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Chapter 1: Background and Context

Background

OASAS oversees one of the largest addictions service systems in the nation, which includes a full array of services to address prevention, treatment, and recovery. Treatment services were provided to nearly 234,000 individuals in 2015 through outpatient, crisis, inpatient, residential, and opioid treatment services. Approximately 327,000 New York State youth received a direct prevention service during the 2015-16 school year.

While the OASAS system of care continues to provide quality, individualized services that are responsive to the needs of the community, the agency recognizes the transformational changes that are occurring in the health care system. OASAS is working with state and local partners to implement a more coordinated system of care that addresses the behavioral and physical health care needs of individuals with substance use disorders. OASAS is collaborating with the Office of Mental Health (OMH), Department of Health (DOH), New York City Department of Health and Mental Hygiene, and the Conference of Local Mental Hygiene Directors (CLMHD) to integrate services through various initiatives, including Health Homes, the Delivery System Reform Incentive Payment (DSRIP) Program, integrated licensure, and the transition to care management for individuals with substance use disorders and mental illness.

Through enhanced oversight and monitoring, technical assistance, credentialing, and ensuring provider compliance with regulatory standards, OASAS is providing significant support to the addictions system in this time of transition.

The following principles underlie all OASAS activities:

- Addiction is preventable. The human toll of the disease of addiction on individuals, families, and communities, as well as the financial cost to society, underscore the critical importance of prevention;

- Addiction is a chronic, treatable illness that requires lifelong attention for sustained recovery, similar to diabetes and heart disease. Successful treatment approaches are modeled on person-centered care and include new addiction medications that, combined with behavioral health approaches, improve outcomes for patients;

- Prevention and treatment programs are being directed to use evidence-based strategies, which yield measurable results and successful outcomes;

- Recovery is a lifelong process that includes healthy lifestyle choices, housing, employment, and support from a recovery movement.

Heroin and Other Opioid Use

Heroin and opioid addiction is a major public health crisis in New York State.
Since 2014, Governor Cuomo has implemented a series of aggressive reforms to combat heroin and opioid addiction, including signing historic Combat Heroin Legislation that year; expanding insurance coverage for substance use disorder treatment; increasing access and enhancing treatment capacity across the state, including a major expansion of opioid treatment and recovery services; implementing the comprehensive I-STOP law to curb prescription drug abuse; and launching a public awareness and prevention campaign to inform New Yorkers about the dangers of heroin use and opioid misuse.

The Governor’s Heroin and Opioid Task Force – a diverse coalition of experts in healthcare, drug policy, advocacy, education, and parents and New Yorkers in recovery – held executive meetings and eight listening sessions across the state. The task force heard directly from health care providers, family support groups, educators, law enforcement officials, and community members and gathered input to develop legislation and policy. Lieutenant Governor Kathy Hochul and OASAS Commissioner Arlene González-Sánchez co-chaired the task force.

On June 22, 2016, Governor Cuomo signed legislation to combat the heroin and opioid crisis in New York State. The comprehensive package of bills was passed as part of the 2016 Legislative Session and marks a major step forward in the fight to increase access to treatment, expand community prevention strategies, and limit the over-prescription of opioids in New York. The legislation includes several best practices and recommendations identified by the Governor’s Heroin and Opioid Task Force, and builds on the state’s aggressive efforts to break the cycle of heroin and opioid addiction and protect public health and safety.

The new legislation includes several initiatives to address rampant heroin and opioid abuse across the state, including measures to increase access to life-saving overdose reversal medication, a law to limit initial opioid prescriptions from 30 to seven days, and ongoing pain management education for all physicians and prescribers. Specifically, the legislation will:

- **Remove Burdensome Barriers to Access for Inpatient Treatment and Medication**

  - *Ends prior insurance authorization to allow for immediate access to inpatient treatment as long as such treatment is needed.* People suffering from addiction who seek treatment need immediate access to services, but prior authorization requirements by insurance companies are often a roadblock to admission to inpatient programs. This legislation requires insurers to cover necessary inpatient services for the treatment of substance use disorders for as long as an individual needs them. In addition, the legislation establishes that utilization review by insurers can begin only after the first 14 days of treatment, ensuring that every patient receives at least two weeks of uninterrupted, covered care before the insurance company becomes involved.

  - *Ends prior insurance authorization to allow for greater access to drug treatment medications.* People seeking medication to manage withdrawal symptoms or maintain recovery must often request prior approval from their insurance company, which slows or stops the individual from getting needed medication. This legislation prohibits insurers from requiring prior approval for emergency supplies of these medications. Similar provisions will also apply to managed care providers treating Medicaid recipients who seek access to buprenorphine and injectable naltrexone.

  - *Requires all insurance companies use objective state-approved criteria to determine the level of care for individuals suffering from substance abuse.* Insurance companies often use inconsistent criteria to determine the covered level of care for persons suffering from substance use
disorder, which often creates barriers preventing these individuals from receiving care. This legislation will require all insurers operating in New York State to use objective, state-approved criteria when making coverage determinations for all substance use disorder treatment in order to make sure individuals get the treatment they need.

- **Mandates insurance coverage for opioid overdose-reversal medication.** Naloxone is a medication that revives an individual from a heroin or opioid overdose and has saved thousands of New Yorkers’ lives. To expand access to this life-saving medication, the new legislation requires insurance companies to cover the costs of naloxone when prescribed to a person who is addicted to opioids and to his/her family member/s on the same insurance plan.

- **Enhance Addiction Treatment Services**
  - **Increase evaluation for individuals incapacitated by drugs from 48 to 72-hours.** Sometimes, individuals suffering from addiction are at risk for overdose and thus pose a threat to themselves. The legislation allows families to seek 72-hours of emergency treatment, an increase from the current 48-hours, for their loved one so that they can be stabilized and connected to longer-term addiction treatment options while also balancing individual rights of the incapacitated individuals.
  
  - **Require hospitals to provide follow-up treatment service options to individuals upon hospital discharge.** Hospitals play an important role in caring for individuals suffering from addiction who are often admitted to hospital emergency rooms after an overdose. This legislation requires hospital medical staff to provide discharge-planning services to connect patients who have or are at-risk for substance use disorder with nearby treatment options to provide continuous medical care.
  
  - **Allow more trained professionals to administer life-saving overdose-reversal medication.** Overdose-reversal medication such as naloxone saves lives. However, the law does not currently allow certain licensed professionals to administer this medication to individuals overdosing from heroin and opioids. To ensure that more people are able to help reverse overdoses, the new legislation authorizes trained professionals to administer naloxone in emergency situations without risk to their professional license.
  
  - **Expand wraparound services to support long-term recovery.** Individuals leaving treatment are at great risk for relapse. To provide services during this critical period, the legislation extends the wraparound program launched in 2014 to provide services to individuals completing treatment including education and employment resources; legal services; social services; transportation assistance, childcare services; and peer support groups.

