The LGU fulfills this responsibility by being embedded in the community and collaborating across multiple systems, including social services, hospitals, child and family services, schools and adult and children criminal justice and the court system. The LGU has extensive knowledge of the community and the services that are available to our population.

This broader view of the healthcare system with a specialized, yet integrated, recovery-oriented behavioral health component holds new promise for manageably operationalizing investments and innovations in how the Medicaid program and the State agencies address integrated healthcare for adults and children with mental illness and substance use disorders. The Regional Planning Consortium (RPC) structure, put forward by the CLMHD, will facilitate regional and community collaborations with a specific focus on managed behavioral health reform issues.

The RPC is a multi-stakeholder group which reflects natural patterns of access to care and is comprised of: Consumers, Families and Youth; LGUs; MCOs and HARPS; adult and child services and housing providers; hospitals and primary care providers, state agencies, county social services and public health departments, the PPSs and the PHIPs. The RPC will function as the vehicle through which behavioral health and Medicaid managed care issues are identified, discussed, brainstormed, resolved locally when possible, and communicated to the State's health agencies (OMH, OASAS and DOH).

A primary function of the RPC in 2015-2016 will be to promote the effective implementation of managed Medicaid behavioral health services. The RPC is a vehicle to promote cross system community collaboration and to assist New York State with problem solving around issues that rise up during and after the transition to behavioral health managed care. The RPC is the early warning system for issues occurring on the ground, such as lack of access to care, timeliness of eligibility determinations and engagement in care.

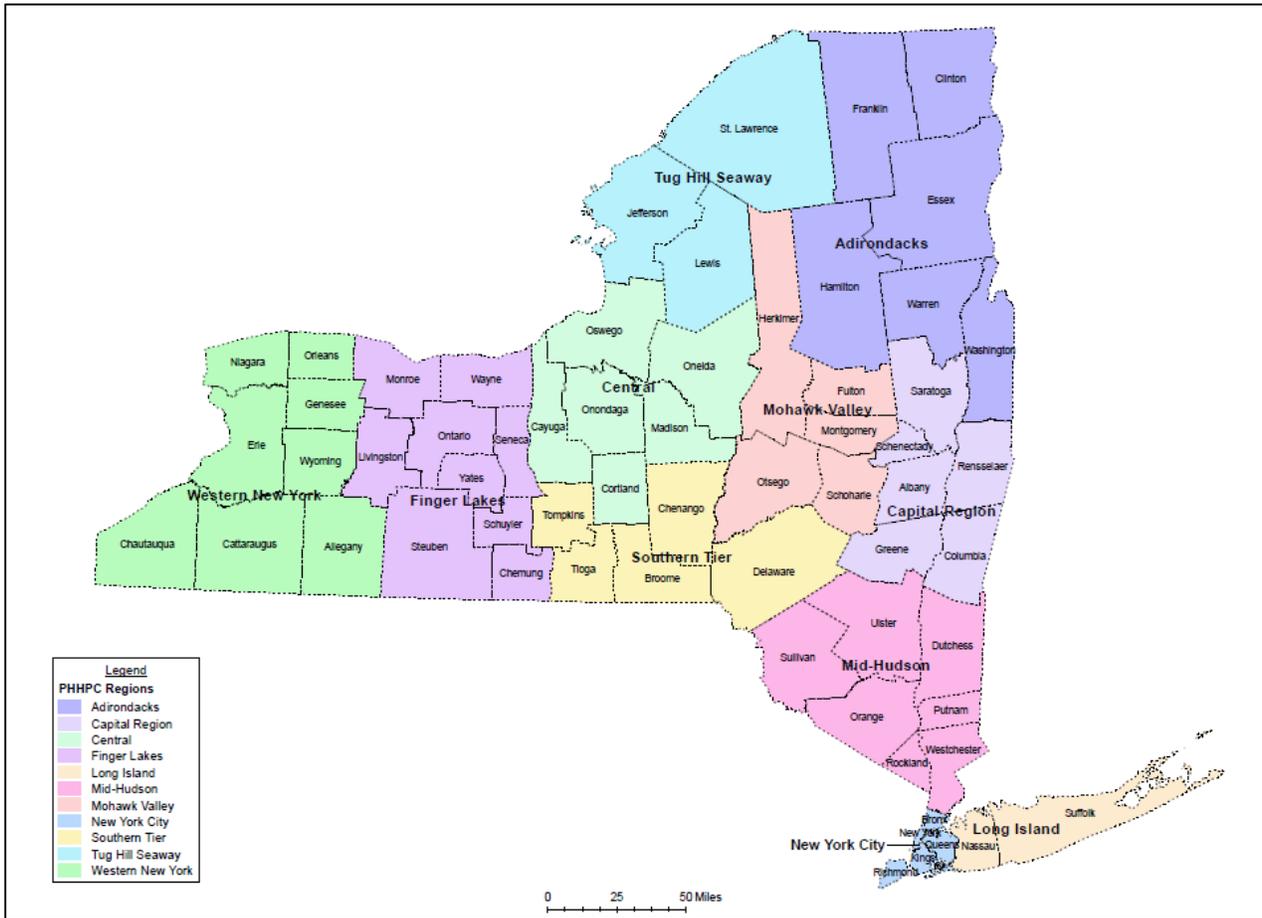
Key functions for the RPC include:

- Facilitation of Improving Services and Outcomes;
- Collaboration and System Improvement; and
- Monitoring Access and Capacity;

The RPC is where the work will be done to integrate local and regional needs and address priorities that are common across the region while ensuring that the unique needs of smaller communities are not lost.

The RPCs will be developed in the summer of 2015 in 11 regions of the state, including New York City. **Figure 2.1** shows the Public Health and Health Planning Council (PHHPC) regions, which is the basis for the RPCs and the LGU assessment of regional issues included in these guidelines. For additional information on the RPCs, please visit the [CLMHD](#) website.

Figure 2.1: Public Health and Health Planning Council (PHHPC) Regions



Counties by PHHCP Regions

Long Island:

Nassau
Suffolk

New York City:

Bronx
Kings
New York
Queens
Richmond

Mid-Hudson:

Dutchess
Orange
Putnam
Rockland
Sullivan
Ulster
Westchester

Capital Region:

Albany
Columbia
Greene
Rensselaer
Saratoga
Schenectady

Adirondacks:

Clinton
Essex
Franklin
Hamilton
Warren
Washington

Tug Hill Seaway:

Jefferson
Lewis
St. Lawrence

Mohawk Valley:

Fulton
Herkimer
Montgomery
Otsego
Schoharie

Central:

Cayuga
Cortland
Madison
Oneida
Onondaga
Oswego

Southern Tier:

Broome
Chenango
Delaware
Tioga
Tompkins

Finger Lakes:

Chemung
Livingston
Monroe
Ontario
Schuyler
Seneca
Steuben
Wayne
Yates

Western New York:

Allegany
Cattaraugus
Chautauqua
Erie
Genesee
Niagara
Orleans
Wyoming

The Prevention Agenda

The New York State [Prevention Agenda 2013-2017](#) is DOH's five-year plan for population health improvement. The goal of the Prevention Agenda is to improve health status and reduce health disparities in five priority areas:

- 1) Prevent Chronic Diseases;
- 2) Promote a Healthy and Safe Environment;
- 3) Promote Healthy Women, Infants and Children;
- 4) Promote Mental Health and Prevent Substance Abuse; and
- 5) Prevent HIV, STDs, Vaccine Preventable Diseases and Healthcare Associated Infections.

The Prevention Agenda establishes goals for each priority area and defines indicators to measure progress toward achieving these goals, including reductions in health disparities among racial, ethnic, and socioeconomic groups and persons with disabilities. The goal is to improve the health status of New Yorkers and reduce health disparities through an increased emphasis on prevention and collaboration. The Prevention Agenda also identifies interventions shown to be effective to reach each goal.

The Prevention Agenda promotes stakeholder collaboration at the community level to assess health status and needs, identify local health priorities and plan and implement strategies for local health improvement, and serves as a guide to local health departments (LHDs) and hospitals as they work together with their community to develop and implement Community Health Assessments, including Community Health Improvement Plans, required of local health departments, and Community Service Plans required of hospitals.

As LHDs and hospitals were encouraged to collaborate with each other and other community partners on the development of the Community Health Improvement Plans (CHIP), they were also encouraged to collaborate with LGUs if they had selected “**Promote Mental Health and Prevent Substance Abuse**” as one of their priority areas. Each LHD was required to address at least two of the five priority areas.

OASAS and OMH staff participated in the development of the guidelines for this priority area, which were endorsed by both agencies. A total of 30 LHDs identified one or more goals associated with promote mental health and prevent substance abuse. As **Table 2.1** shows, a total of 66 separate goals were included in those 30 plans, with 73% of them also included in the corresponding mental hygiene plan. In many cases the language and strategies included in the two plans were not in close alignment. To support and document the continued collaboration and shared goals, LGUs are encouraged to revisit their Prevention Agenda related priorities and work with their LHD to develop common language for their priorities, strategies and metrics.

Table 2.1: Goals Under the Promote Mental Health and Prevent Substance Abuse Priority

Goal	Goal Description	CHIP Goals
1.1	Promote mental, emotional and behavioral (MEB) well-being in communities.	9
2.1	Prevent underage drinking, non-medical use of prescription pain relievers drugs by youth, and excessive alcohol consumption by adults.	11
2.2	Prevent and reduce occurrence of mental, emotional and behavioral disorders among youth and adults.	7
2.3	Prevent suicides among youth and adults.	12
2.4	Reduce tobacco use among adults who report poor mental health.	5
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.	14
3.2	Strengthen infrastructure for MEB health promotion and MEB disorder prevention.	8
	Totals	66

The Promote Mental Health and Prevent Substance Abuse Action Plan is also included in the DSRIP Domain 4a and drives part of the State Health Innovation Plan (SHIP).

