



2017 Local Services Plan Guidelines for Mental Hygiene Services

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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 (LGUs) (57 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 was formed in 2007 to explore opportunities for integrated mental hygiene services planning and became a standing committee of the Inter-Office Coordinating Council (IOCC) in 2008. The Committee Mission Statement states:

To enhance the partnership between counties, regions, state agencies and other stakeholders through an evolving, integrated, and uniform planning process that: identifies and measures current and emerging needs; supports local and regional Mental Hygiene system management and coordination; promotes the continued development of data-informed person-centered actions to address needs; and ultimately, is responsive to and informs State, local and regional priorities, policy and fiscal decisions.

The committee is responsible for coordinating the integrated local planning process of the three mental hygiene agencies and each local governmental unit (LGU). To ensure that the planning process meets the needs of each state agency and is relevant to each county, membership of the committee includes planning staff from the three state agencies, the Conference of Local Mental Hygiene Directors (CLMHD), and several county mental hygiene agencies.

The three state mental hygiene agencies have a fully integrated mental hygiene local services planning process. This results in the development of cross-systems priorities and increased collaborations on the local and regional level. Counties are able 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 mental hygiene services systems, a primary focus of the planning committee is to ensure that the LGUs continue to provide effective oversight of local mental hygiene services for their populations. It is a priority of the committee for LGUs 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 recipient outcomes.

Much of the ongoing activity of the Mental Hygiene Planning Committee is carried out by three standing workgroups. **The Planning Process Workgroup** focuses on improvements to the local/regional/statewide planning processes to provide the timely exchange of information needed to guide policy and practice changes in the context of system transformations including State and national healthcare reforms, Medicaid redesign and the implementation of managed care. Activities of the Planning Process Workgroup include annually reviewing the local services planning process to continually improve the efficiency and utility of plan submissions. All Local Service Plans are submitted in the online County Planning System (CPS). For the 2017 local services planning cycle, the workgroup re-formatted several of the local planning forms. The 2017 Local Needs Assessment and the Priorities Outcomes Forms were revised and refined to reflect current changes in the mental hygiene services sector. Counties are given the opportunity to describe their needs and priorities and if those priorities are aligned with any statewide initiatives, regional planning activities or other local collaborations. The workgroup also focuses on refinements to CPS functionality and the development of output reports of plan data submitted in CPS.

The **Data Workgroup** focuses on improving access to and use of relevant state and local data resources to support planning, oversight and system management. The workgroup meets regularly throughout the year.

Much of the work over the past year has focused on expanding and updating the CLMHD Behavioral Health Portal, which supports the services planning and system oversight work of the LGUs and is particularly helpful in assessing the impact of behavioral and physical healthcare reforms. The portal includes data from several systems, including the following:

- County and regional prevalence estimates on a number of substance use disorder and mental health indicators from the National Survey on Drug Use and Health (NSDUH).
- County and regional estimates of the number of Medicaid Fee-for-Service and Managed Care recipients with a potential need for behavioral health or developmental disability services through the Salient No PHI Medicaid Data System, which contains statewide Medicaid claims and encounter data and associated demographic, diagnostic and service detail.
- County and regional adult inpatient admissions data as reported in the Statewide Planning and Research Cooperative System (SPARCS).
- County and regional Medicaid FFS and managed care service utilization summaries for priority populations, including behavioral health and developmental disability service recipients.
- Local estimates of the number of homeless individuals and households as reported by the U.S. Department of Housing and Urban Development, Annual Continuum of Care Homeless Populations and Subpopulations Reports.

Other data sources will be added over time based on priorities identified by the CLMHD membership and the Mental Hygiene Planning Committee.

The **Community of Practice for Local Planners (CPLP)** is a peer-led state and local partnership. CPLP focuses on fostering and facilitating knowledge sharing to improve local/regional/statewide planning practices. The group conducts orientation and educational webinars devoted to the dissemination of planning innovation, access to planning resources and

dialogue/collaboration to enhance planning performance.

Over the past year, the CPLP conducted six training webinars for LGU staff that primarily focused on information related to the continually developing statewide initiatives focused on behavioral and physical healthcare reform and on the CLMHD Behavioral Health Portal, including the following:

- **Medicaid DSRIP Dashboard (February)** – Provided a review of the Department of Health (DOH) DSRIP tutorial and examples of how two LGUs have utilized the resource in their work.
- **Behavioral Health Portal (March)** – Provided an overview of the changes made to the portal, including updated data sources and how the portal is evolving to support more regional planning.
- **The Initiative Map (May)** – Provided an overview of the many statewide initiatives impacting the behavioral and physical healthcare systems and how they may be connected and how they impact local and regional planning.
- **Portal Inpatient/Outpatient Transitions (June)** – Provided a detailed examination of the data in the portal related to the transition of care from inpatient to outpatient services, focusing on continuity of care, engagement in care, and continuity of medication.
- **PSYCKES for LGUs Dialogue (October)** – Provided an overview of Medicaid claims data from the Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) to identify cohorts of Medicaid clients and their service use.
- **Inquiry Report Webinar and Chart Pack (November)** – Provided an overview and demonstration of the variety of reports available to LGUs on the OASAS website to query the Client Data System (CDS) for treatment utilization data.

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 state agency and county staff to query all completed plans on selected information and generate specific reports in a quick and efficient manner. These reports result in more timely and accurate summary analyses that inform each state agency's statewide planning process and assists in county dissemination of plan results.

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. Each organization in CPS, local government unit, state agency or OASAS provider, has a tailored landing page listing organizational and individual contact information with instructions on how to update the information in the OASAS Provider Directory System or CPS. Beginning last year, each LGU and OASAS provider also have a designated Planning Coordinator, who is the primary point of contact for that organization on planning related matters. The Planning Coordinator has all of the same entitlements as the Administrator.

Today, there are more than 2,400 individuals with a CPS user account in one or more of

fifteen separate user roles. Each role provides the user with specific entitlements depending on their organization and the features and resources they need to access. While the system was designed primarily for county and OASAS provider use, it has expanded significantly over the years. Additional roles have been added for anyone not employed by the three state agencies, the county mental hygiene agencies, or OASAS provider agencies.

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.

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. 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.

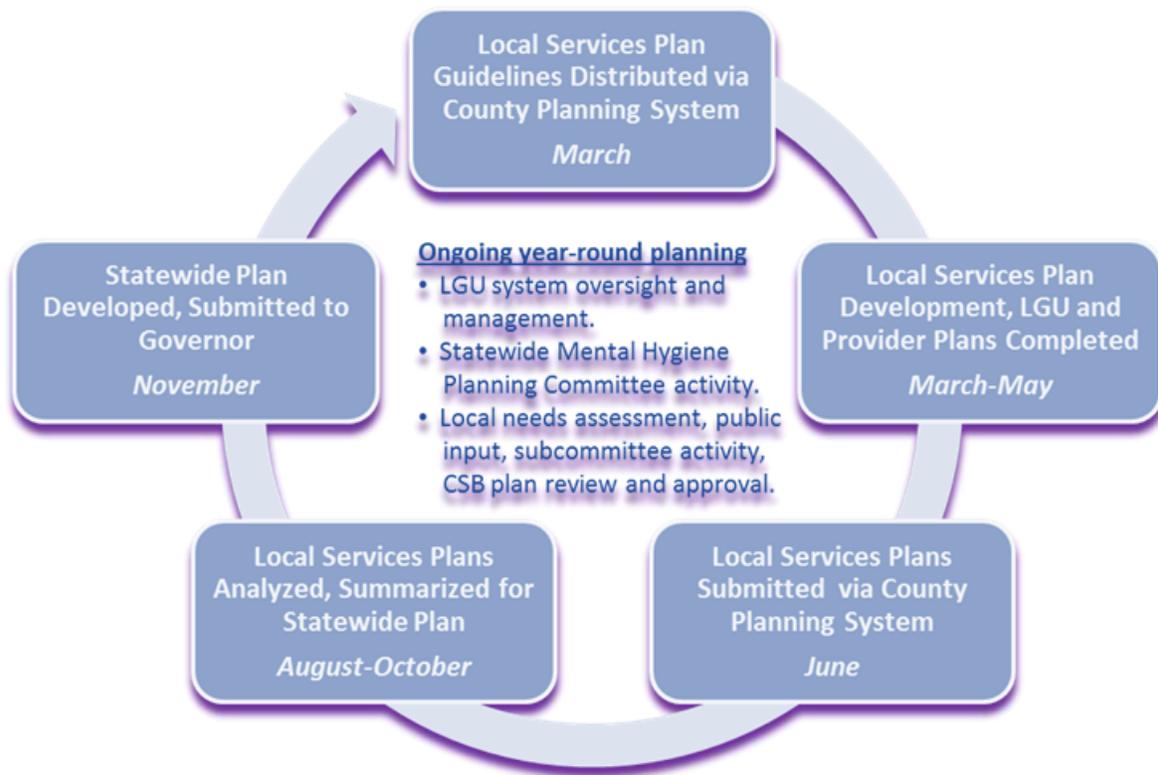
To register an account with CPS, you must already have an [OASAS Applications](#) user account, which can be obtained by completing an OASAS External Access Request Form, an [IRM-15](#),

which is available on the OASAS website. Submit the form to OASAS as instructed and indicate that you are requesting access to the County Planning System. If you are with a Local Governmental Unit you should also request access to the LGU Inquiry Reports, which queries treatment utilization data from the OASAS Client Data System. Once you obtain an OASAS Applications user account, you can go to the [CPS](#) website to register a CPS user account.

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. Local Services Plans are analyzed and reports are generated to support the work of various state agency activities, including informing each agency’s statewide planning process.

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 have 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: 2017 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	Tuesday, March 1, 2016
LSP and CPS training for county planners & OASAS providers	April 22, 2016 OASAS Learning Thursday
Due date for completed OASAS provider planning surveys in CPS	Monday, April 4
Due date for completed LGU Plans in CPS	Wednesday, June 1
State summary analyses of county and provider plans completed	September 2016
OASAS, OMH, OPWDD Statewide Comprehensive Plans released	November 2016
OASAS, OMH, OWPDD Interim Reports released	March 2017

E. Informing Statewide Comprehensive Planning

Section 5.07 of Mental Hygiene Law requires OMH, OASAS and OPWDD to develop a Statewide Comprehensive Plan for the provision of State and local services to individuals with mental illness, substance abuse disorders and developmental disabilities. The purpose of the 5.07 plan is manifold, with some key objectives identified in the statute including: identifying statewide priorities and measurable goals to achieve those priorities, proposing strategies to obtain those goals, identifying specific services and supports to promote behavioral health wellness, analyzing service utilization trends across levels of care and promoting recovery-oriented state-local service development.

The Mental Hygiene Planning Committee supports and aligns local plan data and resources into statewide initiatives' system-planning and regional planning processes. Local priorities have changed over the past several years to reflect the rapidly changing landscape of healthcare reform. Statewide initiatives to improve population health, transform health care delivery, and eliminate healthcare disparities are reflected in local priorities and strategies that focus on service integration and care coordination. In addition, most counties are addressing service needs and gaps through activities around the Medicaid Delivery System Reform Incentive Payment (DSRIP) Program, the Population Health Improvement Program (PHIP), the State Health Innovation Plan (SHIP) and the Prevention Agenda.

Summary analysis from the 2016 Mental Hygiene Local Services Plans (LSPs), which were submitted to the state in the spring of 2015, included identification of mental hygiene problems

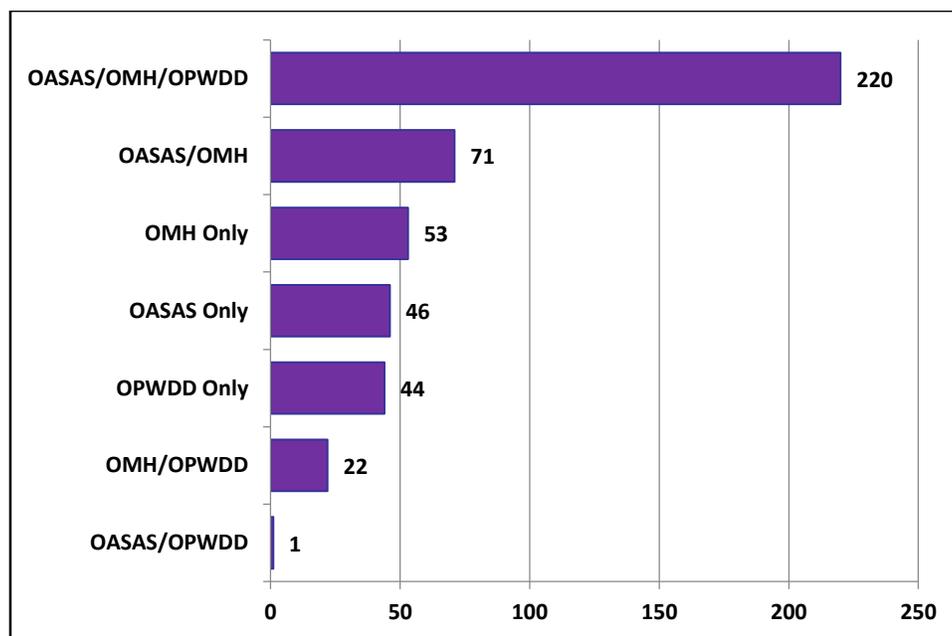
and needs in the community and an assessment of the current gaps in needed services. Needs vary from one county to another, depending on local circumstances and the extent to which services already exist and are accessible to those who need them.