- **Strengthen Community Prevention Strategies**
  - **Reduce prescription limits for opioids from 30-days to seven days.** There is a well-established link between the rise in opioid prescriptions and the current heroin crisis. To reduce unnecessary access to opioids, the legislation lowers the limit for initial opioid prescriptions for acute pain from 30-days to no more than a 7-day supply, with exceptions for chronic pain and other conditions.
- **Require ongoing education on addiction & pain management for all physicians and prescribers.** Physicians and other opioid prescribers are important partners in preventing addiction linked to abuse of prescription opioids. To ensure that prescribers understand the risks presented by prescription opioids, the legislation mandates that these health care professionals complete three hours of education every three years on addiction, pain management, and palliative care.

- **Mandate pharmacists provide easy to understand information on risks associated with drug addiction and abuse.** Consumers may not understand the addiction and abuse risks posed by prescription opioids. To improve consumer awareness about these risks the legislation requires pharmacists to provide educational materials to consumers about the risk of addiction, including information about local treatment services.

- **Require data collection on overdoses and prescriptions to assist the state in providing additional protections to combat this epidemic.** Current and accurate data is critical to combat the heroin and opioid crisis yet gaps currently exist in statewide data on overdoses and usage of opioid reversal medication. To fill that gap the legislation requires the State Commissioner of Health to report county-level data on opioid overdoses and usage of overdose-reversal medication on a quarterly basis.

The State of New York Fiscal Year 2017 Budget invests nearly $200 million through OASAS to combat the heroin and opioid epidemic -- an 82 percent increase in state spending since 2011. This investment includes $66 million for residential treatment beds, including counseling and support services for roughly 8,000 individuals; $38 million to fund medication-assisted treatment programs that serve approximately 12,000 clients in residential or outpatient settings; $25 million in funding for state-operated Addiction Treatment Centers; $24 million for outpatient services that provide group and individual counseling; and $8 million for crisis/detox programs to manage and treat withdrawal from heroin and opioids.

As part of the Governor’s ongoing efforts to address this public health crisis, this funding will allow the addition of 270 treatment beds and 2,335 opioid treatment program slots across the state to help New Yorkers suffering from substance use disorder and to expand vital treatment and recovery resources.

The funding will also provide additional family support navigators across New York to assist substance users and their families locate and access treatment options and cope with addiction. The agreement will also expand the on-call peer program which partners individuals in recovery with people in hospitals suffering from substance use disorder to help connect these individuals to treatment and other resources upon discharge. The state is also increasing the number of Recovery Community and Outreach Centers and Adolescent Club Houses statewide to provide safe spaces for teens in recovery that deliver health and wellness services for teens and young adults.

A multi-agency Opioid Steering Committee oversees the planning and implementation of the range of heroin and prescription drug abuse initiative activities. The Opioid Steering Committee workgroups are addressing the following:

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

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

The Combat Heroin campaign informs and educates New Yorkers about the risks of heroin and prescription opioid use, the signs of addiction, and the resources available to help. In addition to television and radio public service announcements, digital outreach, and print materials, the Combat Heroin campaign includes a website that is easy to navigate and contains information about the warning signs of heroin addiction, a listing of treatment providers, prevention guidance for parents about talking to their children, and information for viewers who want to get involved in the community. The site also contains resources for healthcare professionals.

The Combat Heroin PSAs and videos underscore the message that while addiction can happen to anyone, any family, at any time – recovery is possible. The campaign has also warned that alcohol overuse and abuse of prescription opioid medications are often a gateway to heroin use, provided information about the dangerous health effects of synthetics, and referred those who need help to New York State's 24-hour addiction HOPEline at 1-877-846-7369.

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

In 2015, OASAS lifted capacity limits on Opioid Treatment Programs and provided up to $1 million in funding to open a new Opioid Treatment Program in Utica. To further assist with addressing the heroin and prescription opioid epidemic, in July 2016 OASAS implemented a program to allow certified residential and inpatient programs to increase their current certified capacity by up to 10% on a temporary basis. If the increased capacity remains in place after six months, the program would need to file a Certification Application to permanently raise its certified capacity.

OASAS awarded $1 million to expand substance use disorder treatment in the Southern Tier in July 2016. The funding was awarded to Tompkins County addiction treatment services provider Cayuga Addiction Recovery Services to support the creation of a new 25-bed adult residential treatment program. The residential treatment program, in Trumansburg, will offer a full spectrum of addiction treatment services to residents including counseling, life-skills training, and after-discharge support.

OASAS awarded $1 million to expand substance use disorder treatment in Western New York in August 2016. The funding was awarded to Horizon Village a treatment provider in Niagara County, to support the creation a new 25-bed residential treatment program. The new residential treatment program, in Sanborn, will offer a spectrum of addiction treatment services including counseling, life-skills training, and long-term support.
OASAS mandated by regulation that all Medical Directors in its treatment system must be authorized to prescribe buprenorphine. Buprenorphine is an appropriate medication assisted treatment for some individuals who are dependent on opioids, such as heroin and prescription drugs. Physicians must have a federal waiver to prescribe buprenorphine for the treatment of opioid addiction.

Synthetics

Synthetic cannabinoids, known as synthetics or "synthetic marijuana," can cause dangerous health effects, are extremely dangerous, and addictive according to the National Institute on Drug Abuse (NIDA). Many areas in the state are seeing an increase in hospital emergency department visits due to health emergencies and serious illness associated with synthetic use. In response, Governor Cuomo directed the adoption of emergency regulations targeting the sale of synthetic marijuana. OASAS developed a PSA to educate young people and the general public about the dangers of synthetic drugs. The PSA was aired in fall 2015 and encouraged people to go to the Combat Heroin website for more information.

Joint OASAS-OMH Public Hearing

On October 6, 2015, OASAS and OMH held the fourth annual joint public hearing on their statewide comprehensive plans. The hearing was conducted by videoconference among nine locations: Albany, Buffalo Manhattan, Syracuse, Binghamton, West Brentwood, Rochester, Staten Island, and Ogdensburg. Commissioners Arlene González-Sánchez and Ann Marie T. Sullivan gathered input from stakeholders for consideration in the development of their respective plans and ongoing initiatives to deliver coordinated care to individuals with substance use and mental health disorders.

A total of 180 representatives from local governments, advocacy organizations, providers, and family members attended the hearing with twenty individuals presenting testimony. Among the topics discussed were: utilization of peer services; access to recovery support; establishing inpatient and detox programs in underserved areas of the state; DSRIP; treatment and services for youth; prevention models and evidence based strategies; investment in health information technology (HIT) and technical assistance; support and education for families; the role of counties with integration and regionalization of services; clinical standards; resources for LGBT youth; community investment and engagement in recovery centers; workforce development; and, integrated licensure. OASAS is incorporating stakeholder comments into ongoing planning and service integration initiatives.