In November 2014, a Technical Assistance Day was convened in Albany to bring together the counties that collaboratively identified goals under the mental health and substance abuse focus area in the LHD's Community Health Improvement Plan and the LGU's Local Services Plan. The primary purpose was to identify and share the strategies each county was implementing to address the same goals and to begin developing performance measures to track progress on those goals.

OASAS and OMH planning staff addressed the need for ongoing local collaboration efforts through the county planning process. Content experts from several state agencies and statewide organizations were on hand to provide information and guidance to the counties on best practices related to the various goal areas. Many counties displayed story boards and described the collaborative activities they were engaged in with their local stakeholders. Breakout work groups provided an opportunity for participants to share their experiences and challenges. Data from the 2014 OASAS Youth Development Survey will also provide community-level information on risk and protective factors that are addressed by evidence-based practices (EBPs) in the areas of underage drinking, suicide prevention and opiate misuse.

The Technical Assistance Day was supported in part by the Robert Wood Johnson Foundation, through the University of Kentucky, and DOH. Planning partners included OASAS, OMH, the New York State Association of Community Health Officers (NYSACHO), the New York Academy of Medicine (NYAM), and the Conference of Local Mental Hygiene Directors (CLMHD).

SAMSHA Strategic Initiatives (FY 2015-2018)

In October 2014, the Substance Abuse and Mental Health Services Administration (SAMHSA) announced their action plan for promoting the nation's behavioral health over the next several years. The 2015-2018 Strategic Plan, [Leading Change 2.0: Advancing the Behavioral Health of the Nation](#), outlines the following six strategic initiatives that reflect SAMHSA's mission, vision and goals.

- Prevention of Substance Abuse and Mental Illness
- Health Care and Health Systems Integration
- Trauma and Justice
- Recovery Support
- Health Information Technology, and
- Workforce Development

The new strategic plan was developed to address the evolution of the substance abuse and mental health fields and to follow the guiding principles that behavioral health is essential for health, prevention works, treatment is effective, and people recover.

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 238,000 individuals in 2014 through outpatient, crisis, inpatient, residential and opioid treatment services. Approximately 300,000 New York State youth received a direct prevention service during the 2013-14 school year. 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."* Underlying all OASAS activity are the following guiding principles:

- Addiction is a chronic, treatable illness that requires lifelong attention for sustained recovery, similar to diabetes and heart disease. Successful treatment approaches are modeled on person-centered care and include new addiction medications, which combined with behavioral health approaches improve outcomes for patients.
- Prevention and treatment programs are being directed to use evidence-based strategies, which yield measurable results and successful outcomes.
- Recovery is a lifelong process that includes healthy lifestyle choices, housing, employment, and support from a recovery movement.

That local planning process is required by MHL to be broad-based and participatory. The LGU must engage their providers, consumers, and other stakeholders in that process. Ongoing planning, along with information and guidance from OASAS, helps the LGU to develop an annual plan that includes a local assessment of needs and priorities that will be addressed in the year(s) ahead. Those local priorities help to inform the OASAS statewide planning process. This section

of the plan guidelines contains significant updated policy and programming information that should help to support local system management efforts and inform the local planning process.

Level of Care for Alcohol and Drug Treatment Referral (LOCADTR) 3.0

OASAS will release the revised LOCADTR 3.0 in 2015. LOCADTR 3.0 is a tool used to determine appropriate level of care for individuals seeking substance abuse treatment services, and was developed in collaboration with CASAColumbia. The revised LOCADTR is designed to identify the level of care best suited to an individual based on need, potential risks, and available resources in a setting as near to their community as possible. Substance abuse treatment providers in New York City will be required to use LOCADTR 3.0 on July 1, 2015. Providers in the rest of the state will implement LOCADTR 3.0 on January 1, 2016. These dates align with the transition from fee-for-service to Medicaid managed care for behavioral health care services in New York State. Managed care organizations who serve the Medicaid population are required to use LOCADTR 3.0 or another OASAS-approved level of care tool to assess appropriate placement for substance abuse treatment services. In utilizing a common tool for level of care determination, treatment providers and managed care organizations will have a shared language when assessing client service needs. LOCADTR 3.0 provides clear criteria and a consistent platform for the level of care determination.

OASAS is also proposing a state plan amendment that would allow for clinic visits to be provided off-site to enhance the type of services and improve linkage and continuity of care for people who have not engaged in or who have disengaged from a treatment episode.

Screening, Brief Intervention and Referral to Treatment (SBIRT)

Screening, Brief Intervention and Referral to Treatment (SBIRT) is an evidence-based approach to identify risky alcohol and substance use and reduce dependence. Identifying patients who use alcohol and drugs at high risk levels and then offering a brief intervention or treatment can help prevent or mitigate health consequences, disease, accidents, and injuries.

In 2013, the Substance Abuse and Mental Health Services Administration (SAMHSA) awarded New York State a five-year, \$10 million SBIRT Cooperative Agreement to serve individuals on Long Island and Staten Island who were affected by Hurricane Sandy through a partnership among OASAS, the National Center on Addiction and Substance Abuse at Columbia University (CASA Columbia), and the North Shore-Long Island Jewish Hospital System.

In 2012, the Center for Substance Abuse Treatment (CSAT) approved technical assistance for OASAS to develop a plan to implement SBIRT in school-based health centers. The SBIRT demonstration project was designed for identification and intervention with youth at risk for substance abuse and carried out in collaboration with Basset Healthcare Network in the Cooperstown area, Rochester General Health System, and the University of Rochester. By the end of March 2014, 160 youth had received services.

Residential Redesign

Residential Redesign will be a direct result of Medicaid Redesign and managed care. It will include OASAS residential treatment options to divert appropriate individuals from higher levels of care to more appropriate community-based options and to allow for bedded programs to provide short-term crisis/respite options. There is a need for a residential continuum of care that can provide clinical and medical care based on individual needs. Often people who are in need

of residential levels of care have addiction, medical and psychiatric needs for stabilization and for ongoing monitoring and intervention as they progress through care. There is a system need for levels of care that can provide a safe environment for people who are beginning opioid treatment, experience mild withdrawal or significant urges or cravings that cannot be managed or have mental health symptoms that are not stable. Currently, many of these individuals are served in higher levels of care (e.g., hospital detoxification units) than are necessary or lower levels of care (e.g., outpatient clinic) than are successful.

OASAS envisions a residential continuum of care that is able to meet the needs of each individual based on an assessment of individual risks and resources. Residential Redesign will incorporate the following three elements of treatment:

- **Stabilization** - Individuals will receive medically-directed care to stabilize acute medical, mental health and addiction symptoms.
- **Rehabilitation** - Individuals will learn to manage recovery within the safety of the program. (Note: Within the context of the residential redesign initiative “Rehabilitation” refers to the rehabilitative component of a residential treatment modality and is not synonymous with either the type of treatment/services(s), staffing, or level of medical care provided in an [OASAS certified Part 818 Chemical Dependence Inpatient Rehabilitation Certified Program](#).)
- **Community Re-integration** - Individuals will further develop recovery skills and begin to re-integrate into the community.

OASAS will work with its local government partners as the providers self-assess their readiness to transition to some or all elements of residential services. This would include assessing what does, or will, a program offer and how does this fit within the continuum of services offered in the region or county.

Heroin and Other Opioid Use

In June 2014, Governor Cuomo signed legislation to combat the growing heroin and opioid epidemic in communities across the State. The legislation includes new programs and insurance reforms to improve treatment options for individuals suffering from heroin and opioid addiction; measures to strengthen penalties and put in place additional tools for law enforcement to crack down on the distribution of illegal drugs; support for enhanced public awareness campaigns to prevent drug abuse; and provisions to ensure the proper and safe use of naloxone.

The Centers for Disease Control (CDC) recently released data demonstrating that since 2012, deaths in New York from heroin overdose have increased by 39%. The Youth Risk Behavior Survey found that the percentage of high school students who reported using heroin more than doubled between 2005 and 2011 (1.8% to 4%).

A multi-agency Opioid Steering Committee has been overseeing the planning and implementation of the range of heroin and prescription drug abuse initiative activities authorized in the legislation. The Opioid Steering Committee workgroups are addressing the following:

- Naloxone (Narcan) training and access;
- Data and metrics;
- Prevention/treatment/education;
- Public safety/enforcement.

OASAS coordinates the prevention/treatment/education workgroup. As part of implementing the Heroin/Opioid prevention agenda, OASAS developed a multifaceted media campaign targeting youth, parents, healthcare providers, and the general public. OASAS held listening forums to ensure that the message was developed with input from parents who have lost children due to an overdose, young people in recovery, college students, families not affected by substance use disorders, and prevention and treatment providers.

In addition to television, radio and social media, the Combat Heroin campaign includes a new website that is easy to navigate and contains information about the warning signs of heroin addiction, a listing of treatment providers, prevention guidance for parents about talking to their children and information for viewers who want to get involved in the community. The site also contains resources for healthcare professionals.

OASAS' prevention and treatment network will also utilize all of the tools developed for community outreach to raise awareness of opiate misuse. The agency is working collaboratively with SUNY and CUNY to train and educate college personnel to administer the anti-overdose medication, Naloxone. Through collaboration with the State Education Department, OASAS is providing resources to update the statewide health curriculum used in schools.

OASAS has treatment capacity available to serve individuals addicted to heroin or prescription opioids. There are 70 crisis, 61 inpatient, 110 opioid treatment, 486 outpatient, and 235 intensive residential treatment programs. These programs serve nearly 97,000 individuals on any given day. To ensure the treatment system has sufficient residential treatment capacity, in 2013, OASAS approved the development of two new 25 bed facilities, one on Long Island and the second in Western New York, to serve 18-24 year-olds in particular. A third 24-bed facility was approved for Staten Island.

