



New York State Office of Alcoholism and Substance Abuse Services

Statewide Comprehensive Plan 2009-2013



October 1, 2009

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Dear Stakeholder:

On behalf of Governor David A. Paterson, the New York State Office of Alcoholism and Substance Abuse Services (OASAS) is pleased to announce the release of the *Statewide Comprehensive Plan 2009-2013: A Strategic Plan for New York State's Addiction Services System* developed in accordance with Section 5.07 of Mental Hygiene Law. Its purpose is to help our constituents in a wide array of ways associated with the OASAS mission: **TO IMPROVE THE LIVES OF ALL NEW YORKERS BY LEADING A PREMIER SYSTEM OF ADDICTION SERVICES THROUGH PREVENTION, TREATMENT, RECOVERY.**

OASAS proudly notes the significant public input that contributed to this Plan, including:

- Information provided through the local planning process by the more than 450 providers of prevention, treatment, and recovery services as well as the City of New York and 58 local county governments;
- Direct comments and questions raised by the more than 300 participants in the four Planning Dialogues held in August and September across the State;
- Ongoing feedback from consumers, families, providers, community members, and local government representatives collected throughout the year via the many workgroups, training sessions, and site visits that inform our understanding of how the system is functioning.

The Plan's purposes include:

- Ensuring that key stakeholders, including counties, providers, the Legislature, federal agencies, advocates, and people in recovery have the most up-to-date information about addiction services in New York, including recent achievements and key system and program outcomes;
- Enabling counties and providers to develop initiatives and programs that are aligned with statewide priorities;
- Encouraging collaboration across all major service systems to meet the needs of individuals and families affected by addiction;
- Facilitating program and policy changes and improvements;
- Inspiring innovation and change at all levels of the addiction service system.

All of these purposes, and a range of others, are built on one core principle:

Data and other information included and referenced in this Plan are useful and used by all New Yorkers engaged in:

- *Preventing addiction to alcohol, other drugs, and gambling;*

- *Successfully treating those afflicted with the chronic yet treatable disease of addiction;*
- *Supporting the millions of New Yorkers in recovery.*

We also want to acknowledge our partners in other service systems especially those from the Office of Mental Health (OMH) and Office of Mental Retardation and Developmental Disabilities (OMRDD). Over the past few years, we have collaborated closely to put the needs of people with multiple needs and their families first. Much of this collaboration is coordinated through the Inter-Office Coordinating Council's (IOCC's) Mental Hygiene Planning Committee. The Planning Committee is co-chaired by a county representative from the Conference of Local Mental Hygiene Directors.

Although planning documents are produced and released on regular cycles, we view planning as a year-round process that informs policy development, budgeting, and the development and delivery of services at the State, local, and provider levels. It is our commitment that these collaborative planning efforts will be successful in both guiding future efforts toward our agreed upon mutual goals as well as have the flexibility to respond to inevitable changing conditions.

Please give us your feedback on the use and usefulness of this Strategic Plan by sending your comments to 5YearPlan@oasas.state.ny.us. Your input is invaluable and is critical to ensuring that our planning efforts are responsive to the needs of those New Yorkers we serve.

Sincerely,

Karen M. Carpenter-Palumbo
Commissioner

William Phillips
Associate Commissioner for
Outcome Management &
System Information

OASAS Contact and Staff Acknowledgements

This Plan is submitted in accordance with Section 5.07 of Mental Hygiene Law. For further information about the Plan, please contact principal author William Hogan at 5yearplan@oasas.state.ny.us. Other individuals making key contributions to this Plan include William Phillips, Timothy Williams, Jean Audet, and Andrew Heck.

Planning staff would also like to acknowledge:

- The numerous OASAS subject matter, epidemiological, and data experts that contributed materials for the Plan;
- County and provider staff that completed Local Plans and Surveys via the Online County Planning System;
- Participants in the four Planning Dialogues;
- Our partners at the Office of Mental Health and Office of Mental Retardation and Developmental Disabilities.