Planning for Local Mental Hygiene Services

The local services planning process for mental hygiene services is a collaborative effort among the three state Department of Mental Hygiene agencies - OASAS, OMH, and the Office for People With Developmental Disabilities (OPWDD). For the tenth consecutive year, integrated local services plan guidelines were issued jointly by the three state agencies in 2016. This integrated planning approach has resulted in more person-centered planning at the local level that focuses on the needs of individuals with multiple disabilities and fosters collaboration across different services systems. Rather than completing separate local services plans for each state mental hygiene agency, Local Governmental Units (LGUs) submit a single integrated local services plan to all three agencies through the online County Planning System (CPS).
Mental Hygiene Planning Committee

The Mental Hygiene Planning Committee meets regularly to guide the local planning process and develop resources that support the work of county planners. This collaboration enables LGUs to conduct planning in a more integrated, person-centered fashion that creates system-wide improvements in the quality of services and supports to individuals, families and communities. As a result of significant reforms in the primary health and behavioral health care systems, a primary focus of the planning committee is to ensure that the LGUs continue to provide effective oversight of local behavioral health services for their populations. It is a priority of the committee to provide timely and informed input into state, regional and local decision-making regarding these reforms and to continue to manage their local service systems to achieve cost effective care and better patient outcomes.

Much of the ongoing activity of the Mental Hygiene Planning Committee is carried out by three active work groups. The Data Work Group is focused on improving access to and use of county data to support data-driven local planning and system management. The workgroup identifies county data needs and works with state and county agencies to develop resources that are most helpful in carrying out required needs assessment, planning, and system management responsibilities.

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

The focus of the Planning Process Work Group is continuous quality improvement of the integrated local services planning process and the features and content of CPS. With the rapid changes occurring in the behavioral and physical health care environment, it is critical that the mental hygiene planning process remains relevant and effective, ensuring that it continues to adequately meet the needs of the three state agencies and the LGUs. With an increased emphasis on regional planning involving multiple systems and stakeholder organizations, the work group is exploring process changes that will continue to address local needs while supporting regional priorities and service delivery.

Chapter 2: System Transformation

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. DSRIP will be implemented through regional networks of providers called “Performing Provider Systems” (PPS) that 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
- Population Health

Numerous strategy areas are designed to drive the transformation of hospital systems, in particular, toward more broad-based networks of community services and supports. This will allow for value-based payment constructs to pay for health outcomes where all network partners share accountability for the patient and are reimbursed for the value of care not the volume.

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 that will inform county priorities. Integration of mental health and substance use disorder treatment is an essential component to many of the DSRIP projects. Substance Use Disorder (SUD) and Mental Health (MH) providers will work with the PPS(s) to ensure that community-based providers are included in the network of providers and that the continuum of SUD services are available to the PPS. The overall goal of a 25% reduction in avoidable re-hospitalizations cannot be reached without addressing SUD and MH needs of patients. It is often the undertreated SUD or MH condition that contributes to complications and readmissions for a host of physical health conditions.

**Medicaid Managed Care**

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

- Providing all Medicaid State Plan services for physical health, behavioral health, pharmacy, and long-term care.

- Expanding and enhancing network capacity and the array of evidence-based treatment and support services accessible in the community to facilitate recovery for adults and resiliency for children.

- Clearly specifying the expectation that the behavioral health benefit will result in high-quality care that has a positive impact on member outcomes.

- Requiring routine screening of members in primary care settings to identify unmet behavioral health needs and expedited, effectively made referrals to behavioral health services.

- Requiring routine screening of members in behavioral health settings to identify unmet medical needs and expedited, effectively-made referrals to appropriate physical services.
• Stipulating data integration and predictive modeling approaches to identify individuals who are at high risk for, or have, intensive and costly service needs, and facilitating program evaluation across systems.

• Instituting utilization management, medical management, and quality management protocols and other administrative methods to ensure that behavioral health service delivery, and associated financial and clinical outcomes, are appropriately managed.

• DOH, in conjunction with OMH and OASAS, will pre-approve MCO behavioral health services criteria and practice guidelines for utilization review, prior authorization, and levels of care.

• Each MCO is required to use the Level of Care for Alcohol and Drug Treatment Referral (LOCADTR 3.0) or an OASAS-approved substance use disorder level-of-care tool for all substance use disorder level-of-care decisions.

• Utilizing specialized case management and care coordination protocols to improve the engagement of each person in care, promote self-care, and enhance cross-system coordination—including participation in health home innovations—for people at risk for or experiencing intensive and costly service needs.

• Facilitating system transformation through the provision of comprehensive and ongoing education, training and technical assistance programs for members, behavioral and physical health providers, and MCO staff.

• Developing a transition plan that delineates key milestones and time lines for transitioning behavioral services from fee-for-service to MCOs.

• Health and Recovery Plans (HARPs) having responsibility for providing specialized services for adult Medicaid beneficiaries with significant behavioral health needs based on clinical/functional impairment eligibility requirements. The HARP benefits package will include rehabilitation, crisis intervention, educational and employment support, and peer and self-directed services modeled under the Home and Community Based Services (HCBS) waiver. These services will be available to beneficiaries based on their detailed plan of care, which will be informed by a full functional assessment. Qualified HARPs will rely upon specialized medical and social necessity/utilization review approaches and beneficiaries will have care management through a Health Home.

On October 1, 2015, services and populations were carved into managed care for all New York City residents enrolled in a Medicaid Managed Care Plan. The carve-in included the following design:

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

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

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

Implementation of the management of behavioral health benefits and of HARPs began in July 2016 for plans in the rest of New York State. Adults in the rest of state began receiving HARP passive enrollment letters in April 2016. Children’s enrollment in managed care is targeted for July 2017 in New York City and Long Island and January 2018 for the rest of state.

Health Homes

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

Health Home services include:

- Comprehensive care management;
- Health promotion;
- Transitional care, including appropriate follow-up from inpatient to other settings;
- Patient and family support;
- Referral to community and social support services;
- Use of health information technology to link services.
An individual is eligible for Health Home enrollment if he or she is currently on Medicaid and has multiple chronic conditions, including a substance use disorder, a serious persistent mental illness, or a single qualifying condition such as HIV/AIDS. OASAS and OMH continue to work with DOH on the management and oversight of Health Homes and provider networks across the state. The state agencies developed monitoring instruments and began to evaluate Health Home performance to facilitate the re-designation of currently authorized Health Homes in September 2015. 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 (CASA Columbia).

OASAS and OMH are also engaged with DOH in the development of Health Homes designed to meet the unique needs of children. Children will begin to receive care coordination from Health Homes in 2016.

**Integrated Licensure Regulations**

On January 1, 2015, regulations were adopted establishing standards applicable to programs licensed or certified by OMH, DOH, or OASAS that want to add to existing program services provided under the licensure or certification of one or both of the other agencies. The regulations promote increased access to physical and behavioral health services at a single site and foster delivery of integrated services.