OASAS mandated by regulation that all Medical Directors in its treatment system must be authorized to prescribe buprenorphine. Buprenorphine is an appropriate medication assisted treatment for some individuals who are dependent on opioids, such as heroin and prescription drugs. Physicians must have a federal waiver to prescribe buprenorphine for the treatment of opioid addiction. Statewide, there are 1,713 physicians and 110 opioid treatment programs with the federal waiver to prescribe buprenorphine.

The second phase of New York State's Combat Heroin campaign, which has reached more than 14 million people through social media so far, reached an even broader audience, by public service announcements airing in movie theaters across New York State. Additionally, ten new "Real Story" videos have been posted to the state's [Combat Heroin](#) website. The PSAs and new videos show New Yorkers sharing their stories of recovery and describe the dire consequences of addiction for individuals and families. The PSAs were also shown in movie theaters before select movies rated PG-13 or R from mid-December 2014 through early January 2015, peak movie season.

On February 17, 2015, Governor Cuomo announced the next phase of the statewide Combat Heroin and Prescription Drug Abuse Awareness campaign. The campaign includes messages on billboards, posters, online advertisements, social media and commercials that will be aired across the state for four weeks. The messaging warns that alcohol overuse and abuse of prescription opioid medications are often a gateway to heroin use, and refers those who need help to New York State's 24-hour addiction HOPEline at 1-877-846-7369. The [Combat Heroin](#)

[PSAs and videos](#) underscore the message that while addiction can happen to anyone, any family, at any time – recovery is possible.

Prevention

The OASAS [2014 Prevention Guidelines](#) require that prevention service providers base proposed programming on a needs assessment and a local prevention plan, and that they monitor the outcomes of their services on a two-year cycle. The Guidelines provide minimum program performance standards and provide the structure for the prevention field, counties and regulatory bodies to implement and enhance consistent prevention delivery and oversight throughout New York State.

Evidence-based practices (EBPs) are a required standard of programs and the guidelines ask prevention providers to document their utilization and challenges of implementing particular EBPs. Community coalitions, environmental strategies, education and awareness and community capacity building are all critical components of an effective prevention program or system. OASAS established six Prevention Resource Centers (PRCs) to provide support to local communities, counties and prevention providers to establish and assist community coalition development efforts.

Registry of Evidence-based Programs and Strategies

The OASAS Registry of Evidence-based Programs & Strategies (REPS) was developed to support providers in identifying Evidence-based Programs and Strategies (EBPS) that meet OASAS policy priorities, evidence criteria and to update the providers' "toolbox" with innovative and culturally competent programs.

Providers may submit evidence of effectiveness for an established EBPS or for an innovative program for special populations to the Review Panel for determination of EBPS status. The panel convenes twice a year to review applications from OASAS providers and to consider new research on the existing EBPS grandfathered into the Registry from the former Center for Substance Abuse Prevention (CSAP) Model Program registry.

The Strategic Prevention Framework State Incentive Grant (SPF SIG): In 2009, OASAS was awarded a five-year Strategic Prevention Framework State Incentive (SPF SIG) grant from SAMHSA. The grant funded 11 community coalitions in communities that had an underage drinking prevalence rate above the statewide average (or above the city average in New York City) as determined by the 2008 New York State Youth Development Survey.

Over the past four years, 11 community coalitions (and more recently, an additional five mentee coalitions) worked to build a sustainable prevention infrastructure and implement evidence-based environmental strategies. Coalitions were charged with changing attitudes, behaviors, and norms surrounding underage drinking in their communities. Preliminary results from the 2013 Youth Development Survey indicate that in all the SPF SIG communities, underage drinking and binge drinking have decreased over the course of the grant period. The SPF SIG grant ends on March 31, 2015 and a final report will be released later in the year.

The Strategic Prevention Framework Partnership for Success (SPF PFS): In September 2014, SAMHSA awarded the Research Foundation for Mental Hygiene (RFMH) a five-year \$8.13 million Strategic Prevention Framework Partnership for Success (SPF PFS) grant. OASAS, working with RFMH, will target prevention priorities focused on the following:

- 1) prescription drug misuse and abuse among persons aged 12 to 25, and
- 2) heroin abuse and heroin/opiate overdose prevention among persons aged 12 to 25.

Up to ten high need community coalitions will be selected through a competitive RFP process in early 2015. The coalitions selected will implement environmental strategies in their communities and strive to meet the following goals:

- 1) Prevent the onset and reduce the progression of substance abuse, particularly childhood and underage drinking, and reduce substance abuse related consequences.
- 2) To demonstrate a reduction in risks and increase in protective factors in the sub-recipient communities.
- 3) Build prevention capacity and infrastructure at the State and community levels.

Prescription Drug Misuse

Prescription drug misuse occurs when a person takes a prescription medication that is not prescribed for him/her, or takes it for reasons or in dosages other than prescribed. The nonmedical use of prescription medications has increased in the past decade and has surpassed all illicit drugs except marijuana in the United States. Misuse of prescription drugs can produce serious health effects, including addiction. To start addressing safe prescription disposal, OASAS collaborated with DOH, Department of Environmental Conservation, and New York State Police in the National Prescription Drug Take Back Day. This program allows people to safely dispose of unwanted or unused prescription drugs at local community drop-off sites.

Fetal Alcohol Spectrum Disorders (FASD)

Fetal Alcohol Spectrum Disorders (FASD) is a permanent birth defect caused by maternal alcohol consumption during pregnancy and is the leading known cause of preventable intellectual disabilities. Individuals with FASD can experience a range of lifelong physical health, cognitive, emotional, and behavioral problems with associated cost ranging from \$860,000 to \$4.2 million. The range of these problems for an individual depends on the timing of the prenatal alcohol exposure, the frequency and quantity of the alcohol, as well as maternal and genetic factors. If FASD goes undiagnosed and/or unaddressed, individuals are at risk for secondary disabilities such as mental health, substance use disorders, disrupted school experience, unemployment, homelessness, dependent living, and incarceration. Often women do not know they are pregnant for several weeks (or even months) during which time they may drink alcohol. FASD affects 40,000 babies born each year in this country, so there is still much to be done to educate women and their families about the dangers of prenatal alcohol consumption.

Problem Gambling

OASAS supports statewide prevention and treatment services that target problem gambling. Treatment for problem gambling is provided in 21 outpatient programs and one inpatient program. OASAS also partners with the New York Council on Problem Gambling (NYCPG) to integrate problem gambling awareness into its prevention system.

Over the past year the NYCPG trained at least one person from every prevention provider in the State. Approximately 260 staff attended as well as 5-6 LGUs. All the prevention providers had the training by the Council they were required to do 3 public awareness presentations. This equates to over 500 problem gambling prevention presentations statewide.

The NYCPG also awarded mini-grants to providers who had previous experience working with problem gambling for the implementation of two public awareness projects.

OASAS is directly funding three targeted problem gambling public awareness campaigns in New York City to specific communities and ethnic groups: Hispanic (Bronx), Jewish (Brooklyn), and Asian (Manhattan).

Problem gambling services are provided in 21 outpatient treatment programs and at the state-operated St. Lawrence Addiction Treatment Center (ATC).

To increase access, OASAS is also collaborating with the NYCPG, the National Association of Social Workers and other professional associations to develop a network of private practitioners who are trained and certified by OASAS to treat individuals and families affected by problem gambling.

OASAS is also working with the Council to develop a pilot project for problem gambling to serve the area around Aqueduct Raceway in Queens. This project will help to increase awareness of problem gambling, offer referrals for treatment and supportive services to individuals and families who are dealing with a problem gambling issue. This pilot project could serve as a model for future expansion of problem gambling services.

Recovery

Recovery is one of the primary goals for behavioral health care. Research clearly demonstrates that individuals can and do recover from substance use disorders, including co-occurring disorders, to achieve wellness and a productive life in the community. Recovery is not an event, rather a process of change through which individuals improve their health and wellness, live a self-directed life and strive to reach their full potential. OASAS is partnering with people in recovery and their family members to guide the system and promote individual, program and system-level approaches that foster health and resilience; increase housing to support recovery; reduce barriers to employment, education and other life goals; and secure necessary social supports in their chosen community. There are four major dimensions of recovery:

- **Health:** To recover, people need access to affordable, accessible, and high-quality health and behavioral healthcare. Overcoming or managing one disease(s) or symptoms (e.g., abstaining from the use of alcohol, illicit drugs and non-prescribed medications) and, for everyone in recovery, making informed healthy choices that support physical and emotional well-being.
- **Home:** To recover, people need a stable and safe place to live.
- **Purpose:** To recover, people need meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income, and resources necessary for people to fully participate in their communities.
- **Community:** To recover, people need relationships and social networks that provide support, friendship, love and hope.

Recovery provides a common and motivating goal for consumers/peers, families, providers and service systems that people can and do heal, overcome behavioral health problems and live full and productive lives. For many individuals, recovery may include continuing clinical care and supportive services such as peer supports. The promotion of the four dimensions of recovery will also increase protective factors that assist in the prevention of behavioral health conditions.

Recovery Community Centers: OASAS currently supports four Recovery Community Centers located in Brooklyn, Rochester, Oneonta and Delhi through technical assistance and funding. These Centers function as social support networks for individuals and their families that are in recovery, and function as community resources for the conduct of outreach and engagement of individuals and their families that are experiencing distress due to substance use disorders.

Recovery Support Councils: OASAS intends to develop the infrastructure to conduct outreach to and engage individuals and their families in recovery and advocacy through the formation of regional Recovery Support Councils that are responsive to local community issues regarding substance use disorders. These Councils will facilitate bidirectional communication between OASAS and the communities it serves and will provide a conduit for responding to local needs such as parent training and support network creation. The goal is to assist in the creation of grassroots advocacy that is instrumental for system change. OASAS envisions working with these Councils for inclusion in policy discussions on services moving forward.