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Chapter I: Background and Context

OASAS Mission

To improve the lives of all New Yorkers by leading a premier system of addiction services through prevention, treatment, recovery.

Background

The New York State Office of Alcoholism and Substance Abuse Services (OASAS) estimates that one in seven State residents (2.5 million) suffer from a substance use disorder or problem gambling. The agency estimates that 11 percent, or 1.8 million, State residents age 12 and older experience a substance use disorder (dependence or abuse) annually. (Statewide, almost 1.8 million New Yorkers (over 1.6 million adults and 160,000 adolescents ages 12-17) have a substance abuse problem.) Problem gambling, which has been included in OASAS efforts since 2005, is estimated to affect five percent of all adults, over 600,000 individuals. Among adolescents, problem gambling affects 160,000, or one out of every ten youths. (An additional 160,000 are at risk of developing problem gambling.) Approximately 25 percent of the 160,000 adolescents affected by problem gambling also experience a substance use disorder. These figures do not fully depict the widespread impact of addiction in New York because of the millions of other individuals whose lives are also affected: children, spouses, and extended families. The cost to society is compounded by the consequences of addiction, which impact public safety, health, welfare, and education throughout the State.

Planning Framework

OASAS is required by Mental Hygiene Law to produce a Plan every October 1 and an Interim Report on the Plan on February 15. *A Strategic Plan for New York State's Addiction Services System*, developed in accordance with Section 5.07 of Mental Hygiene Law, informs counties, providers, consumers, people in recovery, their families, other State agencies, the federal government, and other interested parties about major initiatives and future directions. The Plan outlines an ambitious course for OASAS, counties, and providers to pursue over the next several years. It also discusses significant issues, provides updates on major initiatives, and highlights cross-systems collaboration. These are challenging times because of the impact of the worldwide economic crisis on the State's fiscal picture. Despite the daunting fiscal challenges the addiction system faces, OASAS, counties, and providers will continue to work together to deliver essential prevention, treatment, and recovery services to individuals, families, and communities.

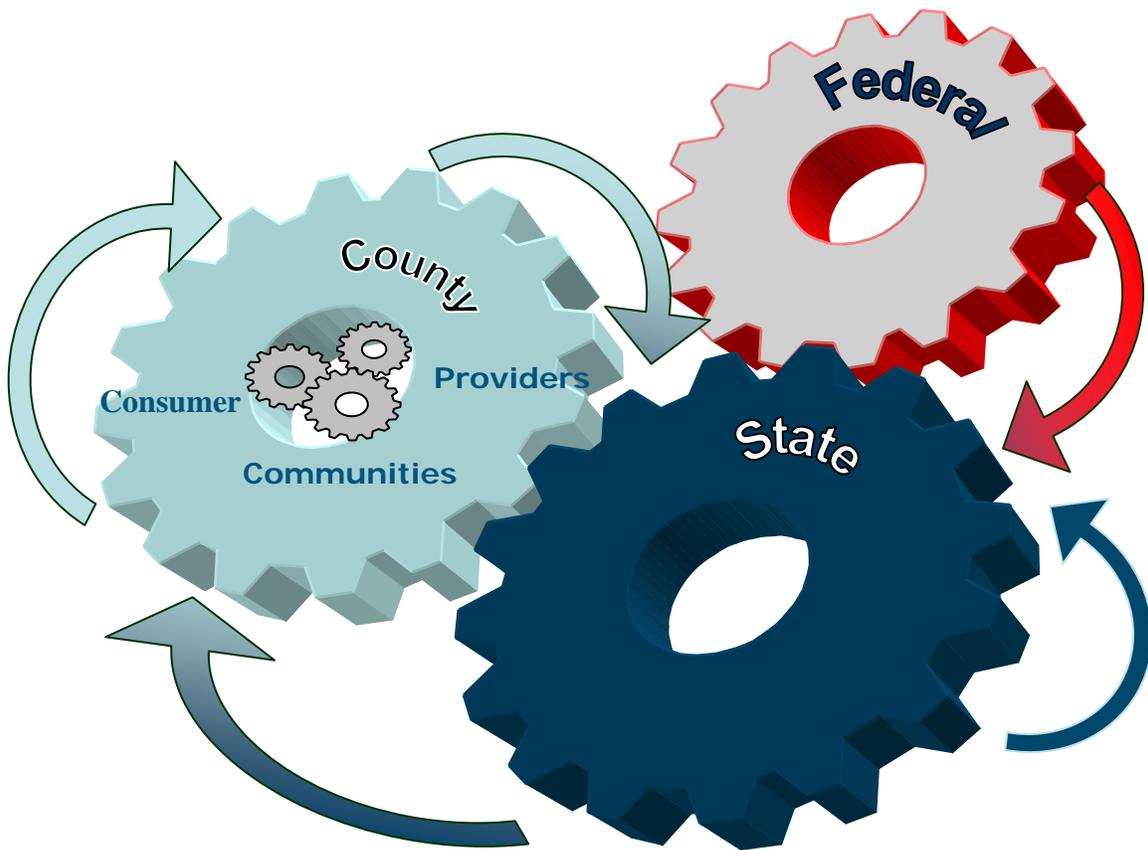
OASAS' top priorities are:

- Implementing a significant expansion of the addiction treatment system to support Rockefeller Drug Law reforms;
- Developing and implementing a new outpatient reimbursement methodology - Ambulatory Patient Groups (APGs) – which will support the delivery of individualized, patient-centered care.

Although planning documents are produced and released on regular cycles, as set by Mental Hygiene Law, OASAS views planning as a year-round process that informs policy development, budgeting, and the development and delivery of services at the State, local, and provider levels. Our collaborative planning efforts with counties, providers, State, and federal agencies will guide future efforts and have the flexibility to respond to changing conditions. OASAS seeks feedback on the use and usefulness of the Strategic Plan. To provide feedback on the Plan, please e-mail 5YearPlan@oasas.state.ny.us.

Acronyms are identified the first time they are used in this Plan. Readers may also consult the definition of acronyms in the Appendix of this document.

Figure 1.1: OASAS Planning Framework



Planning Principles and Purposes

OASAS uses the following principles to guide its planning efforts:

- Planning is an ongoing process that informs policy development, budgeting, and the delivery of services;
- Planning produces documents and reports that are useful and used by stakeholders and customers;
- Planning focuses on desired system and individual outcomes;
- Planning has “buy in” from all key customers including OASAS leaders and staff, other State agencies, counties, providers, patients/participants, and other stakeholders;
- Planning engages stakeholders in meaningful ways at all levels: federal, State, county, and community.

Usefulness

An overarching principle of the planning process OASAS undertakes and the documents it produces is that stakeholders and customers find them useful and apply them in their work. It is one of our objectives that OASAS, counties, providers, and other stakeholders use planning to enhance their particular efforts to monitor and improve performance. Through integrating long-range planning, local services planning, budgeting, and outcomes management, stakeholders will see a demonstrable application of their participation and efforts. OASAS will use the plan to monitor and publicize progress on the agency dashboard. Customers will benefit from the increased transparency related to the functioning of OASAS and the service delivery system.

The Strategic Plan is designed to:

- Inform stakeholders of OASAS directions and destinations;
- Enable counties and providers to develop initiatives and programs that are aligned with OASAS directions and destinations;
- Inspire innovation and change at all levels of the addiction service system;
- Encourage collaboration with other service systems;
- Facilitate program and policy changes and improvements.

Outcomes

OASAS oversees one of the largest addiction services systems in the nation. The agency recognizes how critically important these services are to clients/participants, their families, and communities. One of OASAS’ overarching goals is to ensure that New York has the nation’s premier and most fiscally responsible system for prevention, treatment, and recovery. The agency developed a Strategic Map to define what it means to be a premier system of addiction services and to identify ways to measure progress towards meeting this goal. The Strategic Map clearly defines where OASAS and the service system are headed by clarifying what success will look like for the addiction field. This map is

especially important in our long-range planning activities because it identifies specific steps the agency will take to achieve the desired outcomes.