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

**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 the appropriate level of care for individuals seeking substance abuse treatment services. The tool 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 allowing the person to remain as near to their community as possible. Substance abuse treatment providers in New York City were required to use LOCADTR 3.0 beginning October 1, 2015 and providers in the rest of the state were required to use the tool by July 1, 2016. These dates align with the transition from fee-for-service to Medicaid managed care for behavioral health care services in New York State. Managed care organizations who serve the Medicaid population are required to use LOCADTR 3.0 for level of care determinations. Within the commercial line of business, managed care organizations are required to use LOCADTR 3.0 or another OASAS-approved level of care tool to assess appropriate placement for substance abuse treatment services. In utilizing a common tool for level of care determination, treatment providers and managed care organizations will have a shared standard when assessing individual service needs. LOCADTR 3.0 provides clear criteria and a consistent platform for the level of care determination.
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 the full continuum will be included in the adolescent version of LOCADTR 3.0.

**Off-Site Services**

OASAS is also proposing a Medicaid state plan amendment that would allow for clinic visits to be provided off–site to enhance the type of services and improve linkage and continuity of care for people who have not engaged in or who have disengaged from a treatment episode. OASAS included off-site services in the 1115 demonstration waiver authority, which was approved by the Centers for Medicare and Medicaid Services (CMS). Services for all individuals covered by a managed care plan can be provided in the community. Through a state plan amendment OASAS will request approval for all clinical services to be provided offsite. This will allow for providers to re-engage individuals who have been lost to contact in outpatient services, provide peer services in the community to help engage in recovery supports and to provide better linkages.

**Residential Redesign**

Residential Redesign is a direct result of Medicaid Redesign and managed care. It includes OASAS residential treatment options to divert appropriate individuals from higher levels of care to more appropriate community-based options and to allow bedded programs to provide short-term crisis/respite options. Residential Redesign responds to the need for a residential continuum of care that can provide clinical and medical care based on individual needs. Often people who need 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 receive medically-directed care to stabilize acute medical, mental health, and addiction symptoms.

- **Rehabilitation** - Individuals 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 a Part 818 Chemical Dependence Inpatient Rehabilitation OASAS-certified program.)
- **Community Reintegration** - Individuals further develop recovery skills and begin to reintegrate into the community.

## Chapter 3: System Initiatives

### 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 175 providers operating in schools, community-based organizations, and embedded in the community at large. The providers 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.

Evidence-based programs and strategies (EBPS) are a required standard for all service providers and the guidelines ask prevention providers to document their utilization and challenges in implementing particular EPBS. Community coalitions, environmental strategies, education and awareness and community capacity building are all critical components of an effective prevention program or system. OASAS established six Prevention Resource Centers (PRCs) to support local communities’ implementation of EPBS. The PRCs disseminate current prevention science, through training and technical assistance, to community coalitions and prevention providers.

EBPS have produced scientific evidence that they are effective in preventing substance abuse and other youth problem behaviors. EBPS include educational curricula, multi-component school-based programs, and environmental strategies. Most EBPS provided by OASAS-funded prevention providers are delivered in school settings. OASAS-approved EBPS have been evaluated for effectiveness specifically in preventing or reducing substance abuse and related problems, and are designed to change youth and families’ risk and protective factors, and those community factors that drive illegal consumption and negative consequences due to substance abuse. In 2015, OASAS identified four EBPS for children that address risk and protective factors for both mental, emotional, and behavioral disorders including substance abuse. OASAS is planning to pilot these EBPS in elementary schools in partnership with the New York State Education Department and OASAS providers.

### Strategic Prevention Framework State Incentive Grant (SPF SIG)

In 2009, OASAS was awarded a five-year Strategic Prevention Framework State Incentive Grant (SPF SIG) from the Center for Substance Abuse Prevention (CSAP) of the Substance Abuse and Mental Health Services Administration (SAMHSA). Through a data driven needs assessment process using the 2008 Youth
Development Survey results, OASAS identified underage drinking as a priority issue and social access to alcohol as the primary mechanism through which to reduce underage drinking. OASAS competitively awarded funding to 11 community coalitions to address this issue in rural counties and suburban and urban communities with above average rates of underage drinking.

The community coalitions created data driven strategic plans and implemented targeted environmental strategies to reduce underage drinking among their 9th to 12th grade youth. These strategies included establishing and/or enforcing alcohol social host laws, launching social marketing campaigns, conducting party patrols, implementing the “Parents Who Host Lose the Most” campaign, and training law enforcement and merchants on issues related to underage drinking. Outcomes measured included underage drinking, binge drinking, consequences of drinking, and adult perceptions of underage drinking.

Results varied by community, but the largest and most consistent change was in binge drinking, with eight of 11 communities demonstrating statistically significant decreases. The reduction in underage binge drinking over two years was higher for the SPF SIG coalition communities than the reduction for New York State: 29% project decrease vs. a 16% New York State reduction (2011 to 2013, New York State Youth Risk Behavior Survey). Risk factors significantly reduced included youth attitudes and perceived parental attitudes toward underage drinking. A decrease in the consequences of underage drinking was also shown across communities. The most consistent decreases were in being hung over, getting into an unwanted sexual situation and being drunk at school or work.

In addition to these outcomes, the coalitions improved their capacity to plan and deliver environmental prevention strategies through substantial training and technical assistance from OASAS, the Prevention Resource Centers, and their peers.

**Strategic Prevention Framework Partnership for Success (SPF PFS)**

In September 2014, SAMHSA awarded OASAS a five-year $8.13 million Strategic Prevention Framework Partnership for Success (SPF PFS) grant. OASAS is targeting prevention priorities focused on the following:

1) Prescription drug misuse and abuse among persons aged 12 to 25;
2) Heroin abuse and heroin/opioid overdose prevention among persons aged 12 to 25.

Ten community coalitions were selected in 2015 through a competitive RFP process. These coalitions will implement environmental strategies in their communities:

- Alliance for Better Communities, Watertown, Jefferson County
- Community Coalition for Family Wellness, South Glens Falls, Saratoga County
- Cortland Area Communities That Care, Cortland County
- HOPE Chautauqua, Jamestown, Chautauqua County
- Massapequa Takes Action, Massapequa, Nassau County
- Partnership for Ontario County, Canandaigua, Ontario County
- Putnam County Communities That Care, Carmel, Putnam County
- Tackling Youth Substance Abuse, Staten Island, Richmond County
- TEAM Newburgh, Newburgh, Orange County
West Side Youth Development, Buffalo, Erie County

Prevention Resource Centers

Through its regional Prevention Resource Centers (PRCs), OASAS supports the implementation of environmental prevention strategies by a network of over 170 anti-drug coalitions operating across the state. The regional PRCs are funded to provide training and technical assistance to the community coalitions. Environmental prevention strategies are effective in reducing underage drinking and smoking. They are designed to change the community, social, and economic contexts in which people access alcohol, tobacco, or prescription drugs of abuse. The strategies are primarily aimed at changing the community “environment” through the establishment and enforcement of laws, policies, and regulations. Goals of the six funded PRCs include:

- Sustaining the coalitions that have been established and improving their outcomes;
- Disseminating the Strategic Prevention Framework (SPF) to coalitions and providers;
- Providing training and technical assistance to coalitions and providers on environmental strategies;
- Having a funded prevention provider on every community coalition;
- Establishing at least one coalition in every county;
- Having the PRCs work with LGUs to improve county planning based on needs assessments.