In addition to reporting on their planning and needs assessment efforts over the previous planning cycle, and identifying needs and service gaps specific to their community, LGUs were asked to assess the level of need for a variety of services for both their youth (aged under 21) and adult (aged 21 and over) populations.

Counties were also asked to identify priorities to address their needs. Forty-eight percent of county priorities included in the 2016 plans were associated with multiple mental hygiene service systems. Priorities that address cross-system collaboration, service integration, and care coordination continue to increase each year, as do priorities that address the common needs of individuals served by each disability system, such as housing, transportation, employment, advocacy, and other support services.

Fifty-seven local services plans included a total of 457 priorities. Of those, 220 (48%) were associated with all three state agencies, 71 were associated with both OMH and OASAS, and 22 that were associated with OMH and OPWDD. **Figure 1.2** shows the distribution of priorities by associated disabilities.

Figure 1.2: 2016 Local Services Plan Priorities by Disability Agency (N=457)



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. Behavioral and Physical Health Care Reform

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 the mental hygiene services 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.

After the Affordable Care Act was signed into law in 2010, New York State established the Medicaid Redesign Team in 2011. Behavioral Health Organizations (BHOs), Health Homes, Managed Care Organizations (MCOs), Health and Recovery Plans (HARPs), and the Delivery System Reform Incentive Payment (DSRIP) Program soon followed. These initiatives are laying the groundwork for system transformation from a fee-for-service chronic care model to a community based Medicaid Managed Care model. Population Health Improvement Programs (PHIPs) with the support of Regional Planning Consortia (RPCs) and other state initiatives driven by the Prevention Agenda 2013-2018 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 health and mental hygiene services.

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.

Medicaid Managed Care

The centerpiece of the MRT vision is the expansion and redesign of the State's behavioral health Medicaid program through a broader managed care strategy and "carving in" previously managed care exempt Medicaid services and beneficiaries into a managed, coordinated benefit package.

Adults in Managed Care

For adults aged 21 and older, the integration of all Medicaid behavioral health and physical health benefits under managed care 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 will manage care for adults with significant behavioral health needs. These specialized Plans will facilitate the integration of physical health, mental health and SUD services for individuals requiring specialized expertise, tools and protocols which are not consistently found within most medical plans. In addition to the State Plan Medicaid services offered by mainstream MCOs, qualified HARPs will offer access to an enhanced benefit package comprised of Behavioral Health Home and Community Based Services (BH HCBS) designed to provide the individual with a specialized scope of support services not currently covered under the State Plan. BH HCBS will be available to beneficiaries based on their detailed plan of care, which will be informed by a full functional assessment. In order to qualify as HARPs, Plans were required to demonstrate that they have the organizational capacity and culture to ensure the effective management of behavioral health care and facilitate system transformation.

Beginning with adults in New York City, the first phase Health and Recovery Plan (HARP) enrollment letters were distributed between July 2015 and October 2015, followed by staggered enrollments from October 2015 to January 2016. In October 2015, mainstream plans and HARPs implemented non-HCBS behavioral health services for enrolled members, and HCBS service implementation began for the HARP population in January 2016. In the remainder of the State, the first phase of HARP enrollment letters will go out beginning in April 2016, and in July 2016, mainstream plan behavioral health management and phased HARP enrollment will begin. Children's implementation will begin in New York City and Long Island in January 2017, followed by the remainder of the State in July 2017. The State agencies are working with plans to ensure that they are ready to implement the requirements included in the request for proposals. Access the full [timeline](#) on the DOH website.

The state agencies have also worked with stakeholders to support this transition through several major initiatives including: HARP Behavioral Health Home and Community Based Services (HCBS) and OASAS Residential Redesign. The initial designation process for behavioral health (BH) HCBS was completed in March 2015 for New York City (NYC) and December 2015 for the rest of State. All agencies wishing to provide BH HCBS must [apply to be designated](#) for each service they would like to provide. Applicants may apply at any time for a designation, however the State will only update the designation lists quarterly for each area on a periodic basis. Information on providing BH HCBS can be found in the [BH HCBS Manual](#) on the OMH website.

Children in Managed Care:

The MRT Children's Health and Behavioral Health Team has designed a separate framework for children's integrated health and behavioral health services under managed care. The separate framework is due to recognition of gaps in the current service system, the complexity of multi-systems involvement by children and families, and the fluidity of children's needs and challenges as they develop. The team leadership, which is shared between OMH, OASAS, DOH, and the Office of Children and Family Services (OCFS), has developed a model to guide design. This model takes into consideration the unique specialty health and behavioral health care service needs of children in the mental health, substance use disorder, foster care and health system and their families. The model indicates the importance of:

- Earlier intervention;
- Use of evidence-based practices;
- Application of team based, family-centered approaches; and
- Family empowerment, skill building and advocacy.

Children will begin to receive care coordination from Health Homes starting in 2016, transitioning existing case management programs. This will be followed by the implementation of six new State Plan Services around January 1, 2017 for all Medicaid eligible children who meet medical necessity criteria. These services are:

- Crisis Intervention;
- Community Psychiatric Support and Treatment;
- Psychosocial Rehabilitation Services;
- Family Peer Support Services;
- Youth Peer Training and Support; and
- Other Licensed Practitioners Services.

For more information on the progress of the Medicaid managed care design for children's integrated health and behavioral health, please go to the following link for the Children's MRT Behavioral Health Subcommittee:

https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health_reform.htm

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; and
- 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 substance use disorder, and mental health disorders, or a single qualifying condition such as a serious persistent mental illness or HIV/AIDS. OASAS and OMH have continued working closely 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 was due March 2, 2015. OASAS and OMH, in partnership with DOH, the AIDs Institute, and OCFS, reviewed the applications and in June 2015 identified Health Homes designated contingently to serve children. Enrollment of children is expected to begin in September 2016. For access to the list of Health Home designees, visit the [DOH website](#).

Regional Planning Consortia

In preparation for both the opportunities and challenges the expansion of behavioral health services in Medicaid Managed Care will present at the local level, the state and the counties/New York City collaborated to develop 11 Regional Planning Consortia throughout the State where key stakeholders can discuss and monitor issues inherent to this type of transition. Each RPC represents natural local patterns of access to care and include representatives from LGUs, the State, mental health, substance use disorder, and primary care service providers, the child welfare, criminal and or juvenile justice, housing, and social service systems, Health Homes, hospitals and MCOs, as well as Medicaid recipients and behavioral health service recipients, peers, families, and advocates.

The RPCs are a necessary mechanism for the State and the MCOs to obtain vital, real-time feedback and recommendations for improving the implementation of behavioral health managed care. In addition, the RPC in each region will help align Medicaid managed behavioral healthcare with other system redesign initiatives aimed at improving the quality and integration of the physical and behavioral healthcare delivery systems, as well as strategize ways to use potential future reinvestment funding. To that end, the RPCs should complement the existing work of their respective and participating LGUs in guiding behavioral health policy as it relates to Medicaid Managed Care in each region.

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 Performing Provider Systems (PPS) and the Population Health Improvement Programs (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).

The four core focus areas within the scope of RPC function are:

- Service access and capacity: monitoring the timely access to services, including BH HCBS, for Medicaid recipients of behavioral healthcare, as well as service gaps.
- MCO performance: observing MCO actions with respect to their responsibilities to behavioral health service recipients and providers of Medicaid services.
- System stability & improvement: facilitate collaboration among any and all regional sectors that touch the Medicaid behavioral health system.
- Service quality, efficiency, and efficacy: improving care of behavioral health service recipients overall by voicing concerns as they arise and making recommendations to State Partner Agencies (DOH, OMH, and OASAS).

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 three primary functions of these RPCs are:

- To be the early warning system for locally occurring issues which data would not immediately or necessarily show (such as access to needed services, gaps in services, timeliness of eligibility determinations, and engagement or disengagement in care, etc.); and for ongoing monitoring, deliberation, and forming recommendations to the State in response to issues that arise from stakeholders at the table.
- To understand and improve the parallel process and intersection of the expansion of behavioral health services under Medicaid Managed Care with other system redesign initiatives, especially the Delivery System Reform Incentive Payment (DSRIP) Program and Population Health Improvement Program (PHIP).
- To work with their respective LGUs, which are the points of accountability for MCOs in identifying and addressing local system issues.

The New York City RPC has been in development through 2015, and Rest of State RPCs will be developed during 2016. **Figure 2.1** shows the Regional Planning Consortiums Regions (RPCs) which is the basis of the RPCs and the LGU assessment of regional issues included in these guidelines. For additional information on the RPCs, please visit the [DOH website](#).

Figure 2.1: Regional Planning Consortium (RPC) Regions



Counties by RPC Regions

Long Island:

Nassau
Suffolk

New York City:

Bronx
Kings
New York
Queens
Richmond

Mid-Hudson:

Dutchess
Orange
Putnam
Rockland
Sullivan
Ulster
Westchester

Capital District:

Albany
Columbia
Greene
Rensselaer
Saratoga
Schenectady

North Country:

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

Integrated Licensure Regulations

On January 1, 2015, New York witnessed the culmination of a four-year effort to further the integration of physical and behavioral health services in clinic settings across the state. The new authorization establishes the licensure category “Integrated Outpatient Services” (IOS) and appears identically within regulations for OMH-licensed providers (14 NYCRR Part 598), OASAS-licensed providers (14 NYCRR Part 825), and DOH-licensed providers (10 NYCRR Part 404).

Over the past four years, the OASAS, OMH, and DOH have uniquely partnered in the development, implementation and oversight of the “Integrated Licensure Project.” This collaboration resulted in the development of clinical and physical plant standards, staffing requirements, and a single application and review process – all with the goal to reduce the administrative burden on providers and to improve the quality of care provided to consumers with multiple needs by improving the overall coordination and accessibility of care.

Participating facilities in the Project have been overseen by a single State (“host”) agency, which monitors for compliance with standards at the single site. Therefore, though an agency may have multiple licenses, they are only subject to one survey. Further, the Project has promoted the use of an integrated physical and behavioral health record for recipients.

The now-established IOS regulations further the core principles of the Project:

- Allows a provider to deliver the desired range of cross-agency clinic services at a single site under a single license;
- Requires the provider to possess licenses within their network from at least 2 of the 3 participating State agencies;
- Allows the site’s current license to serve as the “host”; and
- Facilitates the expansion of “add-on” services through request to the State agency currently possessing primary oversight responsibility for such services.

In addition to the opportunity to provide integration of behavioral health and primary care services under the IOS regulations, the DSRIP Program has provided another avenue for clinics within Performing Provider Systems to integrate care under DSRIP Project 3.a.i. OMH, OASAS, and DOH collectively agreed to raise the current licensure thresholds associated with clinics in order to allow a greater number of secondary and tertiary services at existing sites, for those clinics that are part of a DSRIP Project 3.a.i. (which was chosen by all 25 PPSs). However, it is important to note that any clinic providers operating within the existing licensure thresholds or the DSRIP Project 3.a.i. licensure thresholds must also meet certain regulatory requirements outlined by the host model, listed here:

http://www.health.ny.gov/health_care/medicaid/redesign/dsrp/regulatory_waivers/licensure_thresholds.htm

B. Alignment of Delivery System Reform Initiatives

New York State’s increasing recognition of the integration of mental hygiene services and physical health to improve overall population health has recently sparked new statewide initiatives. It is critical that local and regional service planning activities are in alignment with state and national initiatives to assist in transforming healthcare delivery and to eliminate health disparities. While addressing the diverse local community needs; priorities and behavioral health improvements and initiatives should take into account multiple system transformation goals and objectives. Figure 2.2 displays the four overarching delivery system reform initiatives recently put forth by DOH.

Figure 2.2: Alignment of Delivery System Reform Initiatives



The Prevention Agenda

The New York State [Prevention Agenda 2013-2018](#) is plan for population health improvement. Initially intended to be a five-year plan, it has been extended to 2018 to align its timeline with other state and federal health care reform initiatives. The goal of the Prevention Agenda is to improve health status and reduce health disparities in five priority areas:

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

In 2013, all local health departments (LHDs) and general hospitals across New York State were instructed to collaborate with each other and with other community partners on the development of Community Health Improvement Plans to reduce duplication of services. Each LHD was required to address at least two of the five priority areas.