Comprehensiveness/Meaningfulness

In this Plan, OASAS continues to more closely align local planning, long-range planning, budgeting, and outcomes management. In collaboration with the Office of Mental Health (OMH) and Office of Mental Retardation and Developmental Disabilities (OMRDD), OASAS adjusted its local planning cycle to better align it with the State's budgeting timelines. The 2010 local services planning process for mental hygiene services was the second year that all three New York State Department of Mental Hygiene (DMH) agencies—OASAS, OMH and OMRDD—engaged in a collaborative approach to planning. This approach has provided a consistent and efficient foundation for developing solutions to local priority issues and a timetable that better aligns with State long-range planning and budgeting timelines.

This continuing commitment by the three agencies to integrated planning supports a human services system that puts the needs of individuals, rather than institutions or organizations, at the forefront. This person-centered philosophy serves as the underpinning for high-quality, individualized services for New Yorkers and their families. It is the cornerstone to improved outcomes for individuals with multiple needs by addressing the way supports and services are delivered across systems. This planning approach builds upon two major initiatives:

- The Governor's "People First" Coordinated Care Listening Forums, held in the spring and summer of 2007;
- The work of the reinvigorated Inter-Office Coordinating Council (IOCC).

Releasing the *2010 Local Services Plan Guidelines for Mental Hygiene Services* on March 3, 2009 allowed OASAS to use information submitted in the county plans in developing this Strategic Plan and the agency's 2010-2011 Budget Request. OASAS included the County Funding Priorities Form in the Guidelines to improve local input in the development of the OASAS Budget Request and to enable counties to better articulate their most significant local funding priorities.

Collaboration

OASAS believes that collaboration is necessary to ensure that individuals receive the services they need to become healthy and productive members of society. There is a clear linkage between addictive disorders and other social issues including mental and other health disorders, crime, unemployment, child abuse and neglect, homelessness, and educational deficiencies. Effective prevention, treatment, and recovery results in improved health and social outcomes as well as substantial cost savings in related

program areas. In recent years, OASAS has embarked upon various collaborative efforts at the federal, State, and local levels. A major focus is the improved collaboration among the three DMH agencies to meet the unique and varied needs of individuals and families. OASAS also recognizes that counties and providers have engaged in many innovative collaborative projects. Some of these have occurred with the support and involvement of the agency while others have resulted from the initiative of counties and providers. OASAS will continue to encourage and support such local collaborations.

Public Input

A significant amount of public input assisted OASAS in shaping this Plan including:

- Feedback from consumers, family members, providers, community members, and local government representatives during and after the “People First Coordinated Care Listening Forums”;
- Information that counties and providers submitted through the local planning process;
- Comments from counties, providers, and constituency and stakeholder groups during the four Planning Dialogues conducted by Commissioner Carpenter-Palumbo;
- Comments submitted by e-mail to 5YearPlan@oasas.state.ny.us.

People First Coordinated Care Listening Forums

The foundation of OASAS planning efforts is the public input gathered during the “People First Coordinated Care Listening Forums,” held across the State in five locations during the spring and summer of 2007 by the commissioners of the Department of Health (DOH), OMH, OMRDD, and OASAS. The forums provided an opportunity for individuals and their caregivers, to describe their needs and issues in navigating State and local service systems. Over 2,200 consumers, family members, providers, community members, and local government representatives attended one or more of the forums.

People and their families reported experiencing a host of issues in trying to obtain quality health and mental hygiene services. Attendees at the forums identified the greatest opportunities for improvement in:

- Accessing services and supports;
- Receiving quality, coordinated services and supports from a competent workforce;
- Overcoming service barriers created by the systems themselves.

A report summarizing the major concerns raised at the forums was submitted to the Governor and published in October 2007. The report outlined steps the commissioners

were taking in response to those concerns and set forth recommendations for improving and coordinating support for people who have needs that require support from more than one system. The “People First Coordinated Care Listening Forums” Report is available at: <http://www.oasas.state.ny.us/pio/forums/documents/PeopleFirstRpt.pdf>.