The PRCs have also been receiving training to implement the Substance Abuse Prevention Specialist Training (SAPST). The goal is to have at least two trainers in each PRC who are able to implement the SAPST training for new prevention professionals across the state. This will strengthen the Prevention workforce by providing uniform and reliable training.

Talk2Prevent

OASAS developed a three phase Talk2Prevent campaign aimed at giving parents the information and tools they need to talk to their children about the risks of underage drinking and drug use. The first phase of the campaign was released in October 2015 and targeted parents of college age students. It included print and social media information as well as two PSAs that were launched statewide. The second phase of the campaign was released in November 2015 targeting parents of teens and young adults on how to help prevent drinking and drugged driving. The third phase was launched in May 2016 and focused on talking to kids about the dangers of drinking and drug use during prom and graduation season.

The website [www.talk2prevent.ny.gov](http://www.talk2prevent.ny.gov) includes a toolkit for parents that has an agreement, which both parent and child sign to establish a clear understanding of family rules around underage drinking. The toolkit also has conversation starters, texting ideas, and a list of warning signs. In addition, tools on how to develop an exit strategy with your child if they encounter a sticky situation related to drinking or drug use are available.

Another feature of the website is the wide variety of media pieces that New York substance abuse coalitions or prevention providers can use to reach out to parents. These media pieces are part of a toolkit for coalitions and are available for coalitions to download for use in their work. Talk2Prevent resources can also be accessed from the OASAS Facebook page. Resources for parents and coalitions are listed and searchable by county to provide access to local prevention providers.
State Education Department Memorandum of Understanding

In 2015, OASAS and the State Education Department (SED) commenced innovative work via an SED-OASAS MOU on a groundbreaking Promoting Positive Mental, Emotional and Behavioral Health project to update SED’s state-wide health education standards’ curriculum guidance document as called for in the 2014 legislation to address heroin and other opioid use. The initial iteration of this product (e.g., Health Education Standards Modernization Supplemental Guidance Document) has been developed and is currently under review at SED. The guidance document includes functional knowledge content for heroin and other opioids, as well as an instructional framework and resource packet for educators.

Moving forward, efforts are underway with respect to a guidance document regarding Evidence-Based Programs and Practice (EBP) prevention topics. For the applied pilot component of the project, criteria are currently being discussed at an inter-agency level for a pilot program in which elementary schools in at least three districts will use EBPs in a supported manner to reduce the negative consequences of Mental, Emotional and Behavioral (MEB) health disorders. Finally, information for a state-wide database for the MEB Health Planning Index inclusive of five indicators has been amassed in collaboration with SED, entered, formatted, and analyzed for eventual inclusion on the Kids’ Well-being Indicators Clearinghouse (KWIC) website, which is maintained by the Council on Children and Families (CCF).

Prevention Policy Academy

OASAS is developing a planning tool for counties, prevention providers and schools to improve needs assessment for mental, emotional and behavioral (MEB) health promotion and MEB disorder prevention services. With data provided by SED, the tool will help planners map levels of risk factors, such as family poverty and low academic performance, and the prevalence of student MEB health needs by school district. The Council on Children and Families will disseminate this planning tool through the Kids Well-being Indicator Clearinghouse (KWIC).

Planners will be able to view colored thematic maps for all MEB indicators and for a combined MEB Health Planning Index. The new tool will include three years of trend data. OASAS and the MEB policy and planning improvement partners plan to update it annually.

Problem Gambling

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

OASAS continues efforts on integrating problem gambling prevention into the statewide prevention services system. OASAS funded prevention providers are increasing public awareness by integrating problem gambling prevention into their yearly work plan services. OASAS has partnered with the New York State Gaming Commission and the New York Council on Problem Gambling (NYCPG) to form the Responsible Play Partnership. Over the past year, the Partnership has worked to increase awareness of problem gambling and responsible gaming through four “Let’s Begin the Conversation” events. These events brought industry,
prevention and treatment providers, and the general public together to discuss issues and concerns around problem gambling and ways to work together to mitigate problem gambling.

To increase access to care for problem gambling treatment across the state, NYCPG, an OASAS-funded provider, opened the Queens Center for Excellence (QCFE) pilot program in March 2015. Nine clinicians provide services to individuals seeking treatment for problem gambling in Queens County. In the first nine months, the QCFE received 77 calls of which 48 received a referral to treatment. The QCFE placed six freestanding public displays (or Kiosks) throughout Queens, which simultaneously publicize the existence of the program and offer takeaway literature on issues related to the subject of problem gambling. These issues, printed on 9”x 4” inch palm cards, explain what problem gambling is, who is at risk, how to recognize a disorder and, most importantly, how to get help. The Queens Center for Excellence also maintains a blog to provide general information to the public.

The NYCPG has also contracted with various private practitioner groups to develop the Problem Gambling Treatment Opportunity Program (PGTOP). This program will identify and train licensed private practitioners in problem gambling treatment in order to treat individuals seeking services through private practitioners.

**Adolescent Treatment Services**

OASAS continues to work on the Children’s Health and Behavioral Health Medicaid Redesign Team, with DOH, OMH, and OCFS. 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 OMH for Seriously Emotionally Disturbed youth, OCFS Waivers for children and youth in Foster Care, and 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 six State Plan Services for children and youth. The 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 developed an adolescent module to 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 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 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 also has two cooperative agreements through the federal Center for Substance Abuse Treatment (CSAT). The first project - New York Serving Adolescents in Need of Treatment Services (NYSAINST) - began in September 2012 and will end in September 2016. This project implemented Seven Challenges, an evidence-based practice, and the Global Appraisal of Individual Needs (GAIN) at two sites, while also improving the role of youth and families in decision making and enhancing the infrastructure needed to support services for
adolescents with a substance use disorder. During 2016, this project will implement Seven Challenges at four additional 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 implement the evidence-based practice Multi-dimensional Family Therapy (MDFT) in a minimum of eight programs over three years. The project will also assist OASAS in developing Family Peer Supports and Youth Peer Supports. Both of these projects have helped to advance the development of the full continuum of services for adolescents and their families.