One of the five priority areas covered under the Prevention Agenda was “Promote mental health and prevent substance abuse.” When DOH distributed the Prevention Agenda guidelines to the LHDs and hospitals in early 2013, local governmental units (LGUs) were strongly encouraged to proactively reach out to their LHDs to collaborate on this priority area and to begin developing common goals in their own plans. Over the following year, a significant amount of local collaboration took place between the LHDs and their partners, including the LGUs to develop goals and action steps to achieve common priorities.

In 2014, a comparison of the Community Health Improvement Plans (CHIPs) submitted by LHDs in November 2013 and the Local Services Plans (LSPs) submitted by LGUs in June 2014 were reviewed to assess the alignment of common goals related to the Prevention Agenda. A total of 30 Community Health Improvement Plans included one or more goals associated with the “*promote mental health and prevent substance abuse focus*” area. In addition, 56 LSPs included one or more priorities related to the goals identified in the Prevention Agenda.

Within the mental health and substance abuse priority area, there were seven specific goals under three broad focus areas:

- Promote Mental, Emotional and Behavioral Well-Being in Communities;
- Prevent Substance Abuse and other Mental Emotional Behavioral Disorders; and
- Strengthen Infrastructure across Systems.

As **Table 2.1** shows, there were a total of 56 goals that were common to both the LSP and CHIP. Another 37 goals were included in the CHIP but not included in the corresponding LSP. There were 196 goals related to the Prevention Agenda in the LSPs that were not in the corresponding CHIP. Since the LGUs would normally be expected to include goals that promote mental health and prevent substance abuse, this number was not unexpected. There was only one LGU that did not include a goal related to at least one of the seven goals listed.

There were eight counties where the LHD and LGU both identified goals related to preventing underage drinking, non-medical use of prescription pain reliever drugs by youth, and excessive alcohol consumption by adults. All eight addressed the non-medical use of prescription drugs, primarily opioid pain relievers. Strategies included such things as limiting inappropriate access to and prescribing of opioids, increasing the availability of prescription drop boxes, and increasing public awareness of the dangers of misusing prescription drugs. Only three counties had common goals associated with underage drinking or binge drinking. Strategies focused on developing a Social Host Law and implementing evidence-based prevention practices.

There were 19 LGUs that identified suicide prevention as a priority associated with both the substance abuse and mental health systems. There were an additional 20 LGUs that identified suicide prevention as a mental health only priority and 27 LGUs that identified suicide prevention as a substance abuse priority only. Most counties reported that there was an active local suicide prevention coalition that was working on community prevention education and early intervention initiatives, trainings on safe and secure storage of firearms, and implementing suicide prevention specific evidence-based practices.

Interestingly, reducing tobacco use among adults who report poor mental health was a goal in 13 counties, but only one where it was common to the LSP and the CHIP. An additional 19 CHIPs included this goal under an identical goal in the Chronic Disease Prevention priority area.

The LHDs and LGUs continue to collaborate to implement strategies related to the Prevention Agenda over the next three years. DOH, OASAS, OMH and other partners continue to provide assistance on identifying evidence-based interventions and developing meaningful performance measures that will enable counties to monitor progress on improving community health.

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

Goal	Goal Description	CHIP Only	LSP Only	Both
1.1	Promote mental, emotional and behavioral (MEB) well-being in communities.	1	42	8
2.1	Prevent underage drinking, non-medical use of prescription pain reliever drugs by youth, and excessive alcohol consumption by adults.	3	27	8
2.2	Prevent and reduce occurrence of mental, emotional and behavioral disorders among youth and adults.	4	31	3
2.3	Prevent suicides among youth and adults.	20	27	19
2.4	Reduce tobacco use among adults who report poor mental health.	4	8	1
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.	2	31	12
3.2	Strengthen infrastructure for MEB health promotion and MEB disorder prevention.	3	30	5
	Totals	37	196	56

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.

There are 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.

In May 2015, DSRIP PPSs received award letters based on scored DSRIP applications reviewed by PCG, an independent assessor, and the Project Approval and Oversight Panel (PAOP). PPSs that received payment are required to submit reports to the state demonstrating progress on each

of their projects as measured by the milestones and metrics described in their approved DSRIP plan. Based on the reports, the state will calculate the incentive payments for the progress achieved according to the approved DSRIP project plans. These [quarterly reports and project implementation plans](#) are currently available, and can be useful for LGUs that are interested in becoming involved with their local PPS.

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. LGUs will need to work collectively across counties and take a more regional approach as DSRIP and similar health care reform initiatives roll out.

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:

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

The SHIP also identified three enablers:

- Workforce strategy;
- Health information technology; and
- Performance evaluation and measurement.

In December 2014, New York State, in coordination with Health Research, Inc. was awarded a four year, \$ 99.9 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. New York developed the SHIP and the SIM grant application with the support of numerous stakeholders. The state's official project period of the grant begins February 1, 2015 and will continue for four years.

The Population Health Improvement Programs (PHIPs)

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. Eleven regional PHIP contractors began work in late 2014 across the State, providing a neutral forum for identifying, sharing, disseminating and helping implement best practices and strategies to promote population health, reduce health care disparities, and advance the Culturally and Linguistically Appropriate Services (CLAS) standards. In particular, PHIP contractors will help support and advance ongoing activities related to the New York State Prevention Agenda 2013-2018 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 are 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 Consortia. A list of PHIP Lead Organizations by region are now available on the [DOH website](#).

C. Planning For Addiction Services

The mission of The New York State Office of Alcohol and Substance Abuse Services (OASAS) is to improve the lives of all New Yorkers by leading a comprehensive premier system of addiction services for prevention, treatment and recovery. The agency envisions a future where New York State is alcohol safe and free from chemical dependence and compulsive gambling.

OASAS oversees, one of the largest addictions service systems with nearly 1,600 prevention, treatment and recovery programs that are inspected and monitored regularly to guarantee quality of care and to ensure compliance with state and national standards. OASAS chemical dependence treatment programs assist about 97,000 people a day and approximately 236,000 individuals a year. This includes the direct operation of 12 Addiction Treatment Centers, which served over 8,000 persons during 2015. Approximately 312,000 New York State youth received a direct prevention service during the 2014-2015 school year.

Treatment

Using evidence-based practices, OASAS is committed to setting a gold standard of care that is patient centered. Patients can receive medical care for physical or mental health problems, individual and group therapy, educational assistance, life skills development, vocational training, and assistance with housing and family reunification. Treatment for chemical dependence and gambling problems reduces criminal justice activity, increases employment, decreases homelessness, improves health and reduces health care costs.

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, CASA Columbia, and the Northwell Health System(formely North Shore—LIJ Health System).

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

OASAS released the revised LOCADTR 3.0 in early 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 CASA Columbia. The revised LOCADTR is designed to identify the level of care best suited to an individual based on need, potential risks, and available resources while remaining as near to their community as possible. Substance abuse treatment providers in New York City were required to use LOCADTR 3.0 on October 1, 2015 and providers in the rest of the state are encouraged to begin using the tool as soon as possible, but no later than July 1, 2016. These dates align with the transition from fee-for-service to Medicaid managed care for mental health and substance abuse disorder services in New York State. Managed care organizations who serve the Medicaid population are required to use LOCADTR 3.0 for level of care determinations.

OASAS is also tailoring the LOCADTR tool to address the needs of adolescents with substance use disorders and/or co-occurring mental health disorders. OASAS will work with adolescent residential treatment programs to create a full continuum of residential services. The levels of care that comprise this full continuum will be included in the adolescent version of LOCADTR 3.0.

Residential Redesign

Residential Redesign is 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 incorporates 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 Reintegration** - 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 a program will offer and how this fits within the continuum of services offered in the region or county.

Adolescent Treatment Services

OASAS continues to work on the Children's Health and Behavioral Health Medicaid Redesign Team, with the Department of Health, the Office of Mental Health and the Office of Children and Family Services. In addition to moving current services for children and youth under the age of 21 into a Managed Care environment, there will also be a consolidation of current 1915c waivers that are held by the OMH for Seriously Emotionally Distributed youth, the OCFS Waivers for children and youths in Foster Care and the DOH Waivers for the Medically Fragile Youth into the overall 1115 Waiver and the establishment of one set of Home and Community Based Services for youth on Medicaid who meet the targeting criteria. This could include youth with a substance use disorder and youth with a substance use disorder and a co-occurring mental health disorder who meet the targeting criteria.

Additionally, the State is proposing 6 new State Plan Services for children and youth. The current time frame for moving services for children and youth into Medicaid Managed Care is January 2017, for Long Island and New York City and July 2017 for the rest of state. Enrolling youth in Health Homes specifically designed to meet their needs will begin September 2016.

To assist with the transition to Medicaid Managed Care for children and adolescents, OASAS has developed an adolescent module to the LOCADTR 3.0. Once the adolescent module is live, a birth date is typed into the LOCADTR and based on the date, the adolescent questions will be used as opposed to the adult version. OASAS anticipates rolling the adolescent module out in summer of 2016.

OASAS has convened an Adolescent Clinical Advisory Panel (A-CAP) to support and guide the agency's efforts in developing a full continuum of services for adolescents. The A-CAP along with CASA Columbia assisted in the development of the adolescent module of the LOCADTR and will now be working to develop Clinical Practice Guidelines for Adolescent Programs that will assist in establishing a minimum set of baseline clinical practices for adolescent programs.

OASAS is also the recipient of two federal cooperative project agreements through the Center for Substance Abuse Treatment (CSAT). The first project, New York Serving Adolescent in Need of Treatment Services (NYSAIN) began in September of 2012, is in the no-cost extension year and will end in September 2016. This project implemented Seven Challenges, an evidence based practice and the Global Appraisal of Individual Needs (GAIN) in two sub recipient sites, while also improving the role of youth and families in decision making and improving the infrastructure needed to support services for adolescents with a substance use disorder. During 2016 this project will roll the Seven Challenges out to an additional four provider sites, develop a Trauma Informed learning collaborative with 25 to 30 adolescent

providers and develop an on-line learning module on Brain Development and Adolescent Substance Use Disorders.

The second project, New York Focus on Youth and Families, began in October 2015 and will focus on implementing the evidenced based practice Multi-dimensional Family Therapy (MDFT) in a minimum of 8 programs over three years and will assist the office in development of Family Peer Supports and Youth Peer Supports. Both of these projects have helped to further the full continuum of services for adolescents and their families.

In keeping with the OASAS commitment to develop a Recovery Oriented System of Care for all New Yorkers, the agency is also providing \$1.9 million in funding to create first-of-a-kind adolescent (youth- 12-17 years of age) and young adults (18-21 years of age) recovery clubhouses in seven regions across New York State. The clubhouses will provide a safe and inviting place for teens and young adults who are in recovery from a substance use disorder and/or a co-occurring mental health disorder to develop pro-social skills that promote long term health, wellness and recovery. The clubhouses will be a community-based, non-clinical setting that promotes peer-driven supports and services.

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. There were 118,000 admissions to in-state treatment programs for heroin and opioid addictions in 2014, a 17.8% increase from 2009. 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.

New York State's [Combat Heroin](#) campaign has reached more than 14 million people through messages on billboards, posters, online advertisements, social media, commercials and movie theaters across the state. 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.

In addition, OASAS has 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 (322 in OASAS-certified programs) and 445 opioid treatment programs with the federal waiver to prescribe buprenorphine. Of the 682 OASAS-certified treatment programs; 372 are also prescribing naltrexone and 229 vivitrol for opiate dependence.

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.

Problem Gambling

OASAS supports statewide prevention and treatment services targeting problem gambling. Treatment for problem gambling is provided in 19 outpatient programs and one inpatient program. In addition, through partnership with the New York Council on Problem Gambling (NYCPG), Problem Gambling services are being offered through the Queens Center for Excellence (QCFE) in New York. The QCFE is responsible for providing public awareness, community education, and treatment linkages to local private practitioners, recovery support services and industry relations. These efforts will increase awareness and “**drive**” individuals and family members to utilize problem gambling treatment and support services.

NYCPG is also funded to increase public awareness throughout the state of New York. Through the Council’s funding, many OASAS prevention providers are funded to work with youth on Media Literacy and Problem Gambling. This effort aims to empower youth ages 12 to 17 to make healthy, educated decisions surrounding gambling, and to motivate their parents, leaders and communities to join together in the effort to prevent underage gambling. Problem Gambling outreach and education efforts continue to be integrated into the OASAS Substance Abuse Prevention system. All funded prevention providers are required to provide problem gambling public awareness activities to their communities on a yearly basis.

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

Prevention

OASAS prevention service providers use a proactive planning process to deliver proven evidence-based programs to young people, their families, and communities. Substance abuse prevention services are delivered by over 165 programs operating in schools, community-based organizations, and embedded in the community at large. The programs deliver a wide range of services including: evidence-based education programs, environmental efforts to reduce underage drinking, and early interventions for adolescents who have begun to use alcohol and other drugs.