Peer Support Services: OASAS will promote community living for individuals with substance use disorders and their families by increasing the number and quality of peer specialists, recovery coaches and by increasing the young adult and other peer-run/family-run recovery support service provider organizations. Peer workers fill many roles and work in a variety of settings to assist with the engagement and retention of individuals in recovery. The new OASAS Peer Specialist certification offers an opportunity for former recovery coaches to transition to a position that will be Medicaid reimbursable within outpatient clinic settings. It is estimated that there are over 1,000 recovery coaches that have received formal recovery coach training. OASAS is collaborating with the New York Certification Board and the New York Certification Association to conduct outreach to existing coaches and assist them in applying to become certified Peer Specialists over the next two years. Peers in the workforce will strengthen the commitment to person-centered and recovery-oriented approaches. Programs with peers have found that peers can perform many tasks that are helpful to persons served and that peers tend to be more effective with outreach and engagement of people who have been reluctant to participate in behavioral health services.

Peer support services are consumer-delivered services with a rehabilitation and recovery focus. They are designed to promote skills for coping with and managing behavioral health disorder symptoms while facilitating the utilization of natural resources and the enhancement of recovery-oriented principles (e.g., hope and self-efficacy, and community living skills). Peer support uses non-clinical assistance to achieve long-term recovery from behavioral health-related issues.

Peer support activities must be intended to achieve the identified goals or objectives as set forth in the consumer's individualized care plan, which delineates specific goals that are flexibly tailored to the consumer and attempt to utilize community and natural supports. The intent of these activities is to assist recipients in initiating recovery, maintaining recovery, and enhancing the quality of personal and family life in long-term recovery.

The structured, scheduled activities provided by peer support services emphasize the opportunity for peers to support each other in the restoration and expansion of the skills and strategies necessary to move forward in recovery. Persons providing these services will do so through the paradigm of the shared personal experience of recovery.

Housing

In spite of the significant addition of permanent supportive housing (PSH) units to the OASAS housing portfolio in recent years, a majority of LGUs continue to identify this area as a top priority in their local services plan. Forty-one LGUs (72%) included a housing priority in last year's plan. Most of those priorities included working with local housing providers to expand available permanent housing options that will include needed supportive services. Several plans included the development of or expansion of state-supported housing programs, non-licensed, non-funded sober living facilities, and single-room or scatter site housing. Four counties specifically addressed the need for short-term emergency or transitional housing. All counties stressed the need for housing options to be safe, appropriate, and affordable with supportive case management services to enable a unified re-entry into the community while maintaining recovery.

OASAS oversees and administers a housing portfolio that is funded at approximately \$31 million with six distinct brands of permanent supportive housing. The OASAS housing portfolio funds a total of 1,908 apartment units included within the following programs:

- Shelter Plus Care/Continuum of Care Program, which is federally funded and overseen by the U.S. Department of Housing and Urban Development (HUD);
- NY/NY III Homeless Agreement, which is a 10-year NYC/NYS partnership initiative to create up to 9,000 units of permanent supportive housing for chronically homeless adults and families;
- Upstate PSH Initiative, which targets homelessness in counties and regions outside of NYC and its metropolitan (Metro NY) counties;
- NYC-based Re-Entry PSH initiative for Parolees, which is a collaboration with NYS Division of Parole; and
- Medicaid Redesign Team (MRT) Affordable Housing Initiative, which is in its second year of providing permanent supportive housing to single adults that are high cost frequent consumers of Medicaid benefits and has achieved a 98% occupancy rate with its 300 apartment units.

C. Planning for Mental Health Services

The forces of change in Medicaid Redesign, mental health parity, managed behavioral health and the Olmstead Plan continue to drive the transformation of the public mental health system in New York State, 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.

The OMH Transformation Plan for State and Community-Operated Services

The Office of Mental Health (OMH) Transformation Plan aims to rebalance the agency's institutional resources by further developing and enhancing community-based mental health services throughout New York State. By doing so the Plan will strengthen and broaden the public mental health system to enhance the community safety net; allowing more individuals with mental illness to be supported with high quality, cost effective services within home and community-based settings and avoid costly inpatient psychiatric stays. Beginning with the State fiscal year (SFY) 2014-2015 State Budget, the OMH Transformation Plan "pre-invested" \$25 million

(annualized to \$44 million) into priority community services and supports, with the goals of reducing State and community-operated facilities' inpatient psychiatric admissions and lengths of stay.

During the fall and summer of 2013 a broad set of community stakeholders participated in regional advisory bodies which met to set goals focused on the following resources: Supported Housing, Medicaid Home and Community Based Services (HCBS) waiver, State-operated community enhancements, and Aid to Localities funding—in addition to overall systemic reforms required to most effectively use these resources. In early 2014, planning for pre-investment funding began in all areas of the State: Western New York, the Rochester area, the Southern Tier, the North Country, the Syracuse area, the Hudson River region, New York City, and Long Island. Through this process, LGUs, OMH field offices, and State-operated psychiatric center directors are working collaboratively to operationalize these goals.

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 disabling for individuals, and more expensive to treat. Initiatives focused on early identification and intervention include collaborative efforts with the Department of Health on the Prevention Agenda 2013-2017, and initiatives including:

Collaborative Care: To improve outcomes, OMH and the Department of Health (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. The 2014-2015 State Budget includes additional funds to expand Collaborative Care to more sites and to include screening for substance abuse disorders.

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

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. In 2014-2015 the OMH FEP initiative now entitled *OnTrackNY* will be expanding to additional upstate sites, including some more rural, sparsely populated areas that currently have no formal FEP interventions in place.

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.

In June of 2014 OMH formed the *Suicide Prevention Office (SPO)* to coordinate and align OMH's suicide prevention activities. In addition, OMH represented New York as one of only four states to be awarded SAMHSA's first ever *National Strategy for Suicide Prevention* grant which targets the middle aged cohort (ages 25-64); an age group accounting for 70% of all suicides in New York. This grant employs a two pronged approach: a) a narrowly crafted intervention targeting high risk individuals presenting in suicidal crisis to CPEPs; and b) a broad push to advance "suicide safer care" across Article 31 mental health outpatient clinics in what is being called the *New York Academy for Suicide Safer Care (NY ASSC)*. Grant catchment areas are Erie and Monroe Counties with statewide dissemination of lessons learned.

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, to help with early identification of social and emotional challenges in children and youth, 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:

Peer Workforce Expansion: Given the demand for more information on using peer staff, the OMH Office of Consumer Affairs has provided comprehensive in-person training in all New York State regions for both State and community providers. These trainings help agencies recruit, train, and support peer staff in a variety of program types and roles. They will continue through a series of webinars in 2015 and ongoing technical assistance for LGUs and providers as needed. Local governments, voluntary organizations, and other potential peer employers may also obtain resources on peer workforce development through a free federal resource called the [Job Accommodation Network \(JAN\)](#).

In addition to increasing the size of the peer workforce, New York State has a strong commitment to ensuring a qualified peer workforce that provides evidence-based practices. To ensure continued opportunities for peer services, OMH worked with peer leaders to develop a Peer Specialist Certification process which is currently accepting enrollees. The Academy of Peer Services is a free online training platform for individuals delivering peer support services in New York State. The Academy was developed through the collaboration of peer leaders and the Rutgers University School of Health Related Professions. Enrollment in the Academy can be done on the [Academy of Peer Services](#) website.

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. In addition, OMH continues to promote the credentialing of Family Peer Advocates (FPAs) and is working with youth peer advocates on the development of a Youth Peer Advocate credential. The standardization of this credentialing process will help build and sustain the integration of peer services into the future.

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 known as the [New York Employment Services System \(NYESS\)](#). NYESS serves 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.

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.

Preparing for and Serving our Aging Population: Based on its work with a recent round of health integration projects, the OMH Geriatric Technical Assistance Center (GTAC) developed a geriatric health integration planning guide in 2014 to help providers plan and sustain health integration programs for the elderly in either physical or behavioral health care settings. The [Integrated Primary Care and Behavioral Health Services for Older Adults: Options for New York State Providers](#) guide is available on National Council for Behavioral Health website.

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.

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. An addition to the OMH menu of data reports in 2014 was the [County Capacity and Utilization Data Book](#). This tool's purpose is to help users identify the location and utilization patterns for these psychiatric services to further assist in planning improved service delivery.

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 OMH 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

New York State Office for People With Developmental Disabilities (OPWDD) is undergoing a large scale transformation, reflective of the desires and expectations of individuals with developmental disabilities and parents of children with disabilities. The goals embodied in OPWDD's system transformation are designed to ensure that each person is better understood, better served and ultimately experiences better outcomes and community participation to the greatest extent possible. The transformation is focused on creating a system that embodies person-centeredness, community integration and sustainability. Achieving such transformational goals will require coordination between local and state planning efforts. The following sections outline a variety of initiatives and partnerships designed to enhance quality and the overall experience for people seeking support and receiving services.

System Transformation: OPWDD is planning for a system wide transformation that requires 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. In addition to these transformative initiatives, OPWDD is developing a managed care system with an emphasis on individual choice, easing access to community-based services, and coordinating services across service systems for people with developmental disabilities with medical and behavioral healthcare needs.

System Wide Initiatives

The Front Door: The purpose of the Front Door is to help people access the services they need, ensure supports are provided in the most integrated setting possible, and to offer increased opportunities for supported employment and self-direction. 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 all or some of the Front Door process, as well as those who experience a change in support needs or request a modification to their services

Based on feedback from individuals, families and other stakeholders, OPWDD has made several improvements to the Front Door to enhance the experience for individuals seeking services. The changes expedite processes for obtaining services, determining eligibility for services, and developing a preliminary service plan to speed access to needed support.