In August 2008, the four agencies published a report that summarized progress on implementing the recommendations from the “People First Coordinated Care Listening Forums.” The People First Progress Report is available at: <http://www.oasas.state.ny.us/pio/forums/documents/PeopleFirstRpt0808.pdf>.

Local Planning

The importance of an inclusive and collaborative local planning process that involves all key stakeholders cannot be overstated. The information received through the annual local services planning process assists OASAS in identifying emerging issues as well as local and statewide priorities, service gaps, and barriers. It informs the agency’s long-range planning, policy development, budgeting, program improvement, and outcome management efforts. This year, there was 98 percent compliance by counties in submitting their local plans and 95 percent by providers.

Planning Dialogues

Commissioner Carpenter-Palumbo held four planning dialogues to offer people in recovery, counties, providers, and constituency and stakeholder groups the opportunity to make comments and ask questions about planning and service system issues. Dialogues were held in Syracuse, Albany, and New York City (two). The Albany event was webcast to offer stakeholders who could not attend an opportunity to participate in the discussion. Dialogue participants asked questions of and shared concerns with Commissioner Carpenter-Palumbo and key OASAS staff. Over 70 people attended the dialogue in Syracuse, nearly 50 attended in Albany, and over 150 participated during the two New York City sessions.

Comments and questions from dialogue participants focused on a wide variety of topics, however, many of the concerns related to one of several common themes: talent management, cross-systems collaboration, special populations, cultural competency, housing, mandated treatment, problem gambling, and training for counselors and support staff.

In the area of talent management, participating providers expressed gratitude for the low-cost and no-cost talent management tools and resources that OASAS provides for the field, but expressed a continuing concern that low wages make it difficult to recruit, reward, and retain qualified staff. Other talent management related concerns centered on credentialing including reciprocity issues for Credentialed Alcoholism and Substance Abuse Counselors (CASACs) and creating more specified prevention credentials in order

to increase professionalization of the prevention field. OASAS' initiatives, accomplishments, and priorities in the area of talent management are described in greater detail in Chapter IV (metrics 10, 11, and 12) and Chapter V (Metric 9).

Dialogue participants also expressed their concerns about cross-systems issues. Specifically, many providers sought increased attention for people with co-occurring mental health and addiction disorders, whose needs can stretch across multiple public systems. Additionally, some providers shared problems they have encountered working with local human service agencies and other systems that do not understand the complex needs of people with addiction disorders. Information on OASAS' work to address cross-systems issues can be found in Chapter IV (Metric 9) and Chapter V (Metric 7).

The need for OASAS support for special populations was also a common theme that emerged from the planning dialogues. Adolescents, senior citizens, veterans, people suffering from Traumatic Brain Injury (TBI), the Lesbian, Gay, Bisexual and Transgender (LGBT) community, Native Americans, women with children, Asian Americans, and Hispanics are populations that dialogue participants mentioned as needing specialized addiction services. Senior citizens, for example, are a growing population whose demand for services tailored to their needs will likely increase substantially over the next few years. More details about some of the special populations the addiction system serves are found in Appendix II: *Special Population Facts*.

While New York State's addiction system serves many distinct special populations, OASAS believes that every person served in prevention, treatment, or recovery is special and should receive high quality, individualized, and culturally competent services. Several providers attending the dialogues stressed the need for culturally appropriate services for consumers and cultural competency training for staff. OASAS offers training courses in cultural competency and is eager to work with providers to encourage better utilization of these training opportunities. A complete list of free training opportunities is available on the OASAS website at <http://www.oasas.state.ny.us/training/courses.cfm>.

Another area mentioned by multiple dialogue participants is the critical need for safe and affordable housing. Stable, permanent housing is a critical component of recovery from addiction. Providers expressed concern about the difficulties people in recovery have finding places to live once they complete treatment. Lack of access to permanent housing can affect a person's employment prospects and overall recovery. Several providers recommended that OASAS partner with other State agencies in acquiring and sharing affordable housing resources. Details about OASAS initiatives to provide housing to individuals in recovery can be found in Chapter IV (Metric 2) and Chapter V (Metric 3).