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.

Prevention education, environmental strategies, early intervention, prevention counseling information/awareness and community capacity building are all critical components of an effective community prevention system. OASAS established six Prevention Resource Centers (PRCs) to

provide support to community coalitions and prevention providers to establish and support community coalition development and other capacity building efforts.

Evidence-based Programs and Strategies (EBPS) have documented scientific evidence that they are effective in preventing substance abuse and other youth problem behaviors. EBPS include educational curricula, multi-component school-based programs, environmental strategies and early interventions. Most EBPS delivered by OASAS funded prevention providers are delivered in school settings. The OASAS Registry of EBPS includes programs and strategies that have been evaluated for effectiveness specifically in preventing or reducing substance abuse and related problems, and are designed to change the youth, family, school and community level risk and protective factors that drive substance abuse and negative consequences due to substance abuse.

Prevention Reporting System

In January 2015, providers began entering all their prevention activity data into an interim system, named WITNYS. Starting in June 2015, providers began developing their work plans in WITNYS for the 2015-2016 Prevention Planning Year and continue to enter their activity data into the system. Several training webinars were conducted during the past year and more training will be done this spring for new provider staff and as a refresher for existing provider staff.

OASAS is procuring a new Prevention Reporting System that will have more comprehensive functionality than the interim system. It is anticipated that development of the new system will begin in July 2016 and the goal is to have it fully tested and operational by May 2017.

Strategic Prevention Framework Partnership for Success (SPF PFS)

The Strategic Prevention Framework Partnership for Success (SPF PFS) is in its second year of a five-year \$8.13 million grant. The SPF PFS focuses on preventing prescription drug misuse/abuse, heroin abuse and opioid overdose.

Ten high need community coalitions from across New York State were selected in 2015 through a competitive RFP process. The coalitions have completed a thorough assessment of the substance abuse rates, consequences and risk factors in their communities and will begin to implement environmental strategies to reduce prescription drug misuse and abuse and heroin abuse in the spring of 2016.

Talk2Prevent

OASAS has embarked on a four-year plan to advance the prevention agenda in New York State by engaging parents and community members in preventing underage drinking and substance abuse. Beginning in the fall of 2015, a statewide media campaign ran focusing on giving parents the tools to talk to their teens and college students about underage drinking. Resources and materials were, and will continue to be developed for local community coalitions and prevention providers to customize, adapt, and disseminate. The campaign focuses on promoting health, changing social norms, and giving adults the tools they need to talk to teens about underage drinking and substance abuse. The campaign targets different groups, such as schools, health care providers and law enforcement. However, parents are always included as a primary focus. The campaign promotes the Talk2Prevent website and Facebook page as well as the Combat Heroin website as sources of information. Whenever possible, national health observances are tied in as well.

Prevention on College Campuses

The consequences of underage drinking are enormous for students on college campuses and surrounding communities. These include deaths, sexual and other physical assaults, unintentional injuries, unsafe sex, DWI, vandalism, suicide attempts, academic problems, and substance abuse and dependence. While some students enter college with established drinking habits, the college environment can exacerbate the problem. In 2016, OASAS will explore a partnership with SUNY and CUNY to fund Alcohol and Other Drug (AOD) coordinators on multiple campuses throughout NYS. The coordinators will be responsible for implementing campus-wide and community environmental prevention strategies and early intervention services through campus clinics and residence life staff.

State Education Department Memorandum of Understanding

The New York State Education Department (SED) state-wide Health Education standards guidance document was updated by working collaboratively to meet the June 2014 legislation to address heroin and other opioid use and includes functional knowledge content for this area, as well as an instructional framework and resource packet for educators. The **Health Education Standards Modernization Supplemental Guidance Document** was developed, critiqued, and submitted to SED and is currently under final review. For the Evidence-Based Program (EBP) pilot program, planning has commenced to select districts based on inter-agency approved criteria for invitation to apply for participation, during which elementary schools in the three districts will use EBPs in a supported manner beginning with start of the 2016-2017 school year. Work is underway to create a guidance document regarding Evidence-Based Programs and Practices (EBPs) for comprehensive prevention topics (e.g., A Guidance Document to Assist Schools in Creating an Instructional and Supportive Framework for Tobacco, Alcohol and Other Drug Education and Prevention) that will be submitted to SED in mid-2016.

Prevention Policy Academy

In September 2012, CSAP selected OASAS and six other New York State agencies to form a Prevention Policy Academy to begin developing the necessary data infrastructure to support more integrated planning for both mental health promotion and mental, emotional, and behavioral (MEB) health disorder prevention services for children and youth. One outcome of the improved collaboration resulting from the Prevention Policy Academy is an agreement that SED will transmit school district data on five MEB indicators for elementary aged youth to OASAS for analyses. The indicators are: free/reduced price lunch participation; statewide test scores on math and language arts; the prevalence of special education students with MEB related classifications; and suspensions/ expulsions of students with special education classifications.

Population rates of these MEB indicators and a combined MEB Health Planning Index statistic will be computed for school districts, counties and the state. A new planning tool that will produce maps at the school district and county levels for the MEB health planning data is being added to the state's existing "Kids Wellbeing Indicator Clearinghouse" (KWIC) operated by the NYS Council on Children and Families. Planners will be able to view colored thematic maps for all MEB indicators and for the combined planning index. Users will be able to map the MEB indicators and also view the school district locations. Downloads of Excel data files will also be available. The new planning tool is scheduled to be online by early Summer, 2016.

Recovery

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, Home, Purpose, and Community.

[Recovery](#) is one of the primary goals for those afflicted with mental health and substance abuse disorders and OASAS is committed to ensuring that all of its services fully recognize and respond to the needs of those in or seeking recovery. There are multiple pathways to recovery including: treatment, faith/spirituality, natural, criminal justice interventions and drug treatment courts, support from individuals, and/or family, mutual assistance groups, employee assistance programs and recovery community centers.

OASAS is committed to the development of a [Recovery Oriented System of Care \(ROSC\)](#) for all New Yorkers. A ROSC is a network of formal and informal services developed and mobilized to help attain and sustain long-term recovery for individuals and families impacted by substance use. It is not a local, state or federal agency but rather a macro-level organization within a community or state. The development of a ROSC necessitates changing the paradigm from treating addiction as an acute crisis to one which reflects the chronicity of addiction and the need for long-term supports and services.

Recovery Community and Outreach Centers

OASAS supports four Recovery Community and Outreach Centers located in Brooklyn, Rochester, Oneonta and Delhi, with an additional six Centers anticipated to be operational during 2016. The Recovery Community and Outreach Centers will enhance the development of a ROSC by:

- Building statewide infrastructure as OASAS intends to develop Centers throughout the state to represent the diverse geographic locations and needs of the state;
- Engaging multiple stakeholders and partners within the community, inclusive of prevention programs, to develop consensus, shared vision, community ownership and identification of local resources regarding treatment, prevention and recovery supports for individuals and families in the community;
- Providing infrastructure, recovery capital, and referral to treatment and other recovery support resources within local communities;
- Providing assistance to individuals and families to help them learn to navigate access to the substance use treatment system, including assistance in negotiating any insurance issues that may be barriers to treatment access;
- Providing a community-based, non-clinical setting that is safe, trauma-informed, welcoming and alcohol/drug-free for any member of the community;
- Providing recovery support services to individuals and their families that may or may not have previously been involved in formal treatment approaches and/or mutual support groups;

- Providing individuals and families the opportunity to learn from their peers to enhance social connectedness and to achieve personal and common goals related to recovery from addiction;
- Providing participants with the ability to access Peer Advocates, Recovery Coaches and Peer Specialists to enhance the recovery process;
- Promoting long-term recovery through skill building, recreation, education, wellness, employment readiness, civic restoration, and a number of other pro-social activities; and
- Providing activities and an environment that will promote a lifetime of wellness for individuals, families and the community.

Peer Support Services

Peer support services are considered “evidence-based” by the federal Centers for Medicare and Medicaid Services. They are recognized as one critical pathway of support to those overcoming mental health and substance use disorder (SUD) challenges, and for supporting the families of people struggling with these challenges. Peer Services are now Medicaid reimbursable within SUD outpatient clinics when delivered by Certified Recovery Peer Advocates (CRPAs). In addition, Peer Support services delivered by both CRPAs and Certified Peer Specialists will also be Medicaid reimbursable when provided by approved Home and Community Based Service providers (HCBS) to serve both SUD and MH recipients of services. These initiatives are creating unprecedented career opportunities for peer support workers within both systems.

Peer support services are consumer-delivered services with a rehabilitation and recovery focus. They are designed to promote skills for coping with and managing SUD symptoms while facilitating the utilization of community resources to achieve self-efficacy and community living skills. Peer support utilizes non-clinical assistance to achieve long-term recovery from substance use disorder health-related issues. Peer support values include shared experience; self-determination; choice; dignity of risk and right to fail; mutuality; non-hierarchical; self-directed and voluntary.

Peer support activities focus on achieving the identified goals or objectives in the consumer’s individualized recovery care plan. The recovery plan identifies specific goals that are determined by the recipient of services that are achievable in part through community supports. The intent of these activities is to assist recipients in initiating and maintaining recovery, and to enhance 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.

OASAS approved two certification entities to certify peers in New York State to work within OASAS certified outpatient programs and home and community-based services as [Certified Recovery Peer Advocates \(CRPA\)](#). They are:

- The New York Certification Board <http://www.asapnys.org/nycb-home>, and
- The New York Certification Association <http://www.nycertification.org/>.

Certified Recovery Peer Advocates (CRPA) are individuals who hold an OASAS approved certification as a peer advocate. Peer Advocates must be supervised by a QHP staff member to

provide peer support services. Services provided by a Certified Recovery Peer Advocate are Medicaid reimbursable and include the following:

- Helping peers develop Recovery Plans,
- Learning and practicing new skills,
- Helping peers self-monitor their progress,
- Modeling effective coping skills,
- Attending court and other system meetings as a support,
- Facilitating peer support groups, and
- Supporting another peer in advocating for themselves to obtain effective services.

[Recovery Coaching](#) is a peer-based recovery support service that is non-clinical and designed as a form of strength-based supports for persons in or seeking recovery from alcohol and other drugs, and other addictions. Similar to life and business coaching, Recovery Coaching (also known as peer mentoring) is a type of partnership where the person in or seeking recovery self directs his/her recovery while the coach provides expertise in supporting successful change. Recovery Coaching focuses on achieving any goals important to the individual. The coach asks questions and offers suggestions to help the "recoveree" begin to take the lead in addressing his/her recovery needs. Recovery Coaching focuses on honoring values and making principle-based decisions, creating a clear plan of action, and using current strengths to reach future goals. The coach serves as an accountability partner to help the person sustain his/her recovery. The Recovery Coach helps the person access recovery, as well as access systems needed to support recovery such as benefits, health care, etc. All "Certified Recovery Peer Advocates" (CRPA) are required to be certified in "Recovery Coaching".

[Friends of Recovery New York \(FOR-NY\)](#), in collaboration with NYS OASAS, and the Connecticut Community for Addiction Recovery (CCAR), coordinates the delivery of the CCAR [Recovery Coach Academy \(RCA\) and Training of Trainers \(TOT\)](#) across New York State. The RCA is a 5-day training designed to give training participants the knowledge, skills, and experiences to become personal guides/mentors for individuals seeking or already in recovery.

Related OASAS Recovery Projects

OASAS is involved in several collaborative initiatives designed to move our systems of care forward. The Bringing Recovery Supports to Scale-Technical Assistance Center (BRSS-TACS) Policy Academy has been supported since 2013 by SAMHSA through its contractor the Center for Social Innovation. Multiple stakeholders, including OMH, DOH, peers, managed care entities and NYC Department of Health and Mental Hygiene (DOHMH) are engaged on a on a team to expand and enhance recovery supports. The Policy Academy vision is for NYS *to have a recovery-based wellness system in which peer-peer services will be universally accessible, integrated within a collaborative environment of shared experience, and recognized as valuable and equitably reimbursed.* The Academy is sponsoring two Peer Ambassadors during 2016 to conduct outreach and engage providers and peers on the integration of peers within our systems of care.

The Recovery Implementation Team (RIT) was formed by the OASAS Recovery Bureau in January 2008. Membership on the RIT includes: local recovery communities, individuals in recovery, family members in recovery, local governmental units, prevention and treatment organizations, OASAS staff and representatives from other stakeholder systems such as criminal justice, child welfare, and mental health. Team members meet quarterly and are working collaboratively to develop and improve services for persons in recovery.

Permanent Supportive Housing

OASAS recognizes that safe and affordable housing for homeless individuals and families suffering from a substance use disorder (SUD) is a critical recovery support service. Moreover, permanent supportive housing is a major social determinant in the recovery process, as is having opportunities for employment, education, nutritious food, and having access to health care services. OASAS provides opportunities for permanent supportive housing to homeless adults and families through rental subsidies and case managed supportive services.