OPWDD continues to seek input from individuals, families, and other stakeholders as we refine the process further and make the system more responsive to the needs of the people we serve. Additional standardization of practice across the state will ensure a consistent experience for individuals and their families.

Coordinated Assessment System: The Coordinated Assessment System (CAS) is a comprehensive needs assessment tool, designed to evaluate the ability levels of individuals with developmental disabilities, and inform the development of person-centered support plans. OPWDD is in the process of validating the CAS tool, which ensures that the tool is effectively measuring what it is intended to measure. During the validity study approximately 1000 individuals of varying needs will be assessed using the CAS in a variety of settings. Once the tool has been validated, OPWDD will use The CAS to gather information about people seeking supports and services and create a comprehensive profile about the person.

New York Systemic, Therapeutic, Assessment, Respite and Treatment (NY START) Services: OPWDD partnered with leaders at the Center for START Services in July 2012 to develop a START model for New York State. NY START is a community-based program that provides crisis prevention and response services to individuals with developmental disabilities and behavioral health needs, as well as their families and those who provide support within the community. NY START is not a separate system and does not replace existing services. The NY START program enhances the system's capacity for community-based crisis prevention and response to support individuals with developmental disabilities and complex behavioral health needs, and focuses on establishing integrated services with mental health providers. NY START is being implemented statewide via a gradual regional rollout over the next four to five years

Culture Change and the Workforce

OPWDD recognizes the importance of a skilled, competent and ethical workforce, and is investing in the workforce to ensure staff have the tools and support they need to excel at the important work they do supporting individuals with developmental disabilities. To make OPWDD's transformation a success, the shift in the way services are delivered must be supported by a shift in organizational culture throughout the workforce. OPWDD is engaged in a number of exciting initiatives to make that happen.

Positive Relationships Offer More Opportunities to Everyone (PROMOTE): OPWDD is implementing Positive Relationships Offer More Opportunities To Everyone (PROMOTE), a

training curriculum designed to support individuals with developmental disabilities by assisting staff to safely and effectively address potential behavioral challenges. PROMOTE is based upon building positive relationships between staff and the people they serve to address and prevent challenging behaviors. Staff are currently being trained in PROMOTE, which will eventually replace the staff training program known as Strategies for Crisis Intervention and Prevention-Revised (SCIP-R).

Direct Support Professional Core Competencies: To advance the skills and abilities of direct support professionals, the New York State Direct Support Professional (DSP) Core Competencies were created. The core competencies are areas of focus for delivering high quality services, are based on nationally validated community support skill standards, and center on the belief that knowledge, skills and ethics are the foundation of quality. Staff supervisors are being provided training and other tools to ensure all DSPs are proficient in the core competency areas.

Direct Support Professional (DSP) credentialing program: OPWDD is engaged in designing a framework for a comprehensive Direct Support Professional (DSP) credentialing program. The program will review national and international credentialing models, study education and training requirements and career paths, and determine the feasibility and cost of implementing an effective financial incentive program to reward highly qualified and credentialed DSPs.

OPWDD Quality Oversight

An individual's health and safety is the foundation for personal growth and a good life, and OPWDD continues to ensure that the health and safety of the individuals in the service system is our top priority.

Electronic Health Record for State Services: OPWDD is developing an electronic health record system for individuals receiving services through state-operated programs. This important quality improvement initiative will enhance service coordination and provide an integrated health record for individuals served by the State. OPWDD anticipates implementing the system at limited facilities during an initial pilot phase in the fall of 2015. Upon successful completion of the pilot phase, OPWDD will phase in implementation statewide.

Division of Performance Metrics and Data Management: In August 2014, OPWDD created the Division of Performance Metrics and Data Management. The goal of this Division is to improve access and understanding of the information that we currently collect, as well as measuring the impact of policy decisions and programmatic changes by using that data. The Division will help guide future strategic initiatives through data-supported recommendations, and oversee performance data for ongoing and new programs and policies.

OPWDD and the Justice Center: OPWDD works closely with the New York State Justice Center for the Protection of People with Special Needs (Justice Center) to ensure everyone served through the OPWDD system receives high quality services. The Justice Center was created to support and protect the health, safety, and dignity of all people with special needs and disabilities through advocacy of their civil rights, prevention of mistreatment, and investigation of all allegations of abuse and neglect so that appropriate actions are taken. In the coming year, OPWDD will be working with the Justice Center and other state oversight agencies to develop a universal incident management system, which will collect data to aid in continuous quality improvement efforts. Additionally, OPWDD offers trainings to provider agencies on Justice Center requirements, ensuring high quality standards for investigations.

Managed Care in the OPWDD Service Delivery System

OPWDD is developing a managed care system with an emphasis on individual choice, easing access to community-based services, and coordinating services across service systems for people with developmental disabilities with medical and behavioral healthcare needs. Central to this specialized managed care system is enhanced care coordination, which will help people with developmental disabilities to promptly access the support they need to live active and engaged lives in their communities, through an easy to understand process.

DISCOs: The OPWDD specialized managed care system will be organized through managed care entities called **Developmental Disability Individual Support and Care Coordination Organizations (DISCOs)**. DISCOs will specifically serve individuals with developmental disabilities and coordinate care, while services will be provided through a network of service providers. OPWDD, in conjunction with the Department of Health, is evaluating start-up grant applications submitted by organizations that wish to become DISCOs. The start-up grants may be used by DISCOs to develop information systems that will support care coordination, and information sharing that will improve service provision and ensure important information about an individual is available to the entities providing support to the individual.

Transformation Panel: OPWDD is establishing a transformation panel to support planning efforts, answer remaining questions and involve the public in creating solutions. This Panel will review methods to operationalize managed care for the OPWDD system, and issue recommendations for public reaction. The panel will be comprised of experts with experience in Managed care service systems and knowledge of OPWDD. This panel, in addition to the Joint Advisory Committee, will provide critical guidance for the development of specialized managed care services going forward.

Home and Community Based Services (HCBS) Settings Transition Plan

Effective March 17, 2014, the Centers for Medicare & Medicaid Services (CMS) adopted rules that contain standards for Home and Community Based Services (HCBS) settings to ensure that individuals receive services in settings that are integrated in and support full access to the greater community. These new federal regulations are aligned with OPWDD's transformation goals and activities, and will further enhance the delivery of person-centered and person-directed services for all people supported throughout the OPWDD system.

OPWDD continues to work with the New York State Department of Health (DOH) and other state agencies that deliver Home and Community Based Waiver Services to develop the Statewide Transition Plan for adhering to the new federal Home and Community Based Waiver Services regulations and guidance due to CMS in March 2015.

In the future, depending upon approval of OPWDD's HCBS Settings Transition Plan, OPWDD expects to incorporate the standards into certification requirements for certified residential settings and non-residential settings so that each setting:

- Is integrated in and supports access to the greater community;
- Provides opportunities to seek employment and work in competitive integrated settings, engage in community life and control personal resources;
- Ensures the individual receives services in the community to the same degree of access as individuals not receiving Medicaid home and community-based services;

- Is selected by the individual from among setting options, including non-disability specific settings and an option for a private unit in a residential setting if the person’s needs, preferences and resources align;
- Ensures an individual’s rights of privacy, dignity, respect, and freedom from coercion and restraint;
- Optimizes individual initiative, autonomy, and independence in making life choices; and
- Facilitates individual choice regarding services and supports, and who provides them.

Supporting people in community based settings

OPWDD’s goal is to ensure that everyone served through the OPWDD system will have the chance to live, work and play in the most integrated community setting possible. Individuals with developmental disabilities have a right to access their community and OPWDD services aim to support them.

Community Housing Options: Housing options throughout the OPWDD system range from rental support for an independent apartment, to group homes specialized in around-the-clock supervision. It is OPWDD’s priority that individuals are served in the most integrated setting, and are able to live with as great a degree of independence as possible.

Residential Registration List Initiative: OPWDD is developing a comprehensive plan to address the needs of individuals with developmental disabilities who have requested certified residential services outside their family home. The preferences of individuals and their family members for residential services will be addressed through an assessment process focused on building service capacity in the OPWDD system to meet the needs of individuals through person-centered, community-integrated opportunities.

Reducing Institutional Capacity: Over the past thirty years, OPWDD has made major strides in reducing the number of individuals living in institutional settings. These efforts continue through the closure of developmental centers (DCs) and the conversion of Intermediate Care Facilities (ICFs) to community-based models of support. Residents in these institutionally-modeled facilities will be given the opportunity to live in the most community integrated setting possible, and be served in the community with appropriate clinical support to ensure their health and safety.

Developmental Center Closure Plan: In 2013, OPWDD announced plans to close four of its six remaining large campus-based Developmental Centers (DCs), and retain an institutional capacity of 150 opportunities at two separate campuses for individuals who require focused, intensive evaluation and treatment prior to returning to a community setting. Today, fewer than 500 individuals live in OPWDD’s Developmental Centers.

Developmental Center Name	Planned Closure Date
Oswald D. Heck Developmental Center	March 31, 2015
Brooklyn Developmental Center	December 31, 2015
Broome Developmental Center	March 31, 2016
Bernard M. Fineson Developmental Center	March 31, 2017

ICF Transition Plan: An Intermediate Care Facility (ICF) is an institutionally-modeled type of group home. OPWDD established a five-year plan for decreasing its reliance on Intermediate Care Facilities (ICFs) beginning in late 2013, with expected completion by late 2018. During 2015, OPWDD will continue to define how its largest ICFs will be supported to downsize and close, so that by 2018, all residents of ICFs will be supported in individualized ways in community settings. To help support this transition, OPWDD established a funding policy and guidance to assist nonprofit providers to convert ICFs into residential models which offer greater community access and integration. This plan does not apply to Children's Residential Projects which serve to prevent children from out of state placements and other less suitable institutional placements.