Planning dialogue participants also discussed the need for a law that mandates emergency addiction treatment, citing the existence of these laws in other States such as Florida and Massachusetts. Mandated treatment statutes allow authorities to compel individuals to enter treatment when their addiction makes them a threat to themselves.

One specific example of a mandated treatment law that a planning dialogue participant mentioned is Florida's Marchman Act. The Marchman Act, passed in 1993, allows friends and family members of someone suffering from addiction to get a court order to allow for that individual's involuntarily admittance to treatment.

Problem gambling was mentioned by multiple dialogue participants as an issue of growing concern, especially with increases in legal gambling opportunities. Of particular concern to gambling prevention and treatment providers is the gaming industry's targeting of adolescents and young adults through advertisements and promotions. Senior citizens suffering from problem gambling were an additional source of concern expressed by dialogue participants. OASAS' problem gambling epidemiological, prevention, and treatment efforts are discussed in various parts of this Plan. These include implementing the OASAS Hopeline, a media campaign, and integrating problem gambling prevention into the OASAS Strategic Prevention Plan and the new prevention guidelines.

Five-Year Plan E-Mail

In 2008, OASAS created an e-mail address 5YearPlan@oasas.state.ny.us to receive questions and comments from stakeholders on planning and service system issues.

Planning Initiatives

ACTION

On April 15, 2009, Governor David A. Paterson issued Executive Order No. 16, creating the Addictions Collaborative to Improve Outcomes for New Yorkers (ACTION). The ACTION initiative directs the partnership of State agencies with nonprofits and the private sector and coordinates addiction resources in the areas of public health, safety, welfare, and education. ACTION is designed to address alcohol, drug, and gambling addictions that affect nearly 2.5 million New Yorkers. The ACTION Council is coordinated by OASAS and includes the commissioners of 20 State agencies. The ACTION Council is building upon the recently enacted Rockefeller Drug Law reforms, which emphasize treatment over incarceration for non-violent drug offenders. On July 10, 2009, the ACTION Council held its first meeting at the Edgecombe Residential Treatment Program, a facility that is jointly operated by OASAS, Department of Correctional Services (DOCS), and Division of Parole (DOP).

Inter-Office Coordinating Council

The IOCC is a statutorily created body under Section 5.05(b) of State Mental Hygiene Law. Pursuant to this section, the IOCC was created as a result of the breakup of the Department of Mental Hygiene into three separate offices in the 1970s. The IOCC, which had long been dormant, was reinvigorated in 2007 when OMH Commissioner Michael

Hogan, OMRDD Commissioner Diana Jones Ritter, and OASAS Commissioner Karen Carpenter-Palumbo began meeting regularly. The IOCC aims to eliminate barriers to accessing care and to improve coordination of services for people with disabilities, particularly with respect to those issues that involve multiple agencies.

The reinvigoration of the IOCC followed the *People First Coordinated Care Listening Forums* that were held across the State in five locations during the spring and summer of 2007. During the forums, Commissioners Hogan, Ritter, and Carpenter-Palumbo, together with DOH Commissioner Richard Daines, provided consumers and other stakeholders in the health and mental hygiene service systems with the opportunity to share their concerns and make recommendations to help improve the quality of services and make appropriate services more readily accessible.

In 2007, the IOCC commissioners added DOH, Office of Children and Family Services (OCFS), State Education Department (SED), and the Developmental Disabilities Planning Council (DDPC) as ad hoc members. Representatives of these agencies attend all IOCC meetings and fully participate in the policy deliberations.

The IOCC meets quarterly. Agenda and meeting minutes can be found at <http://www.oasas.state.ny.us/pio/collaborate/IOCC/index.cfm>. As required by Chapter 294 of the Laws of 2007, the IOCC submits an annual report on its activities to the Governor and Legislature. The 2007 and 2008 reports are available at: <http://www.oasas.state.ny.us/pio/collaborate/IOCC/document/IOCCAnnualReport2008.pdf>. The next annual report is due December 31, 2009.