OASAS manages and oversees a housing portfolio with seven distinct brands of permanent supportive housing (PSH), funded at approximately \$35.6 million with an additional \$2.1 million for case management services linked to the Continuum of Care Rental Assistance Program (formerly Shelter Plus Care). In FY 2016-'17 OASAS will add 80 units of family housing under the NY/NY III homeless agreement, and plans to issue a RFP to award an additional 90 units of housing targeting homeless families in New York City. Excluding the addition of the 170 NY/NY III family units, the OASAS permanent supportive housing portfolio has a current total of 2,734 apartment units across the following programs:

- Continuum of Care Rental Assistance Program (formerly Shelter Plus Care): Funded and overseen by the U.S. Department of Housing and Urban Development (HUD);
- New York/New York III Homeless Agreement which is a ten-year New York City/New York State partnership to initiative and create up to 9,000 units of permanent supportive housing for chronically homeless adults and families;
 - NY/NY III Population E: (Chronically homeless single adults with active substance abuse)
 - NY/NY III Population F: (Homeless single adults who have completed substance abuse treatment)
 - NY/NY III Population G: (Chronically homeless/at risk of homeless families in which the head of household has a substance use disorder)
- Upstate PSH Initiative that targets homelessness in counties and regions outside of New York City and its metropolitan (Metro New York) counties;
- New York City-based Re-Entry PSH initiative for Parolees, which is a collaboration with State Division of Parole; and
- Medicaid Redesign Team (MRT) Affordable Housing Initiative: Using a housing-first paradigm provides permanent supportive housing to single adults who are high cost frequent consumers of Medicaid benefits. The MRT supportive housing program also encourages enrollment and when applicable links/refers tenants to NYS Health Homes.

D. 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 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) 2014-15 State Budget and continuing through SFY 2015-16, the OMH Transformation Plan "pre-invested" \$59 million annualized into priority community services and supports, with the goals of reducing State and community-operated facilities' inpatient psychiatric admissions and lengths of stay. In addition, \$15 million has been reinvested from Article 28 and 31 inpatient facilities to further support the OMH Transformation Plan 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 2013-2018, 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.

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. The OMH FEP initiative now entitled *OnTrackNY* has expanded to additional upstate sites, with additional plans for expansion statewide as federal Block Grant commitments for early intervention initiatives have been set aside for First Episode Psychosis funding.

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 is the [County Capacity and Utilization Data Book](#), which is updated annually with the most recent Medicaid, licensing, and surveillance data including SPARCS. 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.

E. Planning for Developmental Disability Services

The 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: The State Office for People With Developmental Disabilities is engaged in a system-wide transformation, aimed at improving opportunities for individuals with developmental disabilities in the areas of employment, integrated living, and self-direction of services. These goals are captured in The Transformation Agreement between New York State OPWDD and the Centers for Medicare & Medicaid Services. OPWDD has made great strides in accomplishing many of these transformation goals and continues to work towards fully implementing the Transformation Agenda. In 2015 the Transformation Panel was established to bring together experts and stakeholders, including individuals with developmental disabilities, their families and provider agencies. The panel was charged with developing a clear vision and strategy for implementing the transformation agenda.

Transformation Panel: OPWDD established The Transformation Panel to support planning efforts, address essential questions facing the agency and involve the public in creating solutions. In February of 2015, the Acting Commissioner brought together a panel of experts to examine the challenges in implementing the Transformation Agenda, offering managed care in our system and ensuring its long-term fiscal sustainability for people currently receiving services and those who will need to access our services in the coming years. As one of its priorities, the panel was asked to review how OPWDD proposes to offer managed care prior to the formal request for federal approval to implement managed care in our system. Recognizing the critical need for dialogue and engagement, the panel held public forums across New York State to promote meaningful dialogue, discussion and input. Panel members and OPWDD leaders heard from people receiving services, family members, and providers about the issues and barriers they face at a series of public forums. These comments, questions and ideas informed the panel's recommendations, as well as OPWDD's Statewide Comprehensive Plan and Residential Request List initiative. The full report and findings of the panel are available: [Transformation Panel Report and Findings](#)

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. [The Front Door Report](#) outlines the progress OPWDD has made in making the current process easier to navigate for individuals and families. OPWDD is proud to report that stakeholder satisfaction with the Front Door process has improved significantly after implementing numerous employee and stakeholder recommendations.

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 completed the CAS Validity Study in February 2016, and continues to work on integrating the CAS into the UAS-NY system as well as developing training curriculum to support assessors. These efforts will help ensure that the CAS is a valid measure that will provide accurate and consistent data for the equitable distribution of services. The Transformation Panel developed a set of recommendations specific to the CAS to support the implementation of the tool. Moving forward, 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 has been successfully implemented in Region One and Region Three and continues to be rolled out statewide. In Region Four and Region Five, a gap analysis was conducted to identify service needs in each region, this was used in the development of the RFP and shared with stakeholders.

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 developed a report in 2015 exploring such a credentialing program, the full report and its findings are available: [Direct Support Professional Credentialing Report](#)

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.

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.

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.

Based on OPWDD's HCBS Settings Transition Plan, OPWDD has incorporated the following 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 in living a full and meaningful life.

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. OPWDD is working to advance its housing strategies to better respond to demand and changing models of support that can be more tailored to the individual. 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 multiyear plan to address the needs of individuals with developmental disabilities who have requested residential services outside their family home. Over the past year, OPWDD has made an effort to contact every person who had indicated an interest in residential services through the Residential Request List, formerly known as the NY Cares list. This outreach helped OPWDD determine immediate needs that must be met and plan for future residential services. Based upon this outreach, and other work with individuals, families, advocates, and providers, OPWDD is developing strategies to address the need for safe, accessible, affordable and individualized housing supports for people with developmental disabilities. Results of this initiative are available: [Residential request List Report](#)

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 300 individuals live in OPWDD's Developmental Centers.

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 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 understands how critical

employment and opportunities for positive social interaction are to individuals and remains focused on retaining the positive aspects of the current system while striving to expand opportunities through greater exposure to local communities.

OPWDD's [Work Settings Report](#) lays out a comprehensive plan to assist individuals currently working in sheltered workshop programs as such programs transition to integrated work settings that are consistent with federal requirements and a plan to meet the needs and goals of people who choose not to transition to community-based integrated work settings. OPWDD remains committed to continuing our collaboration with all stakeholders as individuals, families and providers adapt to new federal requirements.

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 One of these guidelines, Mental Hygiene Law requires each LGU to develop and annually submit to each state 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.

The Needs Assessment Form and Priority Outcomes Form have been revised this year to better reflect the sweeping transformational changes toward integrated care in the physical and behavioral health care sectors. The regional needs assessment piece has been dropped from The Needs Assessment Form and collaborative planning questions have been added. Not all the needs identified by the county may result in a priority outcome, but it is important for the county to establish needs and service gaps first before they formulate their priority outcomes and strategies. Addressing some needs may be out of the control of the LGU. Priority outcomes and associated strategies address the needs that the LGU has some control over and a reasonable opportunity to resolve. The focus areas and metrics have been dropped from the form this year but alignment with statewide initiatives and consistency with regional priorities has been added.

This year, OMH is conducting a survey that addresses the OMH Transformation Plan, and OASAS is including a new form to collect the LGU's Emergency Manager Contact information. LGUs are no longer being asked to maintain the Alcohol and Substance Abuse (ASA), Mental Health (MH), and Developmental Disabilities (DD) Sub-Committee Rosters in CPS. The New York City and LGU Community Service Board Rosters will continue to be maintained, however, information previously reported was not brought forward from last year and LGUs are being asked to complete this form new this year.

All plans must be completed, certified, and submitted in CPS by Wednesday June 1, 2016.

Questions, problems or concerns regarding planning forms or the County Planning System (CPS) may be directed to Marialice Ryan at 518-485-0506 or Marialice.Ryan@oasas.ny.gov.

A. Mental Hygiene Needs Assessment Report Form

- 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. You have the option to attach documentation, as appropriate.

- 2. Analysis of Service Needs and Gaps** – In this section, describe and quantify (where possible) 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 the gaps between services needed and services provided. Describe

existing barriers to accessing needed services. Identify specific underserved populations or populations that require specialized services. You have the option to attach documentation, as appropriate.

- 3. Assessment of Local Needs** – For each category listed in this section, indicate the extent to which it is an area of need by checking the appropriate check box under “High,” “Moderate,” or “Low” for each population: Youth (Under 21) and Adults (21 and Over). When considering the level of need, compare each issue category against all others rather than looking at each issue category in isolation. For each issue that you identify as a “High” need, answer the follow-up question to provide additional detail.

Issue Category	Youth (<21)			Adult (21+)		
	High	Mod.	Low	High	Mod.	Low
Substance Use Disorder Services:						
a) <u>Prevention Services</u>	<input type="checkbox"/>					
b) <u>Crisis Services</u>	<input type="checkbox"/>					
c) <u>Inpatient Treatment Services</u>	<input type="checkbox"/>					
d) <u>Opioid Treatment Services</u>	<input type="checkbox"/>					
e) <u>Outpatient Treatment Services</u>	<input type="checkbox"/>					
f) <u>Residential Treatment Services</u>	<input type="checkbox"/>					
g) <u>Housing</u>	<input type="checkbox"/>					
h) <u>Transportation</u>	<input type="checkbox"/>					
i) <u>Other Recovery Support Services</u>	<input type="checkbox"/>					
j) <u>Workforce Recruitment and Retention</u>	<input type="checkbox"/>					
k) <u>Coordination/Integration with Other Systems</u>	<input type="checkbox"/>					
l) Other (specify): <input type="text"/>	<input type="checkbox"/>					
Mental Health Services:						
m) <u>Prevention Services</u>	<input type="checkbox"/>					
n) <u>Crisis Services</u>	<input type="checkbox"/>					
o) <u>Inpatient Treatment Services</u>	<input type="checkbox"/>					
p) <u>Clinic Treatment Services</u>	<input type="checkbox"/>					
q) <u>Other Outpatient Services</u>	<input type="checkbox"/>					
r) <u>Care Coordination</u>	<input type="checkbox"/>					
s) <u>HARP HCBS Services (Adult)</u>	---	---	---	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
t) <u>HCBS Waiver Services (Children)</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	---	---	---
u) Other Recovery Support Services*	<input type="checkbox"/>					
v) <u>Housing</u>	<input type="checkbox"/>					
w) <u>Transportation</u>	<input type="checkbox"/>					
x) <u>Workforce Recruitment and Retention</u>	<input type="checkbox"/>					
y) <u>Coordination/Integration with Other Systems</u>	<input type="checkbox"/>					
z) Other (specify): <input type="text"/>	<input type="checkbox"/>					

*This category refers to those recovery, vocational, and support services that are not specifically HARP HCBS services for adults or in the children’s HCBS Waiver program.

Developmental Disability Services:

aa) Crisis Services	<input type="checkbox"/>					
bb) Clinical Services	<input type="checkbox"/>					
cc) Children Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	---	---	---
dd) Adult Services	---	---	---	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ee) Student/Transition Services	<input type="checkbox"/>					
ff) Respite Services	<input type="checkbox"/>					
gg) Family Supports	<input type="checkbox"/>					
hh) Self-Directed Services	<input type="checkbox"/>					
ii) Autism Services	<input type="checkbox"/>					
jj) Person Centered Planning	<input type="checkbox"/>					
kk) Residential Services	<input type="checkbox"/>					
ll) Front Door	<input type="checkbox"/>					
mm) Transportation	<input type="checkbox"/>					
nn) Service Coordination	<input type="checkbox"/>					
oo) Employment	<input type="checkbox"/>					
pp) Workforce Recruitment and Retention	<input type="checkbox"/>					
qq) Coordination/Integration with Other Systems	<input type="checkbox"/>					
rr) Other (specify): <input type="text"/>	<input type="checkbox"/>					

The following question should be answered for each issue category and disability above that was identified as a “High” need.

3a1-3hh1. [Issue category populated from above] Briefly describe the issue and why it is a high need for the population(s) selected.

Local needs generally do not change significantly from one year to the next. It often takes years of planning, policy change, and action to see real change. In an effort to assess what changes may be happening more rapidly across the state, indicate below if the overall needs of each disability population got better or worse or stayed about the same over the past year.

4. How have the overall needs of the **mental health** population changed in the past year?

- a) Overall needs have stayed about the same.
- b) Overall needs have improved.
- c) Overall needs have worsened.
- d) Overall needs have been a mix of improvement and worsening.
- e) Not sure

NOTE: If option a, b, c, or d was selected above, please answer the appropriate question below.

4a. If you would like to elaborate on why you believe the overall needs of the mental health population have stayed about the same over the past year, briefly describe here.

4b. If you would like to elaborate on why you believe the overall needs of the mental health population have improved over the past year, briefly describe here.