Keeping with the OASAS commitment to develop a Recovery Oriented System of Care for all New Yorkers, the agency is developing a Youth Clubhouse Model for youth (12 – 17 years of age) and/or Young Adults (18-21 years of age), who are in recovery from a substance use disorder and/or a co-occurring mental health disorder and for youth who wish to maintain a drug free life style. The model will incorporate elements of the International Center for Clubhouse Development Model and OASAS’ Recovery Centers. The purpose of a clubhouse is to provide a safe and inviting place for adolescents and young adults to develop pro-social skills that promote long term health, wellness and recovery. This is also a place where youth and young adults can go to have fun.

On January 28, 2016, Governor Cuomo announced more than $1.6 million in annual funding to create first-of-their-kind adolescent substance use disorder clubhouses in seven regions across New York State. These community-based clubhouses will promote peer-driven supports and services in a non-clinical setting for young New Yorkers in recovery or at risk for substance use disorders. The seven organizations receiving funding will help individuals in recovery develop social skills that promote prevention, long-term health, wellness, recovery and a drug-free lifestyle. A variety of services and activities will be available, including homework help and tutoring, college and job preparation, community service opportunities, sports and fitness activities, group entertainment activities, and peer mentoring. Youth and family advisory board members at each clubhouse will help shape activities and programming.

The following organizations are being funded under the Clubhouse initiative:

- **New York City** - The Lesbian, Gay, Bisexual and Transgender (LGBT) Community Center - $250,000

OASAS also approved an additional $275,000 in funding to support a new outpatient substance use disorder treatment program at the LGBT Community Center. This first-of-its-kind program is specifically designed to meet the needs of LGBT adolescents, and will feature individual, group and family counseling as well as strong peer supports and services. With the addition of this adolescent treatment track funding, LGBT youth at the Center will benefit from a full continuum of services including prevention, treatment, and recovery programming in a stigma-free environment.

- **Mohawk Valley/North Country** - HFM Prevention Council (The Alcohol and Substance Abuse Council of Hamilton, Fulton and Montgomery Counties) - $250,000

- **Central New York** - Friends of Recovery Delaware and Otsego (FOR-DO) - $121,600
• Long Island - HELP Services, Inc. - $242,900
• Mid-Hudson - YMCA of Yonkers - $250,000
• Finger Lakes - Partnership Ontario County - $250,000
• Western New York - Restoration Society, Inc. - $250,000

Screening, Brief Intervention and Referral to Treatment (SBIRT)

SAMHSA recognizes New York State as a leader in the use of SBIRT, an evidence-based approach to identify risky alcohol and substance use and reduce dependence. OASAS works closely with DOH and OMH to bring SBIRT to physical and behavioral healthcare settings. As part of the state’s effort to better integrate care, SBIRT provides a means to address risky and problematic substance use in conjunction with other health screenings.

As healthcare delivery systems move toward better integration, SBIRT is a practice that can form the basis for collaborative and integrated forms of treatment. Primary care physicians and health clinics will have an opportunity to work with specialty substance use disorder treatment providers to develop screening, brief intervention, and referral to treatment protocols. Implementing SBIRT will aid the healthcare system in building capacity to better identify the risky use patterns and substance use disorders that impact on overall health outcomes managed at the primary care physician’s office.

Through grants and state initiatives OASAS is supporting the use of SBIRT in various settings. These efforts include: STD clinics in New York City and medical settings in Jefferson County through a SAMHSA award (2011 – 2016), and emergency department and primary care settings within the North Shore-Long Island Jewish Hospital System on Long Island and Staten Island where individuals were affected by Hurricane Sandy (SAMHSA award, 2013-2018 in partnership with CASA Columbia).

Through initiatives like the DSRIP program, OASAS and DOH recognize SBIRT as an important practice to include in an integrated approach to health care. Performing Provider Systems (PPS) will carry out a plan to achieve system transformation, clinical management and improved population health as demonstrated by a 25% reduction in avoidable hospital use over five years, with many PPSs implementing SBIRT in healthcare settings to support their effort to reach that goal.

Recovery

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

- **Health:** To recover, people need access to affordable, accessible, and high-quality health and
  behavioral healthcare. Overcoming or managing one disease or symptom (e.g., abstaining from the use
  of alcohol, illicit drugs and non-prescribed medications) and, for everyone in recovery, making
  informed, healthy choices that support physical and emotional well-being.

- **Home:** To recover, people need a stable and safe place to live.

- **Purpose:** To recover, people need meaningful daily activities, such as a job, school, volunteer
  opportunities, family caretaking, or creative endeavors, and the independence, income, and resources
  necessary to fully participate in their community.

- **Community:** To recover, people need relationships and social networks that provide support,
  friendship, love, and hope.

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

**Recovery Community Centers**

In June 2016, Governor Cuomo announced $10.5 million in funding over five years to support six new
Recovery Community and Outreach Centers in communities across New York State. The new centers, funded
by OASAS, will provide health, wellness, and other critical support for individuals and families who are
recovering from a substance use disorder or are seeking recovery services.

These six sites were selected through a competitive OASAS request for proposal evaluation and will be located in:

- Long Island: Mineola
- New York City: Staten Island
- Hudson Valley: Newburgh
- Capital Region: Saratoga Springs
- Central NY: Watertown
- Western NY: Buffalo

The Recovery Community and Outreach Centers will provide a community-based, non-clinical setting that is
safe, welcoming and alcohol/drug-free for any member of the community. Each recovery center will respond
to the local area’s specific needs related to obtaining substance abuse treatment services and addiction recovery
supports. The centers will promote long-term recovery through skill building, recreation, wellness education,
employment readiness, civic restoration opportunities, and other social activities. Services will be accessible
not only during the daytime hours, but also during evening and weekends, to meet the needs of individuals and families who may be in need of assistance at varying hours.

Recovery center staff will provide assistance to individuals and families to help them navigate the addiction treatment system and secure insurance coverage for various levels of addiction treatment. The centers will also provide an opportunity for individuals and families to connect with peers who are going through similar challenges so that they can benefit from shared experiences and commitment to common goals for recovery. Access to peer advocates, recovery coaches, and addiction peer specialists through these recovery centers will help to further enhance the recovery process.

**Peer Support Services**

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

Peer support activities should focus on achieving the identified goals or objectives in the consumer’s individualized care plan, which delineates specific goals that are flexibly tailored to the consumer and attempt to utilize community and natural supports. The intent of these activities is to assist recipients in initiating recovery, maintaining recovery, and enhancing the quality of personal and family life in long-term recovery.

OASAS is committed to increasing the number and quality of Peer Specialists, Recovery Coaches, and the young adult and peer-run/family-run recovery support service organizations that offer these services. Peer Specialists fill many roles and work in a variety of settings to assist with the engagement and retention of individuals in recovery. Peers tend to be especially effective with outreach and engagement of people who have been reluctant to participate in behavioral health services.

The new OASAS Peer Specialist certification offers an opportunity for former recovery coaches to transition into a position that allows for Medicaid reimbursement in outpatient clinic settings. It is estimated that there are over 1,000 recovery coaches that have received formal training. OASAS is collaborating with the New York Certification Board and the New York Certification Association to conduct outreach to existing coaches and assist with the application process to become certified Peer Specialists. Peers in the workforce will strengthen the commitment to person-centered, recovery-oriented approaches.