Assisting People to Become Employed

OPWDD shares Governor Cuomo's vision, as put forward through the Employment First Commission, that employment in the community will be the first option considered when supporting individuals with developmental disabilities to engage in integrated, meaningful activities. The OPWDD employment plan includes strategies to:

- Increase the number of individuals engaged in competitive employment;
- Increase the number of students that transition from high school to competitive employment;
- Collaborate with the educational system to ensure that stakeholders are aware of employment services; and
- Transition workshop participants to competitive employment or other meaningful community activities.

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 implementing a career planning service called Pathway to Employment, person-centered, comprehensive career planning and support service designed to help participants obtain, maintain or advance in competitive or self-employment. 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. OPWDD implemented Pathway to Employment in July 2014. Once individuals find a job they are successful in, there are plans to improve job retention by creating financial incentives for providers to deliver supported employment. These incentives include a new supported employment billing and fee structure that more accurately reflects the cost of supported employment. There will also be ongoing provider training and performance monitoring to improve providers' ability to bolster supported employment.

Sheltered Work Transition: OPWDD is currently working with providers to develop opportunities for approximately 8,000 current "sheltered workshop" participants. Individuals with disabilities have the right to be employed in settings that do not segregate them from the community and to that end, OPWDD has ended new admissions to sheltered workshops.

OPWDD is working with providers operating sheltered workshops to identify ways in which they can convert their business models to provide an integrated employment opportunity for individuals. In addition, OPWDD is assisting individuals to pursue other integrated options such as supported employment.

OPWDD is committed to ensuring that each and every individual is given the opportunity to participate in competitive and integrated employment opportunities or other community-integrated activities. For workshop participants that do not transition to competitive employment, there are other options available such as prevocational, community habilitation and day habilitation which ensure no one will be left behind.

The OPWDD expects the transition from sheltered workshops to integrated employment to be complete by April of 2020, providing ample time for a gradual and measured transition process.

Enhancing Self-Direction

Self-direction offers people with developmental disabilities the greatest level of control over how and when they receive their supports, by allowing them control over their personalized budget and staffing decisions (such as who to hire.)

To improve access to self-direction, OPWDD developed new processes at the Front Door to educate people about self-direction and ensure they are able to make an informed choice about the option to self-direct. Decision-making is supported and guided by the principle of explaining options to the individual so they can make informed choices, often with the help of family and friends.

Individual Directed Goods and Services: In addition to access and education initiatives, OPWDD has made changes to allow more flexibility and choice for individuals and family members that choose to self-direct their services. Individual Directed Goods and Services (IDGS) is a new service, available to people who are self-directing their personalized budget, to cover the cost of resources an individual may need while living an independent life in the community. Qualified expenses include tuition for community classes, clinical consultants or transportation. IDGS allows individuals to customize their support plan to achieve the outcomes that are most important to them.

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, 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.

When the Priority Outcomes Form was modified three years ago, the Needs Assessment Form was dropped from the plan guidelines and a new section was added to describe the rationale for each priority included in the plan. The information included in the rationale provided important context for the priority issue being addressed, but did not provide a means for the LGU to describe other issues and needs in any detail. Because not all the needs identified by the county may result in a priority outcome, important information was being left out of the plan. Therefore, the needs assessment component of the plan guidelines is being reintroduced this year. This form also allows the state agencies to request additional specific information to support statewide planning efforts and the work of the Mental Hygiene Planning Committee.

A. Mental Hygiene Needs Assessment Report

PART A: Local Needs Assessment (all LGUs)

- 1. Assessment of Mental Hygiene and Associated Issues** – In this section, describe the nature and extent of mental hygiene disabilities and related issues. Use this section to identify any unique conditions or circumstances in the county that impact these issues. Provide documentation, where available.
- 2. Analysis of Service Needs and Gaps** – In this section, describe and quantify the prevention, treatment and recovery support service needs of each disability population, including other individualized person-centered supports and services. Describe the capacity of existing resources available to meet the identified needs, including those services that are accessed outside of the county and outside the funded and certified service system. Describe and quantify the gaps between services needed and services provided. Describe existing barriers to accessing needed services. Use this section to identify specific underserved populations or populations that require specialized services. Provide documentation, where available.
- 3. Assessment of Local Issues Impacting Youth and Adults** – For each issue listed in this section, indicate the extent to which it is an area of need at the local (county) level for each disability population listed on the right. The online form will have a drop down menu in each box with the options: High Need; Moderate Need; and Low Need. For each issue that you identify as either a “High” or “Moderate” need, answer the follow-up questions to provide additional detail.

Issue Category	Youth (Under 21 years)			Adults (21+ years)		
	CD	MH	DD	CD	MH	DD
a) Access to Prevention Services	<input type="checkbox"/>					
b) Access to Crisis Services	<input type="checkbox"/>					
c) Access to Treatment Services	<input type="checkbox"/>					
d) Access to Supported Housing	<input type="checkbox"/>					
e) Access to Transportation	<input type="checkbox"/>					
f) Access to Home/Community-based Services	<input type="checkbox"/>					
g) Access to Other Support Services	<input type="checkbox"/>					
h) Workforce Recruitment and Retention	<input type="checkbox"/>					
i) Coordination/Integration with Other Systems	<input type="checkbox"/>					
j) Other (specify): <input type="text"/>	<input type="checkbox"/>					
k) Other (specify): <input type="text"/>	<input type="checkbox"/>					

If any of the issue categories listed above is identified as either a “high” or “moderate” county need to be addressed, additional follow-up questions will need to be completed. Provide a brief description of the issue and why it is important to address it at the county level. Identify any strategies that could potentially be pursued to address the issue. If this issue is also included on the Priority Outcomes Form, the outcome statement and strategies should be copied here.

Issue Category: Will automatically appear if a high or moderate need is indicated.

4a1. Briefly describe the issue and why it is a moderate or high need at the county level. If this involves high need populations or special circumstances, clarify those here.

4a2. Identify strategies that could potentially be pursued to address this local issue.

5. Please indicate how useful each of the following data resources is for your planning, needs assessment, and system management work.

Data Resource	Very Useful	Somewhat Useful	Not Very Useful	Never Used
a) CLMHD Data Dashboard	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) OASAS Client Data Inquiry Reports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) OMH County Mental Health Profiles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) OMH PSYCKES Medicaid Portal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) BHO Performance Metrics Portal (on OMH Website)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) New York Employment Services System (NYESS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) DSRIP Dashboard (on DOH Website)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) Health Data NY (DOH Health Data Portal)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) Open NY (New York’s Open Data Portal)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. In addition to the data resources listed in #5 above, identify other data resources that you found helpful and why they were helpful.

PART B: Regional Needs Assessment (LGUs Outside NYC)

The 2016 Local Services Plan Guidelines describe planning regions of the Public Health and Health Planning Council (PHHPC) that the Population Health Improvement Program (PHIP) and Regional Planning Consortia (RPC's) will operate in. Responses to the following questions should be made based on the PHHPC planning regions.

7. Collaborative Planning Activities – Counties are strongly encouraged to work with other counties in their region to identify the major issues that have a regional impact. In this section, describe the planning and needs assessment activities that your agency participated in during the past year with other counties within your PHHPC region. Identify the other counties that were involved in the collaborative planning activities.

8. Assessment of Regional Issues Impacting Youth and Adults – For each issue listed in this section, indicate the extent to which it is an area of need at the regional level for each disability population listed on the right. The online form will have a drop down menu in each box with the options: High Need; Moderate Need; and Low Need. For each issue that you identify as either a “High” or “Moderate” need, answer the follow-up questions to provide additional detail.

Issue Category	Youth (Under 21 years)			Adults (21+ years)		
	CD	MH	DD	CD	MH	DD
a) Access to Prevention Services	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
b) Access to Crisis Services	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
c) Access to Treatment Services	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
d) Access to Supported Housing	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
e) Access to Transportation	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
f) Access to Home/Community-based Services	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
g) Access to Other Support Services	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
h) Workforce Recruitment and Retention	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
i) Coordination/Integration with Other Systems	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
j) Other (specify): <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
k) Other (specify): <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

If any of the issue categories listed above is identified as either a “high” or “moderate” regional need to be addressed, additional follow-up questions will need to be completed. Provide a brief description of the issue and why it is important to address it at the regional level. Identify any strategies that could potentially be pursued to address the issue. If this issue is also included on the Priority Outcomes Form, the outcome statement and strategies should be copied here. **Note: If the issue and the potential strategies are the result of collaborative planning efforts with other counties in the region, it is strongly encouraged that common language be included in each plan.**

Issue Category: Will automatically appear if a high or moderate need is indicated.

9a1. Briefly describe the issue and why it is a moderate or high need at the regional level. If this involves high need populations or special circumstances, clarify those here.

9a2. Identify strategies that could potentially be pursued to address this regional issue.

10. In addition to collaborating with the other counties in your PHHPC region, has your agency collaborated with counties outside your PHHPC region on any planning and needs assessment activities in the past year?

a) Yes

b) No

If "Yes," identify the counties that you collaborated with and briefly describe the collaborative activity.

B. Warm Line and Mobile Crisis Capacity Survey

This survey was developed from OMH regional planning discussions in which areas of need were identified across the State. Existing data do not provide a clear picture of current capacity for the two program areas referenced below. Therefore LGUs are being asked to provide some basic information. All questions related to this survey should be directed to Jeremy Darman at Jeremy.Darman@omh.ny.gov or at (518) 474-4403.