4c. If you would like to elaborate on why you believe the overall needs of the mental health population have worsened over the past year, briefly describe here.

4d. If you would like to elaborate on why you believe the overall needs of the mental health population have been a mix of improvement and worsening over the past year, briefly describe here.

5. How have the overall needs of the **substance use disorder** population changed in the past year?

- a) Overall needs have stayed about the same.
- b) Overall needs have improved.
- c) Overall needs have worsened.
- d) Overall needs have been a mix of improvement and worsening.
- e) Not sure

NOTE: If option a, b, c, or d was selected above, please answer the appropriate question below.

5a. If you would like to elaborate on why you believe the overall needs of the substance use disorder population have stayed about the same over the past year, briefly describe here.

5b. If you would like to elaborate on why you believe the overall needs of the substance use disorder population have improved over the past year, briefly describe here.

5c. If you would like to elaborate on why you believe the overall needs of the substance use disorder population have worsened over the past year, briefly describe here.

5d. If you would like to elaborate on why you believe the overall needs of the substance use disorder population have been a mix of improvement and worsening over the past year, briefly describe here.

6. How have the overall needs of the **developmentally disabled** population changed in the past year?

- a) Overall needs have stayed about the same.
- b) Overall needs have improved.
- c) Overall needs have worsened.

- d) Overall needs have been a mix of improvement and worsening.
- e) Not sure

NOTE: If option a, b, c, or d was selected above, please answer the appropriate question below.

6a. If you would like to elaborate on why you believe the overall needs of the developmentally disabled population have stayed about the same over the past year, briefly describe here.

6b. If you would like to elaborate on why you believe the overall needs of the developmentally disabled population have improved over the past year, briefly describe here.

6c. If you would like to elaborate on why you believe the overall needs of the developmentally disabled population have worsened over the past year, briefly describe here.

6d. If you would like to elaborate on why you believe the overall needs of the developmentally disabled population have been a mix of improvement and worsening over the past year, briefly describe here.

In addition to working with local mental hygiene agencies, LGUs frequently work with other government and non-government agencies within the county and with other LGUs in their region to identify and address the major issues that have a cross-system or regional impact. The following questions ask about the nature and extent of those collaborative planning activities.

7. In the past year, has your agency been included in collaborative planning activities related to the Prevention Agenda 2013-2018 with your Local Health Department?

- a) Yes
- b) No

7a. If you answered “Yes” to #7, briefly describe those planning activities with your Local Health Department.

8. In the past year, has your agency participated in collaborative planning activities with other local government agencies and non-government organizations?

- a) Yes
- b) No

8a. If you answered “Yes” to #8, briefly describe those planning activities with other local government agencies and non-government organizations.

9. In the past year, has your agency participated in collaborative planning activities with other LGUs in your region?

a) Yes

b) No

9a. If you answered "Yes" to #9, list each activity and the LGU(s) involved in that collaboration and provide a brief (one or two sentence) description of the activity.

9b. If you answered "Yes" to #9, did your collaborative planning activities with other LGUs in your region include identifying common needs that should be addressed at a regional level?

a) Yes

b) No

9c. If you answered "Yes" to #9, did the counties in your region reach a consensus on what the regional needs are?

a) Yes

b) No

9d. If you answered "Yes" to #9c, briefly describe the consensus needs identified by the counties in your region.

Glossary of Terms Used on this Form

Substance Use Disorder Services:

Prevention Services: Refers to OASAS-funded primary prevention services, which may include service approaches such as: prevention education, environmental strategies, community capacity building, positive alternatives, and information awareness; or other prevention services such as prevention counseling and early intervention services.

Crisis Services: Refers to OASAS-certified chemical dependence withdrawal and stabilization services (Part 816), including medically managed withdrawal, medically supervised withdrawal (inpatient or outpatient), and medically monitored withdrawal services. May also include non-OASAS certified hospital-based detoxification services.

Inpatient Treatment Services: Refers to OASAS-certified chemical dependence inpatient rehabilitation services (Part 818) and chemical dependence residential rehabilitation services for youth (Part 817).

Opioid Treatment Services: Refers to OASAS-certified treatment programs that are approved to administer methadone or other approved medications to treat opioid dependency, including opioid detoxification, opioid medical maintenance, and opioid taper services (Part 822).

Outpatient Treatment Services: Refers to OASAS-certified treatment programs that provide outpatient services that assist individuals suffering from a substance use disorder and their family members and/or significant others (Part 822). May also provide outpatient rehabilitation services designed to assist individuals with more chronic conditions. May also include outpatient chemical dependency services for youth (Part 823).

Residential Treatment Services: Refers to OASAS-certified treatment programs that provide 24/7 structured treatment/recovery services in a residential setting. Programs may provide residential stabilization, rehabilitation, and/or reintegration services in congregate or scatter-site settings (Part 820). May also include intensive residential rehabilitation, community residential, and supportive living services (Part 819).

Housing: Refers to OASAS-funded permanent supportive housing services that includes one and two-bedroom apartments with support services necessary to assist families in gaining stability, daily life skills and marketable work skills, with supportive services to help families maintain physical and emotional health, assist with educational and employment opportunities, and sustain healthy relationships and quality of life. May also include non-OASAS funded short-term transitional housing options for individuals leaving substance use disorder treatment.

Transportation: Refers to the ability of individuals involved in the substance use disorder service system to get to SUD treatment services, as well as other needed health care services, school, work, training, or other destinations necessary to support their treatment and recovery.

Other Recovery Support Services: Refers to services that help to support recovery from a substance use disorder that are not tied to housing and that are in addition to transportation. May include educational and vocational services, peer support services, and services provided by OASAS Recovery Centers or clubhouses.

Workforce Recruitment and Retention: Refers to the ability of OASAS-certified and funded prevention and treatment programs to effectively provide high quality, qualified, trained, and culturally competent services to individuals suffering from a substance use disorder and their families. This does not refer to recruiting and retaining LGU staff or vocational services for clients.

Coordination/Integration with Other Systems: Refers to the need to coordinate services with other systems that individuals with a substance use disorder may be involved with, including mental health, developmental disabilities, public health, social services, criminal justice, education, etc. Also refers to engagement in regional and statewide initiatives such as DSRIP, PPS, PHIP, Prevention Agenda, RPC, etc.

Mental Health Services:

Please refer directly to the linked content as displayed below for explanations of categories.

Prevention https://www.health.ny.gov/prevention/prevention_agenda/2013-2017/plan/mhsa/ebi/

Crisis Services: <http://bi.omh.ny.gov/bridges/definitions#03>

Inpatient Treatment Services: <http://bi.omh.ny.gov/bridges/definitions#3>

Clinic Treatment Services: <http://bi.omh.ny.gov/bridges/definitions#2100>

Other Outpatient Services: <http://bi.omh.ny.gov/bridges/definitions#4>

Care Coordination: <http://bi.omh.ny.gov/bridges/definitions#24>

HARP HCBS Services (Adult): <http://www.omh.ny.gov/omhweb/bho/hcbs.html>

HCBS Waiver Services (Children): <http://bi.omh.ny.gov/bridges/definitions#2300>

Other Recovery & Support Services: This category refers to those recovery, vocational, and support services that are not specifically HARP HCBS services for adults or in the children's HCBS Waiver program.

Housing: <http://bi.omh.ny.gov/bridges/definitions#5>

Developmental Disability Services:

Crisis Services: <http://www.opwdd.ny.gov/ny-start/home>

Clinical Services: http://www.opwdd.ny.gov/opwdd_resources/information_for_clinicians

Children Services: http://www.opwdd.ny.gov/opwdd_services_supports/children

Adult Services: Refers to the supports and services available to adults with developmental disabilities. This includes OPWDD's ability to support aging adults live a high quality life.

Student/Transition Services:

http://www.opwdd.ny.gov/opwdd_services_supports/children/transition-students-developmental-disabilities

Respite Services:

http://www.opwdd.ny.gov/opwdd_services_supports/supports_for_independent_and_family_living/respice_services

Family Supports:

http://www.opwdd.ny.gov/opwdd_services_supports/supports_for_independent_and_family_living

Self-Directed Services: <http://www.opwdd.ny.gov/selfdirection>

Autism Services: http://www.opwdd.ny.gov/opwdd_community_connections/autism_platform

Person Centered Planning:

http://www.opwdd.ny.gov/opwdd_services_supports/person_centered_planning

Residential Services:

http://www.opwdd.ny.gov/opwdd_services_supports/residential_opportunities

Transportation: Refers to the ability of individuals involved in the OPWDD service system to get to supports and services, as well as other needed health care services, school, work, training, or other destinations necessary to enjoying a full life.

Service Coordination:

http://www.opwdd.ny.gov/opwdd_services_supports/service_coordination

Employment:

http://www.opwdd.ny.gov/opwdd_services_supports/employment_for_people_with_disabilities

Workforce Recruitment and Retention: Refers to the ability of OPWDD and provider agencies to offer high quality, qualified, trained, and culturally competent services to individuals with developmental disabilities and their families.

Coordination/Integration with Other Systems: Refers to the need to coordinate services with other systems that individuals with developmental disabilities may be involved with including mental health, substance use, public health, social services, criminal justice, education, etc.

(End of survey)

B. 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 is intended to improve the ability of counties to conduct local planning and develop priorities consistent with state goals and priorities.

This year, modifications were made to the Priority Outcomes Form that are intended to display greater alignment with relevant statewide health planning initiatives and regional priorities rather than the detailed focus areas that were often too broad and overlapping to achieve the objective of more easily and accurately categorizing priorities. Another change to the form was to drop the metric under each strategy and replacing it with an opportunity to report progress on the overall priority outcome.

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."

Progress Report (New, Optional) - This is an opportunity to report progress on an existing priority outcome since the submission of last year's plan. Where possible, include specific measurable accomplishments and milestones achieved. You may also want to identify barriers to achieving stated objectives and describe the rationale for any changes made to the priority outcome statement or associated strategies.

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.

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

Alignment with Statewide Health Planning Initiatives (New, Required) - New York State's increasing recognition of the integration of behavioral health and physical health to improve overall population health has sparked multiple statewide initiatives. Indicate if this priority is aligned with any of the following initiatives. PLEASE CHECK ALL THAT APPLY. Also, specify any other initiatives the priority is associated with or if it is NOT associated with any statewide initiative. (Check all that apply)

- [The Prevention Agenda 2013-2018](#)
- [The State Health Innovation Plan \(SHIP\) / State Innovation Models \(SIM\)](#)
- [Population Health Improvement Plan \(PHIP\)](#)
- [Medicaid Delivery System Reform Incentive Payment Program \(DSRIP\)](#)
- [Medicaid Behavioral Health Managed Care Implementation \(Adult\)](#)
- [Medicaid Behavioral Health Managed Care Implementation \(Youth & Child\)](#)

- [OMH Transformation Plan](#)
- [Combat Heroin and Prescription Drug Abuse](#)
- [Talk2Prevent](#)
- [Fully Integrated Duals Advantage Program \(FIDA\)](#)
- [OPWDD People First Transformation](#)
- Other (specify):
- None of The Above

Is this priority also a regional priority? (New, Required)

- Yes
- No
- Do Not Know

Strategy Statement – 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 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.

(End of survey)

C. 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:

(End of survey)

D. 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.

(End of survey)

E. 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.

(End of survey)

F. 2017 OMH TRANSFORMATION PLAN SURVEY

The 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) 2014-15 State Budget and continuing through SFY 2015-16, the OMH Transformation Plan "pre-invested" \$59 million annualized into priority community services and supports, with the goals of reducing State and community-operated facilities' inpatient psychiatric admissions and lengths of stay. In addition, \$15 million has been reinvested from Article 28 and 31 inpatient facilities to further support the OMH Transformation Plan goals.

1. Did your LGU/county received OMH Transformation Plan reinvestment resources (State and locally funded) over the last year?

- Yes
- No
- Do Not Know

2. If you answered "Yes" to #1, please briefly describe any impacts the reinvestment resources have had since implementation, particularly as it relates to impacts in State or community inpatient utilization. If known, identify which types of services/programs have made such impacts.

3. Please provide any other comments regarding Transformation Plan investments and planning.

[APPLICABLE TO ALL RESPONDENTS]

(End of survey)

G. LGU Emergency Manager Contact Information

Emergency Manager contact information is necessary in order for OASAS to communicate directly with each LGU and OASAS-certified treatment programs to ensure proper planning and preparedness during emergency situations. A rapid and coordinated response to an emergency is necessary to ensure the safety of staff and patients and continuity of care. The information entered here will be maintained in CPS until it can be incorporated into the OASAS Provider Directory System (PDS) where other program contact information is maintained.