**Permanent Supportive Housing**

OASAS recognizes that safe and affordable housing for homeless individuals and families suffering from a 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 access to health care services. OASAS provides opportunities for permanent supportive housing to homeless adults and families through rental subsidies and dedicated case managed supportive services.
OASAS oversees and administers a housing portfolio of 2,734 apartment units with total funding of approximately $35.6 million for six distinct brands of permanent supportive housing (PSH) to include:

- Continuum of Care Rental Assistance Program (formerly Shelter Plus Care) which is federally funded and overseen by the U.S. Department of Housing and Urban Development (HUD);
- New York/New York III Population F targeting homeless single adults;
- New York/New York III Population G targeting homeless families (wherein the head of household has a SUD disorder);
  - New York/New York III is a ten-year New York City/New York State agreement to provide permanent supportive housing for chronically homeless adults and families in New York City;
- Upstate Permanent Supportive Housing, which targets homeless single adults and families in counties and regions outside of New York City and its metropolitan (Metro NY) counties;
- New York City-based Re-Entry, which is a PSH initiative for parolees. This PSH program is a collaboration with Division of Parole and targets single adults;
- Medicaid Redesign Team (MRT) Supportive Housing, which is in its third year of providing permanent supportive housing to single adults who are high cost frequent consumers of Medicaid benefits. The MRT housing initiative with its 300 apartment units has sustained an average occupancy of 95 to 98 percent over the past two years, as well as an approximate 60% Health Home enrollment.

In October 2015, OASAS awarded 80 units of permanent supportive housing among four providers in New York City targeting homeless families (NY/NY III Population G). That award was Round Four of the New York/New York III Homeless Agreement, which is a ten-year New York City/New York State partnership initiative to create up to 9,000 units of permanent supportive housing for chronically homeless adults and families in New York City.

**Chapter 4: County Planning**

New York State Mental Hygiene Law requires that OASAS, OMH, and OPWDD guide and facilitate an annual local services planning process. Each county and the City of New York is required to conduct a broad-based planning process to identify the mental hygiene service needs in the community and develop a local services plan to address them. In addition to describing their own local priorities and strategies, these plans also inform each state agency’s statewide comprehensive planning process.

Local priorities have changed over the past two 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.

This chapter contains a summary of key information contained in the 2016 local services plans (LSPs) that were submitted to the state during the summer of 2015. Specifically, this includes a summary analysis of local needs and priorities that were identified as being associated with the OASAS service system.
Local Needs Assessments

An important component of the local services plan is the Needs Assessment Report, where LGUs identify the mental hygiene problems and needs in the community and provide 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. For each service listed, they were asked to indicate if the local need was “High,” “Moderate,” or “Low.” A review of all 57 local needs assessments was completed to assess the greatest needs identified across the state. One LGU did not complete this component of the needs assessment report, so the following analysis included 56 LGUs.

As Figure 4.1 shows, the needs of the youth and adult populations were similar for some services and quite different for other services. Twenty-nine LGUs identified supported housing as a high need for their adult substance use disorder population, while only 13 LGUs identified it as a high need for their youth population. This need is further reflected in the high number of priorities included in the plans to address the lack of sufficient supported housing, as reported below. Only eight LGUs indicated that supported housing was a low need for their adult SUD population.

Reliable and affordable transportation has long been identified as a high need for all populations served in the local mental hygiene system. Twenty-eight LGUs identified transportation as a high need for their adult SUD population, and 23 identified it as a high need for their youth SUD population. Only seven LGUs indicated that transportation was a low need for their adult SUD population. This was the highest need identified for the youth population. Many counties identified the lack of available public transportation, the lack of funding for transportation, the lack of coordinated transportation services across systems of care, and problems associated with the local Medicaid transportation system as the greatest needs to be addressed.

Figure 4.1: High Need Services for the Local SUD Population (N=56)
The lack of available crisis services for adults was identified as a high need by 26 LGUs, and for youth by 21 LGUs. Most counties identified the need to develop or expand local or regional mobile crisis capacity, while several others indicated a need to develop alternative non-hospital based detox services. Some counties identified the need to develop crisis services specifically to address the increasing demand for detoxification from opioids.

Workforce recruitment and retention needs associated with the adult population (22 LGUs) and with the youth population (18 LGUs) focused primarily on the shortage of professional staff positions that need to be filled, particularly psychiatrists, psychiatric nurses, nurse practitioners, therapists (including social workers and CASACs), and prescribing physicians. Several LGUs identified a high need to train new and current staff, particularly on integrated care and Medicaid.

Other high need areas included engaging the service system in the healthcare reform initiatives focused on regional, integrated and coordinated services, and the need to develop or expand specific prevention and treatment services. Many of these were translated into specific priorities that are described below.

**Local Priorities**

County planning continues to focus extensively on the needs of individuals with multiple disabilities who may need services from more than one system and on the significant reforms that are affecting the delivery of services to individuals suffering from mental illness, substance use disorders, or developmental disabilities. 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, 338 (74%) were associated with OASAS, including 71 that were associated with both OMH and OASAS and 220 that were associated with all three mental hygiene agencies. Only 46 priorities were associated with OASAS only. There was an average of four OASAS-associated priorities per LGU. Figure 4.2 shows the distribution of priorities by associated disabilities.

Figure 4.2: 2016 Local Services Plan Priorities by Disability Agency (N=457)

Nearly half of all county priorities were associated with all three disability areas, reflecting the high degree to which they are intended to address needs that require a more comprehensive cross-system approach. Of the priorities associated with OASAS, 94 (28%) addressed service coordination, integration and collaboration within the existing local prevention, treatment and recovery services. Most of these priorities included strategies involving the integration of primary and behavioral health care.

Each year LGUs are asked to categorize each priority by selecting a primary focus category from a list provided by each state agency. This step was added to clarify the LGU’s objective and minimize subjective interpretation in situations where a priority overlaps multiple categories. For example, to address the need for outpatient treatment services, a county may choose to expand service capacity, implement an evidence-based treatment model, and provide training to clinical staff. The focus area allows the LGU to emphasize its primary objective. Table 4.1 shows the distribution of OASAS-associated priorities based on the focus categories selected by the LGUs.
Table 4.1: Primary Focus of OASAS-associated Priority Outcomes (N=338)

<table>
<thead>
<tr>
<th>Priority Focus Category</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Improvement/Enhancement</td>
<td>100</td>
<td>30%</td>
</tr>
<tr>
<td>Service Coordination/Integration</td>
<td>94</td>
<td>28%</td>
</tr>
<tr>
<td>Service Capacity Expansion</td>
<td>82</td>
<td>24%</td>
</tr>
<tr>
<td>Service System Planning/Management</td>
<td>51</td>
<td>15%</td>
</tr>
<tr>
<td>Workforce Development</td>
<td>11</td>
<td>3%</td>
</tr>
</tbody>
</table>

LGUs were also asked to rank their top five priorities to provide additional weight to the most important ones. Sixty percent of all priorities received a top five ranking, including 68% of the priorities associated with OASAS.