1. Does your county have access to a local or regional mental health [warm line](#)?

a) Yes

b) No (go to #6)

2. What is the phone number for the mental health warm line?

3. What are the days and hours of operation of the mental health warm line?

4. Is the warm line operated/staffed by peers (current and/or former recipients of mental health services)?

a) Yes

b) No

c) Don't Know

5. Additional comments.

6. Does your county have access to a mobile crisis intervention program or mobile crisis team?

a) Yes

b) No (end of survey)

7. What is the phone number for the mobile crisis intervention program/team?

8. What is the name of the operator/provider of the mobile crisis intervention program/team?

9. What are the days and hours of operation of the mobile crisis intervention program/team?

10. Additional comments.

Glossary:

[Warm Line](#) - A warm line typically provides peer support and referrals for people with mental health issues. Warm lines can be a resource for people experiencing emotional distress, but are not typically a suitable resource for people experiencing an acute psychiatric episode or crisis.

C. 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.

Because of the reintroduction of the needs assessment component of the plan this year, it is assumed that each priority will be documented there. Therefore, the rationale section of this form has been discontinued.

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 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."

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 this priority has 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
 - 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): _____

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
 - 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.

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

D. 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 2016 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 2016 local services planning process.

E. 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:

F. 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.

G. Community Services Board Roster (Counties Outside NYC)

LGU: _____

Community Services Board Chair

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

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

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

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

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

H. 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.

I. 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.

J. 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.

K. 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:

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 **Wednesday, April 1, 2015**. 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 category in the Official Compilation of the Codes, Rules and Regulations of the State of New York. For additional information, please refer to the [applicable regulations](#) located on the OASAS Website.

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 #4	Program Name #4	<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	Health Coordinator #1				Health Coordinator #2			
		Services Provided		Hours/Week	Hourly Rate	Services Provided		Hours/Week	Hourly Rate
		On-site	Off-site	Worked as a Health Coordinator	(dollars)	On-site	Off-site	Worked as a Health Coordinator	(dollars)
a) PRU #1	Program Name #1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
b) PRU #2	Program Name #1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
c) PRU #3	Program Name #1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
d) PRU #4	Program Name #1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>

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 (example: 35.00).

PRU	Program Name	Service Provided		Hours per Week	Hourly Rate
		On-site	Off-site	Worked as a Health Coordinator	(dollars)
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"/>
d) PRU #4	Program Name #4	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>

B. Health Information Technology for Integrated Care and Practice Improvement Survey (treatment providers)

A number of initiatives resulting from changes through health care reform and Medicaid redesign encourage the adoption and implementation of Health Information Technology (HIT). In addition to accommodating practice improvement in areas such as billing, quality monitoring and reporting, [Electronic Health Records \(EHRs\)](#) facilitate coordination of care within an integrated care model. The following questions are designed to assess the current status of the OASAS provider network with respect to HIT. All questions related to this survey should be directed to Connie Burke at 518-485-0501 or at Constance.Burke@oasas.ny.gov.

1. Which of the following best describes this agency’s current use of an [Electronic Health Record \(EHR\)](#) for electronic exchange of health and behavioral health information?

- a) The agency currently utilizes an EHR.
- b) The agency is actively pursuing the adoption of an EHR within the next 12 months.
- c) The agency has no plans to adopt an EHR to exchange electronic health and behavioral Health information within the next 12 months. *(Go to #2)*

1.1 Please identify the name of the EHR system that your agency currently uses or plans to acquire within the next 12 months.

2. Which of the following best describes this agency’s current use of [secure direct messaging](#) services for electronic exchange of health and behavioral health information?

- a) The agency currently utilizes [secure direct messaging](#) services.
- b) The agency is actively pursuing the adoption of a secure direct messaging service within the next 12 months.
- c) The agency has no plans to adopt a secure direct messaging service to exchange electronic health & behavioral health information within the next 12 months. *(Go to #3)*

2.1 Please identify the name of the secure direct messaging service that your agency currently uses or plans to acquire within the next 12 months.

3. Some agencies may utilize an EHR for some, but not all of the programs they operate. Indicate whether an EHR system is utilized within each of the following programs operated by your agency. If your agency also operates an OMH-licensed service, please indicate whether an EHR system is utilized within that service.

PRU	Program Type	Utilizes EHR		Does Not Apply
		Yes	No	
PRU No.	Program Type	<input type="checkbox"/>	<input type="checkbox"/>	
PRU No.	Program Type	<input type="checkbox"/>	<input type="checkbox"/>	
PRU No.	Program Type	<input type="checkbox"/>	<input type="checkbox"/>	
OMH-licensed Service		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. How does your agency currently accept referrals from care coordinators or external providers? (check all that apply)
- a) The agency accepts referrals by phone.
 - b) The agency accepts referrals by email.
 - c) The agency accepts referrals by fax.
 - d) The agency accepts referrals through secure direct messaging.
 - e) The agency accepts referrals through a [health information exchange](#).
5. How does your agency currently accept referrals from care coordinators or external providers? (check all that apply)
- a) The agency accepts referrals by phone.
 - b) The agency accepts referrals by email.
 - c) The agency accepts referrals by fax.
 - d) The agency accepts referrals through secure direct messaging.
 - e) The agency accepts referrals through a health information exchange.
6. How does your agency currently relay referral results to care coordinators or external referring providers? (check all that apply)
- a) The agency relays referral results by phone.
 - b) The agency relays referral results by email.
 - c) The agency relays referral results by fax.
 - d) The agency relays referral results through secure direct messaging.
 - e) The agency relays referral results through a health information exchange.
 - f) The agency does not relay referral results.

Key initiatives relevant to the adoption of HIT for OASAS providers include development of a Health Information Exchange coordinated through [Regional Health Information Organizations \(RHIOs\)](#), implementation of [Health Home](#) Networks and coordination of Performing Provider Systems (PPSs) undertaking collaborative projects through the [Delivery System Reform Incentive Payment Program \(DSRIP\)](#). The following questions pertain to your agency's current or anticipated status with respect to these initiatives.

7. What is your organization's current relationship with a local RHIO?
- a) The agency is currently part of a RHIO.
 - b) The agency is actively pursuing membership in a RHIO.
 - c) The agency is interested in membership in a RHIO, but has yet to actively pursue it.
 - d) The agency has no plan to join a RHIO.

8. What is your organization's current status regarding participation in a Health Home Network?
- a) The agency is currently part of a Health Home Network.
 - b) The agency is actively pursuing membership within a Health Home Network.
 - c) The agency is interested in becoming part of a Health Home Network, but has yet to actively pursue it.
 - d) The agency has no plan to join a Health Home Network.
9. The DSRIP program organizes system change through statewide networks called Performing Provider Systems (PPS). What is your organization's current status regarding participation in a PPS?
- a) The agency is currently part of a PPS.
 - b) The agency is actively pursuing membership within a PPS.
 - c) The agency is interested in membership within a PPS, but has yet to actively pursue it.
(Go to #10)
 - d) The agency has no plan to join a PPS. (Go to #10)
- 9.1 DSRIP payments are distributed based on successful completion of proposed projects. Is the PPS to which you belong or plan to join developing projects that incorporate the adoption or use of HIT?
- a) Yes
 - b) No
 - c) Don't Know
10. Please provide any additional comments or questions you have regarding Health Information Technology for Integrated Care and Practice Improvement.
-

Glossary:

[Electronic Health Record \(EHR\)](#) - a digital version of a patient's paper chart. EHRs are real-time, patient-centered records that make information available instantly and securely to authorized users and may be used across providers to coordinate patient care.

[Secure Direct Messaging](#) - a secure electronic communication service featuring point-to-point encryption for clinical providers and others who regularly transmit and/or receive protected health information (PHI).

[Health Information Exchange](#) - the transmission of health and/or behavioral health-related patient-level data among clinical providers with shared standards for interoperability, security and confidentiality.

[Regional Health Information Organizations \(RHIOs\)](#) - a type of health information exchange organization that coordinates health information within a defined geographic area.

[Health Home](#) - a care management service model whereby all of an individual patient's caregivers coordinate service provision so that all of a patient's needs are addressed in a comprehensive manner.

[Delivery System Reform Incentive Payment Program \(DSRIP\)](#) - a State reinvestment of Medicaid savings focusing on system reform to achieve a 25% reduction in avoidable hospitalizations through the promotion of regional collaboration amongst medical and behavioral health providers operating as Performing Provider Systems.

C. Implementation of Evidence-based Programs and Strategies Survey (prevention programs)

Evidence-based programs and strategies (EBPSs) are those that are backed by scientific research which demonstrate their effectiveness in preventing substance abuse and other youth problem behaviors. OASAS requires that at least 50 percent of staff resources must be dedicated to the delivery of EBPSs. EBPSs may include educational curricula, early intervention programs, and environmental strategies. This survey seeks information about the EBPSs currently delivered in OASAS-funded prevention programs and any challenges that were encountered while implementing those EBPSs. All questions regarding this survey should be directed to Scott Brady at 518-457-4384 or at Scott.Brady@oasas.ny.gov.

1. Check each EBPS listed below that has been implemented in this program. For each EBPS checked, please answer the follow-up questions pertaining to that EBPS. If this program has implemented an EBPS that is not listed here, be sure to identify it in the final question at the end of the survey.