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

First Name:	<input type="text"/>
Last Name:	<input type="text"/>
Job Title:	<input type="text"/>
Email Address:	<input type="text"/>
Main Work Phone:	<input type="text"/>
Desk Work Phone:	<input type="text"/>
Home Phone:	<input type="text"/>
Mobile Phone:	<input type="text"/>

NOTE: To ensure privacy, home and mobile phone numbers will not be displayed in CPS output reports.

(End of survey)

G. 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 2017 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 2017 local services planning process.

(End of survey)

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 One 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 **Monday, April 4, 2016**. 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. We are asking that the survey be completed by **Monday, April 4, 2016**. 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		Worked as a Health Coordinator	Hourly Rate (dollars)	Services Provided		Worked as a Health Coordinator	Hourly Rate (dollars)
		On-site	Off-site	Hours/Week		On-site	Off-site	Hours/Week	
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
		On-site	Off-site	Worked as a Health Coordinator	Rate (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"/>

(End of survey)

B. Talent Management Survey (Treatment Providers)

It is important for OASAS to identify which licenses and certifications staff hold who perform clinical functions that are protected in statute by the Social Work and Mental Health Practitioner Scopes of Practice. Currently, all SUD treatment services operated, funded and/or certified by OASAS are exempt from the Social Work and Mental Health Practitioner scopes of practice, but since this is a temporary exemption, it is necessary for OASAS to understand how many staff are benefiting from this exemption.

It is important to note that CASACs and CASAC-Trainees are permanently exempt from the restricted scopes of practice for the work they do in OASAS certified programs, but other certifications and certain supervisory functions may be impacted if the more general exemption were to sunset, and this data will assist OASAS in identifying these impacts. More information on these Scopes of Practice and the exemptions can be found at:

Social Workers: <http://www.op.nysed.gov/prof/sw/>

Mental Health Practitioners: <http://www.op.nysed.gov/prof/mhp/>

In addition, OASAS is implementing a SUD Counselor Scope of Practice. More information about the SUD Counselor Scope of Practice can be found on the OASAS website at: <http://www.oasas.ny.gov/workgroup/tm/index.cfm>

OASAS is surveying all treatment providers and each of their programs to collect information that will inform the issues involving the scopes of practice described above. We are asking that the survey be completed by **Monday, April 4, 2016**. All questions regarding these surveys should be directed to Julia Fesko at 518-457-6511 or at Julia.Fesko@oasas.ny.gov.

1. How many part-time and full-time clinical staff are currently employed in all of this agency's OASAS-certified treatment programs?

Staff Category	Part-time	Full-time
<u>Clinical Staff:</u>		
a) Qualified Health Professional (QHP)	<input type="text"/>	<input type="text"/>
b) CASAC Trainee	<input type="text"/>	<input type="text"/>
c) Other Non-Qualified Health Professional	<input type="text"/>	<input type="text"/>
<u>Non-Clinical Peer Workers: (Only those solely working in this capacity)</u>		
d) Certified Recovery Peer Advocate (CRPA)	<input type="text"/>	<input type="text"/>

e) [Certified Addiction Recovery Coach \(CARC\)](#)

2. The following QHPs would be impacted if and when the exemption were to sunset. Please indicate how many staff in each category your agency currently employs.

- a) [Licensed Master Social Worker \(LMSW\)](#)
 b) [Certified Rehabilitation Counselor](#)
 c) [Certified Therapeutic Recreation Therapist](#)
 d) [Certified Counselor](#)

Glossary of Terms Used on this Form

Qualified Health Professional (QHP): Any of the professionals listed in OASAS Chemical Dependence Regulations (Part 800) who are in good standing with the appropriate licensing or certifying authority, with a minimum of one year of experience or satisfactory completion of a training program in the treatment of substance use disorders.

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).

Certified Recovery Peer Advocate (CRPA): A non-clinical individual certified by one of the OASAS approved CRPA Certification Boards.

Certified Addiction Recovery Coach (CARC): A non-clinical individual certified by the New York Certification Board, an entity of the Association of Substance Abuse Programs (ASAP).

Licensed Master Social Worker (LMSW): An individual currently licensed and registered as a LMSW by the New York State Education Department.

Certified Rehabilitation Counselor: An individual currently certified as a rehabilitation counselor by the Commission of Rehabilitation Counselor Certification.

Certified Therapeutic Recreation Therapist: An individual currently certified by the National Council on Therapeutic Recreation or the American Therapeutic Recreation Association; or a person who holds a baccalaureate degree in a field allied to therapeutic recreation and, either before or after receiving such degree, has five years of full-time, paid work experience in an activities program in a health care setting.

Certified Counselor: A Counselor certified by and currently registered as such with the National Board for Certified Counselors.

C. Program Talent Management Survey (Treatment Programs)

It is important for OASAS to identify which licenses and certifications staff hold who perform clinical functions that are protected in statute by the Social Work and Mental Health Practitioner Scopes of Practice. Currently, all SUD treatment services operated, funded and/or certified by OASAS are exempt from the Social Work and Mental Health Practitioner scopes of practice, but since this is a temporary exemption, it is necessary for OASAS to understand how many staff are benefiting from this exemption.

It is important to note that CASACs and CASAC-Trainees are permanently exempt from the restricted scopes of practice for the work they do in OASAS certified programs, but other certifications and certain supervisory functions may be impacted if the more general exemption were to sunset, and this data will assist OASAS in identifying these impacts. More information on these Scopes of Practice and the exemptions can be found at:

Social Workers: <http://www.op.nysed.gov/prof/sw/>

Mental Health Practitioners: <http://www.op.nysed.gov/prof/mhp/>

In addition, OASAS is implementing a SUD Counselor Scope of Practice. More information about the SUD Counselor Scope of Practice can be found on the OASAS website at:

<http://www.oasas.ny.gov/workgroup/tm/index.cfm>

OASAS is surveying all treatment providers and each of their programs to collect information that will inform the issues involving the scopes of practice described above. We are asking that the survey be completed by **Monday, April 4, 2016**. All questions regarding this surveys should be directed to Julia Fesko at 518-457-6511 or at Julia.Fesko@oasas.ny.gov.

1. How many part-time and full-time clinical staff are currently employed in this program? **NOTE: If someone is full-time in the organization but part-time in this program, count that person as part-time here.**

Staff Category	Part-time	Full-time
Clinical Staff:		
a) Qualified Health Professional (QHP)	<input type="text"/>	<input type="text"/>
b) CASAC Trainee	<input type="text"/>	<input type="text"/>
c) Other Non-Qualified Health Professional	<input type="text"/>	<input type="text"/>
Non-Clinical Peer Workers: (Only those solely working in this capacity)		
d) Certified Recovery Peer Advocate (CRPA)	<input type="text"/>	<input type="text"/>
e) Certified Addiction Recovery Coach (CARC)	<input type="text"/>	<input type="text"/>

2. Each category of professional license or certification listed below is included in the list of Qualified Health Professionals (QHPs) as defined in the OASAS Part 800 Regulations. For all the part-time and full-time clinical staff/QHPs indicated in #1a above, how many possess each of the following professional licenses or certifications? **NOTE: If someone possesses multiple licenses or certifications, include that individual in the count under each category.**

Professional License/Certification	Part-time	Full-time
Clinical Staff/QHP		
a) Registered Professional Nurse (RN)	<input type="text"/>	<input type="text"/>
b) Nurse Practitioner	<input type="text"/>	<input type="text"/>
c) Physician's Assistant (PA)	<input type="text"/>	<input type="text"/>
d) Physician (MD or DO)	<input type="text"/>	<input type="text"/>
e) Licensed Master Social Worker (LMSW)	<input type="text"/>	<input type="text"/>
f) Licensed Clinical Social Worker (LCSW)	<input type="text"/>	<input type="text"/>
g) Limited Permit – Licensed Master Social Worker (LP-LMSW)	<input type="text"/>	<input type="text"/>

- h) [Licensed Psychologist](#)
- i) [Licensed Mental Health Counselor \(LMHC\)](#)
- j) [Licensed Marriage and Family Therapist \(LMFT\)](#)
- k) [Licensed Occupational Therapist](#)
- l) [Licensed Creative Arts Therapist \(LCAT\)](#)
- m) [Certified Rehabilitation Counselor](#)
- n) [Certified Therapeutic Recreation Therapist](#)
- o) [Certified Counselor](#)
- p) [CASAC](#)

Scope of Practice for Substance Use Disorder (SUD) Counselors: Similar to the Social Work and Mental Health Practitioner Scopes of Practice, and as a means to protect what SUD Counselors are now allowed to do, OASAS developed a [Scope of Practice for Substance Use Disorder \(SUD\) Counselors](#) which describes five different counselor categories, the educational, QHP, and training requirements for each category, and the functions that each counselor is allowed to perform. Please answer the following questions for each category.

3. Counselor Assistant: With supervision, can perform screening, orientation, case management, and basic crisis response with supervision. With intensive supervision, can perform intake, group co-facilitator, psycho-education, referral, care coordination, and reporting and recordkeeping.

- a) How many staff within this program perform these functions and do not have at a minimum a GED/HS Diploma?
- b) How many staff within this program perform these functions and have not completed 6 hours of Ethics Training?

4. CASAC Trainee: With supervision, can perform screening, intake, orientation, group co-facilitator, case management, basic crisis response, client education, referral, reporting and recordkeeping, and care coordination. With intensive supervision, can perform SUD assessment, SUD diagnostic impression, treatment planning, individual and group counseling, psycho-education, family orientation, and support.

- How many staff within this program perform these functions and are not, at a minimum, a CASAC Trainee?

5. CASAC 1/QHP: With supervision, can perform screening, intake, orientation, assessment, diagnostic impression, treatment planning, individual and group counseling, family counseling*, psycho-education, case management, crisis intervention, client education, referral, reporting and recordkeeping, and care coordination.

(*specific to the addiction competencies identified in TAP 21 relating to counseling families, couples and significant others.)

- a) How many staff within this program perform these functions and are not, at a minimum, a CASAC or other QHP?
- b) Of the staff within this program that perform these functions and are not, at a minimum, a CASAC or other QHP, how many do NOT at least possess a Bachelor's Degree?

Note: If staff is not a CASAC or QHP and possesses at a minimum a Bachelor's degree they qualify for a time limited provisional appointment to this level so they may obtain a CASAC or QHP status.

Clinical and Administrative Supervision: The SUD Counselor Scope of Practice would only allow a CASAC 2/QHP to perform administrative supervision and Advanced Counselors to perform administrative and clinical supervision. OASAS will grandparent all current CASACs to be CASAC 2s, which will allow them to perform administrative supervision. OASAS will grandparent all current clinical supervisors who are QHPs or have at least a Bachelor's Degree to the Advanced Counselor level, which would allow them to continue to perform clinical supervision and would like to project the number of people who would be included in the categories listed below:

6. CASAC 2/QHP: With supervision, can perform screening, intake, orientation, assessment, diagnostic impression, treatment planning, individual and group counseling, family counseling*, psycho-education, case management, crisis intervention, client education, referral, reporting and recordkeeping, care coordination, and administrative supervision. (*specific to the addiction competencies identified in TAP 21 relating to counseling families, couples and significant others.)

a) How many staff within this program perform administrative supervision and are not, at a minimum, a CASAC or other QHP?

b) Of these staff within this program that perform these functions and are not, at a minimum, a CASAC or other QHP, how many do NOT possess at least a Bachelor's Degree?

Note: Although Associate's Degree will be required for new CASAC 2s, existing CASACs will all be grandparented into the CASAC 2 category and those who have at least a Bachelor's degree will be eligible for a time limited provisional status as a QHP.

7. Advanced Counselor: With supervision, can perform screening, intake, orientation, assessment, diagnostic impression, treatment planning, individual and group counseling, family counseling*, psycho-education, case management, crisis intervention, client education, referral, reporting and recordkeeping, care coordination, clinical supervision, and administrative supervision. (*specific to the addiction competencies identified in TAP 21 relating to counseling families, couples and significant others.)

a) How many staff within this program perform clinical supervision and are NOT, at a minimum, a CASAC or other QHP?

b) Of these staff within this program that perform clinical supervision and are not, at a minimum, a CASAC or other QHP, how many at least do NOT possess a Bachelor's Degree?

b) How many staff within this program that perform these functions who have at least a CASAC or other QHP OR at least a Bachelor's Degree, have NOT completed 30 hours of clinical supervision training?

Note: Clinical Supervisors at this level with at least a minimum of a Bachelor's Degree will be grandparented in to the Advanced Counselor level.

8. Master Counselor: With supervision, can perform screening, intake, orientation, assessment, diagnostic impression, treatment planning, individual and group counseling, family counseling*, psycho-education, case management, crisis intervention, client education,

referral, reporting and recordkeeping, care coordination, clinical supervision, and administrative supervision. (*specific to the addiction competencies identified in TAP 21 relating to counseling families, couples and significant others.)

How many staff within this program perform these functions and meet all requirements for this category which includes a Master's Degree in Human Services and, 3 years of qualifying work experience in an SUD setting and 30 Hours of Clinical Supervision training?