**Service Improvement/Enhancement:** Of the five focus areas, service improvement and enhancement was mentioned most frequently as an OASAS-associated priority. Fifty-five of these (55%) were ranked as a top five priority. Thirteen LGUs had service improvement and enhancement as a number one ranked priority. Strategies mentioned most often included implementation of best or promising practices (16); implementation of recovery services (6); recruitment and training of the workforce (10); and improved outreach to target populations (10).

Specific services identified in this focus category included prevention (11), recovery support (9), behavioral health (6), services to adolescents (6); housing (5), crisis services (4), transportation (4); suicide prevention (4); vocational services (4) and services to individuals involved in the criminal justice system (4). Improving and increasing community education, strategies for integrated care and managed care preparedness were also listed as strategies.

**Service Coordination/Integration:** Forty-five LGUs included 94 OASAS-related priorities related to coordinating or integrating behavioral and physical health services. Sixty-eight (72%) of these were ranked as a top five priority. Thirty-eight priorities (40%) documented the need to coordinate and/or to promote integration with other health systems such as mental health, primary health and developmental disabilities to prepare and enhance service delivery for successful transition in a rapidly changing environment. Seventeen LGUs identified expansion of services and improved access to all health care systems as a top five priority in this category and twenty-six priorities (28%) focused on service coordination and integration within specific service types, including recovery support services (5); housing (3); opioid treatment (3); prevention services (4); criminal justice services (4); vocational services (5); suicide prevention services (2); adolescent services (2) and transportation services (1).

**Service Capacity Expansion:** There were 82 priorities that identified service capacity expansion, with 59 (72%) ranked as a top five priority. Thirty-three priorities (40%) specifically identified housing; seventeen priorities (21%) identified expansion and improved access to all substance use disorder services a priority; and twelve priorities (14%) focused on opioid addiction. Other service included in service capacity expansion priorities were adolescent services (5); suicide prevention (4); recovery support (5); transportation (3); vocational services (1) and prevention (1).
Service System Planning and Management: Planning and management of the behavioral health service system has increasingly taken on more importance each year due largely to a system-wide transformation of care and a rapidly changing service delivery environment. When asked to categorize priorities by focus areas, 33 LGUs included 51 priorities (15%) that were dedicated to service system planning and management. Thirty-eight (74%) of these were ranked as a top five priority, the highest percentage of any priority focus category. In addition to the priorities in this category, service system planning and management was a component of a large number of priorities listed under other categories.

Specific strategies identified in this category included promoting alignment of community services with systems change initiatives, developing plans to address the social determinants of health for those needing behavioral health services, and exploring a transition age initiative that brings together child and adult service systems regarding the needs of individuals between the ages of 16 and 25. Several LGUs included a priority to complete a needs assessment to help prepare the local mental hygiene service system for Medicaid Redesign and Managed Care.

Top Priorities by Special Topic: While each priority was categorized by the primary focus areas listed above, many of the topics covered by those priorities overlapped focus areas. The topic most frequently mentioned across focus categories was housing, identified in 45 separate top five priorities. The need to address the significant housing shortage for people with disabilities is critical to ensure that safe and affordable housing is available to all, with the appropriate supports to promote successful community living and full community integration. Safe and affordable housing has been shown to contribute to more successful outcomes concerning long-term recovery and is integral to the health and well-being of residents across all systems.

Suicide prevention affects all mental hygiene disabilities and was identified in 38 top five OASAS-related priorities. Most strategies to prevent suicide among youth and adults included developing a county wide cross systems approach to improve early intervention efforts and impact suicide rates. Suicide prevention coalitions are active in many counties, developing comprehensive suicide prevention plans to better serve local communities and school districts. Specific strategies included providing community education related to the symptoms of depression, suicide warning signs and how to access services through various venues such as written and audio media sources, and community presentations/trainings. Continued collaboration with the NYS Suicide Prevention Initiative will provide training and technical support for local school districts to effectively address youth suicide, discuss and plan prevention strategies and keep at-risk students safe.

Another topic that was identified in multiple focus categories was the prevention of opioid abuse. This topic has increased as a local priority over the last several years and was addressed in 21 priorities this year. Several counties have established coalitions to develop strategies to address the epidemic of heroin and prescription opioid overdoses. Strategies included increasing community awareness and prevention efforts, expanding the availability of Naloxone, developing comprehensive treatment approaches, and collaborating across systems of care.

Other topics that were frequently mentioned across multiple focus areas included the expansion and enhancement of adolescent services, preventing underage drinking, improving peer-based services, improving transportation services, and expanding access to vocational services.
Progress on the Prevention Agenda 2013-2017

The Prevention Agenda 2013-2017 was developed in conjunction with DOH’s new health improvement plan and is the blueprint for local action to improve the health of all New Yorkers in five priority areas. 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 next 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 compared 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:

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

As Table 4.2 shows, there were a total of 48 goals that were common to both the LSP and CHIP. Another 18 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 relievers 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. Of the 39 total, 12 had a corresponding priority in the CHIP. 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 4.2: Goals Under the Promote Mental Health and Prevent Substance Abuse Priority

<table>
<thead>
<tr>
<th>Goal</th>
<th>Goal Description</th>
<th>CHIP Only</th>
<th>LSP Only</th>
<th>Both</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>Promote mental, emotional and behavioral (MEB) well-being in communities.</td>
<td>1</td>
<td>42</td>
<td>8</td>
</tr>
<tr>
<td>2.1</td>
<td>Prevent underage drinking, non-medical use of prescription pain relievers drugs by youth, and excessive alcohol consumption by adults.</td>
<td>3</td>
<td>27</td>
<td>8</td>
</tr>
<tr>
<td>2.2</td>
<td>Prevent and reduce occurrence of mental, emotional and behavioral disorders among youth and adults.</td>
<td>4</td>
<td>31</td>
<td>3</td>
</tr>
<tr>
<td>2.3</td>
<td>Prevent suicides among youth and adults.</td>
<td>0</td>
<td>27</td>
<td>12</td>
</tr>
<tr>
<td>2.4</td>
<td>Reduce tobacco use among adults who report poor mental health.</td>
<td>4</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td>3.1</td>
<td>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.</td>
<td>2</td>
<td>31</td>
<td>12</td>
</tr>
<tr>
<td>3.2</td>
<td>Strengthen infrastructure for MEB health promotion and MEB disorder prevention.</td>
<td>3</td>
<td>30</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td><strong>Totals</strong></td>
<td><strong>18</strong></td>
<td><strong>196</strong></td>
<td><strong>48</strong></td>
</tr>
</tbody>
</table>