Environmental Strategies - Policy, Regulations, and Laws

- a) Public Advertising Restrictions
- b) Alcohol Sponsorship Restrictions at Public Events
- c) Public Availability and Alcohol Use
- d) School Substance Use Policies
- e) Workplace Substance Use Policies
- f) Require Alcohol Outlet Server/Seller Training
- g) Alcohol Use Restrictions at Public Events
- h) Social Host Ordinance
- i) Restrict AOD Merchandise Sales at Public Events

Environmental Strategies - Enforcement/Compliance

- j) Alcohol Outlet Compliance Checks (Off-Premise)
- k) Alcohol Outlet Compliance Checks (On-Premise)
- l) Alcohol Outlet Compliance Surveys (Off-Premise)
- m) Shoulder Tap Surveillance (Off-Premise)
- n) Party Patrols
- o) Alcohol Outlet Server Training (On-Premise)
- p) Alcohol Outlet Server Training (Off-Premise)
- q) Retail Outlet Compliance Reporting Hotlines
- r) Underage Drinking Party Dispersal

Environmental Strategies - Communication/Media Campaigns

- s) Informational/Warning Sign Campaign (Outlets)
- t) Social Marketing Campaign
- u) Media Advocacy Campaign
- v) Retail Outlet Recognition Campaign
- w) Social Norms Misperception Campaign

Early Intervention

- x) Teen Intervene
- y) BASICS

Educational Curriculum

- z) Across Ages
- aa) Active Parenting Now
- ab) Active Parenting of Teens
- ac) Alcohol Literacy Challenge
- ad) All Stars - Core
- ae) All Stars - Booster
- af) All Stars - Plus
- ag) Athletes Training and Learning to Avoid Steroids (ATLAS)
- ah) Big Brothers/Big Sisters
- ai) Building Skills
- aj) Challenging College Alcohol Abuse
- ak) Class Action
- al) Creating Lasting Family Connections (CLFC)
- am) DARE to Be You
- an) Early Risers Skills for Success
- ao) Families and School Together (FAST)
- ap) Family Matters
- aq) Guiding Good Choices
- ar) Incredible Years – Child Dinosaur
- as) Incredible Years – School Age Parent Program
- at) Keepin' it Real
- au) Life Skills Training (LST) - Elementary
- av) Life Skills Training (LST) - Middle School
- aw) Life Skills Training (LST) - Middle School Level 2 Booster
- ax) Life Skills Training (LST) - Middle School Level 3 Booster
- ay) Life Skills Training (LST) – Booster High School
- az) Lions-Quest Skills for Adolescence
- ba) Olweus Bullying Prevention
- bb) Multidimensional Family Therapy
- bc) Parenting Wisely
- bd) Positive Action Elem.
- be) Positive Action M. S.
- bf) Primary Project
- bg) Project Alert M. S.
- bh) Project Alert Booster
- bi) Project Northland - Slick Tracy
- bj) Project Northland - The Amazing Alternatives
- bk) Project Northland - Booster: Power Lines
- bl) Project SUCCESS

- bm) Project Toward No Drug Abuse (TND)
- bn) Project Towards No Tobacco Use (TNT) – Gr. 6-8
- bo) Project Towards No Tobacco Use (TNT) – Gr. 6-8 Booster
- bp) Project Venture
- bq) Promoting Alternative Thinking Strategies (PATHS) - Kindergarten Module
- br) Promoting Alternative Thinking Strategies (PATHS) - Grade 1
- bs) Promoting Alternative Thinking Strategies (PATHS) - Grade 2
- bt) Promoting Alternative Thinking Strategies (PATHS) - Grade 3
- bu) Promoting Alternative Thinking Strategies (PATHS) - Grade 4
- bv) Promoting Alternative Thinking Strategies (PATHS) - Grade 5/6
- bw) Protecting You/Protecting Me
- bx) Reconnecting Youth (RY)
- by) Residential Student Assistance Program (RSAP)
- bz) Responding in Peaceful and Positive Ways (RIPP)
- ca) Second Step - Elem. Gr. K-5
- cb) Second Step - M.S. Gr. 6-9
- cc) Second Step - M.S. Gr. 6-9
- cd) Second Step - M.S. – Gr. 6-9 Booster 1
- ce) Second Step - M.S. – Gr. 6-9 Booster 2
- cf) SPORT
- cg) Staying Connected with Your Teen
- ch) Strengthening Families Program (SFP)
- ci) Strengthening Families Program 10-14 - Core
- cj) Strengthening Families Program 10-14 - Booster
- ck) Students Managing Anger and Resolution Together (SMART)
- cl) Too Good For Drugs (TGFD) - Elem.
- cm) Too Good For Drugs (TGFD) - M.S.
- cn) Too Good for Violence (TGFV) - Elem.
- co) Too Good for Violence (TGFV) - M.S.
- cp) Too Good for Drugs and Violence (TGFDV) - H.S.

Each EBPS checked will get the follow-up questions below.

EBPS Category: Category will automatically appear if checked above.

You indicated that this EBPS is currently delivered by this program. Please answer the following question(s) related to this EBPS.

- 2.x. Did your program experience any challenges implementing or delivering this EBPS with fidelity?
- a) Yes
 - b) No
- 3.x. Indicate the reason(s) why this EBPS was a challenge to implement with fidelity. (Check all that apply)
- a) Cost of the curriculum, purchase of materials, training, etc. was prohibitive.

- b) Examples given in the EBPS training and support materials were not culturally appropriate.
- c) The school (or other sponsoring organization) did not allow the number of sessions to be delivered that are required or expected.
- d) There were no implementation materials or guidance materials for the EBPS.
- e) The EBPS was too complicated to implement with fidelity (e.g., there were too many components).
- f) This EBPS was not effective for the special population(s) our program serves.
- g) The same group of students/participants was not available for all sessions.
- h) Other challenges were encountered while implementing this EBPS.

4.x. Provide any additional information to explain the challenges checked above that were encountered while implementing this EBPS.

5. OASAS created the list of approved Evidence-based Programs and Strategies (EBPSs) based on an earlier SAMHSA Model Program registry and subsequent additions from the OASAS EBPS Review Panel. Please identify any EBPSs that are not on the OASAS approved EBPS list that you would like to be considered/classified as an EBPS. Please include a link (if one exists) to the suggested EBPS.

D. 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 continuing the Drug Use Trend Survey to monitor regional and statewide trends in drug use behavior.

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 Kathy Dixon at 518-485-1664 or at Kathy.Dixon@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"/>				

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 type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Tranquilizers/Sedatives (specify): <input 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 type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
q. Inhalants (specify): <input 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 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)

Glossary:

[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 Synthetic Opiates](#) - includes the misuse, abuse or diversion to non-intended users of Percocets, Percodan, Vicodin, OxyContin, Codeine, Demerol, Dilaudid, Morphine, Non-prescription Methadone, , other drugs derived from opium.

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

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

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

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

[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. 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*)

E. Qualified Health Professional Survey (treatment programs)

OASAS participates in NY Performs, a web-based performance management system for New York State agencies. NY Performs includes Key Performance Indicators (KPIs) that measure the performance of OASAS and other state agencies. One of these KPIs measures the proportion of the OASAS clinical workforce that meet the criteria of Qualified Health Professional. The information collected in this survey will be used to report on this measure. For the purposes of this survey, clinical staff is defined as staff who provide assessment, treatment planning, and group or individual counseling. All questions related to this survey should be directed Connie Burke at 518-485-0501 or at Constance.Burke@oasas.ny.gov.

1. For each category of clinical staff listed below, indicate the number of part-time and full-time staff that provide direct care clinical services in this program. **Note: If a staff person holds more than one license, include the person in each relevant category. If any staff split their time across multiple programs, report them under each program in which they provide direct care services.**

<u>Clinical Staff Category</u>	Part-time Staff	Full-time Staff
a) Registered Professional Nurse	<input type="text"/>	<input type="text"/>
b) Nurse Practitioner	<input type="text"/>	<input type="text"/>
c) Physician's Assistant	<input type="text"/>	<input type="text"/>
d) Physician	<input type="text"/>	<input type="text"/>
e) Licensed Master Social Worker	<input type="text"/>	<input type="text"/>
f) Licensed Clinical Social Worker	<input type="text"/>	<input type="text"/>
g) Licensed Psychologist	<input type="text"/>	<input type="text"/>
h) Licensed Mental Health Counselor	<input type="text"/>	<input type="text"/>
i) Licensed Psychoanalyst	<input type="text"/>	<input type="text"/>
j) Licensed Marriage/Family Therapist	<input type="text"/>	<input type="text"/>
k) Licensed Occupational Therapist	<input type="text"/>	<input type="text"/>
l) Licensed Creative Arts Therapist	<input type="text"/>	<input type="text"/>

- | | | |
|--|----------------------|----------------------|
| m) Certified Rehabilitation Counselor | <input type="text"/> | <input type="text"/> |
| n) Certified Therapeutic Recreation Therapist | <input type="text"/> | <input type="text"/> |
| o) Certified Counselor | <input type="text"/> | <input type="text"/> |
| p) CASAC | <input type="text"/> | <input type="text"/> |
| q) CASAC-Trainee | <input type="text"/> | <input type="text"/> |
| r) Other Non-Qualified Health Professional | <input type="text"/> | <input type="text"/> |

2. In total, how many clinical staff belong to each of the categories below? **Note: If any staff are employed full time by your agency, but split their time across multiple programs, please count them as part-time staff in each program.**

<u>Clinical Staff Category</u>	<u>Part-time Staff</u>	<u>Full-time Staff</u>
a) Qualified Health Professional	<input type="text"/>	<input type="text"/>
b) Non-Qualified Health Professional	<input type="text"/>	<input type="text"/>

Glossary:

[Certified Counselor](#) - A Counselor certified by and currently registered as such with the National Board for Certified Counselors.

[Non-Qualified Health Professional](#) - A member of the **clinical** staff who does **not** hold a license or certification as provided in the list of clinical staff (e.g. social work intern).

F. 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 2016 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 2016 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.

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.

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 **2016 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 #2: Estimated Project Cost: If the estimated cost is less than \$100,000, a PAS-34 Minor Rehabilitation Request should be submitted separately to the Field Office.

Question #3: Briefly Describe the Physical Plant Problem and Corrective Work Required:

Question #4: Indicate Approximate Square Footage of Space to be Added or Affected by the Proposed Capital Project:

Question #5: Briefly Describe the Proposed Scope of Work in the Project:

Question #6: Provide a Detailed Statement of the Need for the Project and a Justification for it. Describe the need/benefit to the program's operation, to the improvement of the physical plant and the need/benefit to the financial operation of the facility.

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

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.