9. Since the state agency exemption for social work and mental health practitioner scopes of practice are temporary, it is also important to understand how many LMSWs are currently not supervised by a LCSW should the exemption sunset and how many other licensed professionals may also be impacted if the exemptions were to sunset.

a) How many LMSWs on staff in this program are not being supervised by an LCSW?

b) How many other licensed professionals on staff in this program are not being supervised according to their Scopes of Practice? (Please see the [NYSED Scopes of Practice](#) to determine the supervision requirements for each licensed professional).

(End of survey)

Glossary of Terms Used on this Form

Qualified Health Professional (QHP): Any of the professionals listed in OASAS Chemical Dependence Regulations (Part 800) who are in good standing with the appropriate licensing or certifying authority, with a minimum of one year of experience or satisfactory completion of a training program in the treatment of substance use disorders.

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).

Certified Recovery Peer Advocate (CRPA): A non-clinical individual certified by one of the OASAS approved CRPA Certification Boards.

Certified Addiction Recovery Coach (CARC): A non-clinical individual certified by the New York Certification Board, an entity of the Association of Substance Abuse Programs (ASAP).

Registered Professional Nurse (RN): An individual currently licensed and registered as a Registered Professional Nurse by the New York State Education Department.

Nurse Practitioner: An individual currently licensed and registered as a Certified Nurse Practitioner by the New York State Education Department.

Physician's Assistant (PA): An individual currently licensed and registered as a Physician's Assistant by the New York State Education Department.

Physician (M.D.) or (D.O.): A physician who has received the doctor of medicine (M.D.) or doctor of osteopathy (D.O.) degree and is currently licensed and registered as such by the New York State Education Department.

Licensed Master Social Worker (LMSW): An individual currently licensed and registered as a LMSW by the New York State Education Department.

Licensed Clinical Social Worker (LCSW): An individual currently licensed and registered as a LCSW by the New York State Education Department.

Limited Permit Master Social Worker (LP-LMSW): An individual currently licensed and registered as a LP-LMSW only if such person has a permit which designates the OASAS-certified program as the employer and is under the general supervision of a LMSW or a LCSW.

Licensed Psychologist: An individual currently licensed and registered as a Licensed Psychologist by the New York State Education Department.

Licensed Mental Health Counselor (LMHC): An individual currently licensed and registered as a Licensed Mental Health Counselor by the New York State Education Department, including individuals with a Limited Permit Licensed Mental Health Counselor (LP-LMHC).

Licensed Marriage and Family Therapist (LMFT): An individual currently licensed and registered as a Licensed Marriage and Family Therapist by the New York State Education Department.

Licensed Occupational Therapist: An individual currently licensed and registered as a Licensed Occupational Therapist by the New York State Education Department.

Licensed Creative Arts Therapist (LCAT): An individual currently licensed and registered as a Licensed Creative Arts Therapist by the New York State Education Department.

Certified Rehabilitation Counselor: An individual currently certified as a rehabilitation counselor by the Commission of Rehabilitation Counselor Certification.

Certified Therapeutic Recreation Therapist: An individual currently certified by the National Council on Therapeutic Recreation or the American Therapeutic Recreation Association; or a person who holds a baccalaureate degree in a field allied to therapeutic recreation and, either before or after receiving such degree, has five years of full-time, paid work experience in an activities program in a health care setting.

Certified Counselor: A Counselor certified by and currently registered as such with the National Board for Certified Counselors.

Credentialed Alcoholism and Substance Abuse Counselor (CASAC): An individual who has a current valid credential issued by OASAS, or a comparable credential, certificate or license from another recognized certifying body as determined by OASAS.

(End of survey)

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. We are asking that the survey be completed by **Monday, April 4, 2016**. All questions regarding this survey should be directed to Nina Gargon at 646-728-4608 or at Nina.Gargon@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)

(End of survey)

Glossary of Terms Used on this Form

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 Percocet, 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*)

(End of survey)

E. Clinical Supervision Contact Information Survey (Treatment Programs)

(NOTE: If you completed this survey in Fall 2015, please update and verify information)

The OASAS Clinical Supervision Survey should be completed by all OASAS- certified and funded treatment programs. The goal of clinical supervision is to continuously improve client care, support ongoing staff development and, ultimately, improve client outcomes. The implementation of a strong Clinical Supervision program results in enhanced staff understanding of clinical situations, prevention of escalating clinical crises, better assessment, stronger case conceptualization, treatment strategies and discharge planning. It also provides a vehicle by which directives are followed and helps facilitate the implementation of evidence-based practices and institutional awareness.

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

To ensure that the agency has the most up-to-date information, all OASAS-certified and funded treatment programs are being asked to complete the following brief survey and provide contact information for each clinical supervisor in the program. In addition to developing a culture based practice, this information will facilitate communication on relevant topics and resources to clinicians and provide clinical guidance issued by OASAS. Accordingly, clinical supervisors will have additional tools to better perform their essential role in assuring quality treatment to clients.

We are asking that the survey be completed by **Monday, April 4, 2016**. If you have any questions about this survey, please email PICM@oasas.ny.gov.

Thank you for taking the time to complete this survey and for your agency’s role in helping us to update our information.

For each clinical supervisor employed by this program, please enter his/her name and email address. If you need to enter contact information for additional clinical supervisors, click on the + sign next to the first supervisor’s name and a new row will open for you to enter the additional information.

Name	Email Address	Phone Number
+ <input type="text"/>	<input type="text"/>	<input type="text"/>

F. Program Emergency Manager Contact Information Form (All treatment programs)

Emergency Manager contact information is necessary in order for OASAS to communicate directly with each OASAS-certified treatment program to ensure proper planning and preparedness during emergency situations. A rapid and coordinated response to an emergency is necessary to ensure the safety of staff and patients and continuity of care. An Emergency Manager must be designated for each program site, so we are asking that contact information be provided for each PRU. The information entered here will be maintained in CPS until it can be incorporated into the OASAS Provider Directory System (PDS) where other program contact information is maintained.

We are asking that the survey be completed by **Monday, April 4, 2016**. All questions regarding this survey should be directed to Kevin Doherty, OASAS Emergency Manager, at (518) 485-1983, or at KevinDoherty@oasas.ny.gov.

First Name:	<input type="text"/>
Last Name:	<input type="text"/>
Job Title:	<input type="text"/>
Email Address:	<input type="text"/>
Main Work Phone:	<input type="text"/>
Desk Work Phone:	<input type="text"/>
Home Phone:	<input type="text"/>
Mobile Phone:	<input type="text"/>

NOTE: To ensure privacy, home and mobile phone numbers will not be displayed in CPS output reports.

(End of survey)

G. Human Trafficking Special Population Survey (treatment programs)

OASAS is conducting this survey to collect information on the victims of [Human Trafficking](#) that come into OASAS treatment programs. Human trafficking is a crime. According to the United States Department of Justice, it is the second largest international criminal industry, second only to the drug trade. Any person, regardless of race, sexuality, gender, and ethnicity or immigration status may be a victim of this crime.

Victims who are trafficked are forced to work against their will for the purpose of forced labor or [sexual exploitation](#). It is found in even legitimate industries such as agriculture, construction, domestic work, hotels, restaurants and others. Human trafficking victims often suffer physical and psychological abuse at the hand of their traffickers, resulting in health problems, addiction and mental illness. The need for assistance and treatment among victims is great.

Identifying trafficking victims can be a challenge. Traffickers often rely on various tactics to maintain physical and psychological control over their victim, which prevents those individuals from fleeing the situation or reporting the victimization to law enforcement. The proper identification of victims is critical to connecting them with the vital services available to assist survivors in meeting their needs. For more information on Human Trafficking, please go to <http://otda.ny.gov/programs/bria/trafficking.asp> or <http://ocfs.ny.gov/main/humantraff/>.

OASAS is one of fourteen executive state agencies represented on the [Interagency Task Force for Human Trafficking](#), which in cooperation with the Governor's Office, is working on educating organizations, the community and public on how to identify the signs of human trafficking; training local government and law enforcement officials on identifying individuals who may have been trafficked; proposing legislation to crack down on traffickers and developing strategies for referring survivors to local support services.

Please direct any questions or concerns regarding this survey to Jannette Rondo at 518-485-6914 or Jannette.Rondo@oasas.ny.gov.

Most of the victims of human trafficking will not disclose their experiences and may be assessed or identified for other reasons such as [domestic violence/ intimate partner violence](#), date or rape violence or [Post-Traumatic Stress Disorder \(PTSD\)](#) and [Developmental Trauma Disorder](#). Please go to [OASAS Learning Thursday](#) on "*The Intersection of Sex Trafficking, Trauma, and Substance Abuse*" for more information on assessing for trafficking, recognizing the signs and effects on individuals from the social, emotional and health impacts of human trafficking victimization.

1. During the past 12 months, has this program seen any known or suspected victims of human trafficking?
 - a) Yes
 - b) No (skip to #5)
 - c) Unknown (skip to #5)

2. Did this program provide treatment services to any of these individuals?
 - a) Yes
 - b) No
 - c) Unknown

3. Approximately how many of these individuals were treated in this program during the past 12 months?
- a) More than 20
 - b) 16-20
 - c) 11-15
 - d) 6-10
 - e) 1-5
4. Did this program provide referral services to any of these individuals in the past 12 months?
- a) Yes
 - b) No
- If yes, check all that apply:
- [NYS Referral Process for Human Trafficking](#)
 - [Federal Certification Program for Human Trafficking](#)
 - Other _____
5. Please indicate which of the following your program is screening for (check all that apply).
- a) [Domestic Violence/Intimate Partner Violence](#) victimization and perpetration
 - b) [Sexual Exploitation](#)
 - c) [Post Traumatic Stress Disorder](#) (PTSD)
 - d) [Developmental Trauma Disorder](#)
 - e) [Human Trafficking](#)
 - f) None of the above
6. Would this program be interested in training, screening tools, treatment strategies and appropriate referrals for victims of Human Trafficking?
- a) Yes
 - b) No
7. Is there any information you would like to add about this program's experiences with victims of human trafficking to further OASAS' understanding of this population?
-

(End of survey)

Glossary:

Human Trafficking: Human Trafficking is the illegal trade or use of a person against their will for the purpose of forced labor or sexual exploitation.

Sexual Exploitation: Sexual exploitation means taking the advantage of sexuality and attractiveness of a person to make a personal gain or profit. It is the abuse of a position of vulnerability, differential power, or trust for sexual purposes.

Interagency Task Force on Human Trafficking: *The New York State Response to Human Trafficking Program (RHTP)* was established by OTDA under Social Services Law when the New York State Human Trafficking Law was signed into law on June 6, 2007 (Chapter 74 of the Laws of 2007). The anti-human trafficking law establishes state crimes of sex trafficking and labor trafficking, provides a mechanism to allow confirmed victims of human trafficking who would be otherwise ineligible to receive social services to qualify for certain services, and creates an Interagency Task Force on Human Trafficking.

Domestic Violence/ Intimate Partner Violence: Domestic Violence can be used to describe any abuse that occurs within the context of one's home or family. Intimate Partner Violence is a pattern of coercive tactics, which can include physical, psychological, sexual, economic and emotional abuse, perpetrated by one person against an adult intimate partner, with the goal of establishing and maintaining power and control over the victim.

Post – Traumatic Stress Disorder (PTSD): a condition of persistent mental and emotional stress occurring as a result of injury or severe psychological shock, typically involving disturbance of sleep and constant vivid recall of the experience, with dulled responses to others and to the outside world.

Developmental Trauma Disorder: Developmental Trauma Disorder is the result of abandonment, abuse and neglect during childhood or adolescence that disrupts cognitive, neurological and psychological development and attachment to adult caregivers.

New York State Referral Process for Human Trafficking: New York State has a referral process in place that allows human trafficking victims located within New York State to immediately become eligible for services while they await federal certification, or if they would be otherwise ineligible for benefits due to immigration status. The Office of Temporary and Disability Assistance (OTDA) funds six providers across the state to provide a wide range of services to these victims. For more information, or to obtain a referral form to refer a victim via secure fax, please visit: <http://otda.ny.gov/programs/bria/trafficking.asp>

Federal Certification Program for Human Trafficking: Federal certification allows victims of trafficking who are non-U.S. citizens to be eligible for a special visa and certain benefits and services under any Federal or state program or activity to the same extent as a refugee. Victims of trafficking who are U.S. citizens do not need to be certified to receive benefits. As U.S. citizens, they may already be eligible for many benefits. The Federal certification process requires that the victim meet certain certification guidelines. More information may be found at: http://www.fns.usda.gov/sites/default/files/cert_victims.pdf

H. 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 **2017 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.

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

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

New York State Office of Alcoholism and Substance Abuse Services, SCHEDC2009

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

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

New York State Office of Alcoholism and Substance Abuse Services, SCHEDC2009