Communities of Solution

Communities of Solution (CoS) is a framework for collaborating with counties, providers, consumers, and community partners as they assess the needs, concerns, and opportunities within their communities. The CoS model builds upon the local government planning process to increase access, improve program quality, increase positive consumer outcomes, and improve efficiencies in communities statewide. County data, community feedback, and consumer experience guide CoS initiatives.

The CoS initiative aims to:

- Maximize community involvement and ownership of addiction issues;
- Increase the community's capacity for jointly reaching the goals of preventing addiction and increasing recovery;
- Provide an opportunity to utilize existing resources differently, while operating within the current law and maintaining core services.

To facilitate CoS discussions, OASAS provided counties with a Summary County Profile and Statewide Maps. County and provider staff can access these on the county data page of the Online County Planning System (CPS) at <http://cps.oasas.state.ny.us/cps>. The Summary County Profile includes more than 50 different county level metrics from OASAS databases, as well as statewide comparisons for each. Some of the metrics provided include: treatment prevalence; treatment demand estimate; unmet demand; key demographic descriptors: paid Chemical Dependency Medicaid claim dollars; and county residents served. The Statewide Maps provide up-to-date county by county comparisons on selected measures in the areas of prevalence and service demand, services inventory, dollars spent, treatment and prevention performance measures, etc.

OASAS is reaching out to counties to encourage a collaborative approach by sharing the information with community stakeholders. The stakeholders consider an area to focus on (access, quality/outcomes, and efficiency) and submit a letter of interest to their OASAS Field Office representative following the CoS guidelines.

The World Café is a model that engages and empowers multiple consumers and stakeholders to generate ideas, identify priorities, and create strategies that will close the gap between the current reality and a desired vision or outcome. This methodology enhances the capacity for collaborative thinking about critical issues by linking small group and large group conversations. In order to initiate the CoS framework, OASAS held six “[World Café](#)” meetings with representatives of local communities; county and other State government agencies; service providers; and consumers of prevention, treatment, and recovery services. OASAS uses World Café events to stimulate innovative thinking as well as to capture ideas that will improve the addiction system of services - prevention, treatment, and recovery.

Community of Practice for Local Planners

The Community of Practice for Local Planners (CPLP) is a subcommittee of the IOCC’s Mental Hygiene Planning Committee. This county-led group of local Mental Hygiene planners is organized around common interests, activities, and needs. OASAS, OMH, and OMRDD support the CPLP by providing data resources for planning and by designating a section in CPS dedicated to CPLP activities. The CPLP gives counties access to data tools and supports, so that they can collaborate in developing local services plans. By participating in the CPLP, counties will be able to provide OASAS with addiction prevention, treatment, and recovery plans that better reflect local priorities and needs. This will enhance OASAS’ ability to develop statewide strategies and services that address local concerns.

Chapter II: System Overview

As overseer of one of the nation's largest addiction systems, OASAS provides a full continuum of services to a large and diverse population with 1,550 certified or funded providers delivering prevention, treatment, and recovery services throughout the State. Approximately 35,000 paid and volunteer addiction professionals serve 110,000 individuals a day. Treatment services are provided in inpatient, outpatient, and residential settings. In addition, OASAS operates 12 Addiction Treatment Centers (ATCs). New York State's service continuum also includes school and community-based prevention services and intervention, support, and recovery services.

OASAS, counties, and providers collect and analyze a great deal of information, which informs all aspects of service delivery. These data support policy development, planning, funding decisions, and performance monitoring. As OASAS moves to an outcomes management approach and adopts evidence-based programs and practices to achieve the best possible outcomes, the use of data becomes even more critical to the provision of high quality services.

The following chapter provides information on the nature and extent of the alcohol, other drug, and gambling problems in New York State. It also presents information on the size of the OASAS system, services delivered, demographics of the people served, and special populations, which have been a focus of programming efforts.

National Outcome Measures

The federal Substance Abuse and Mental Health Services Administration (SAMHSA) developed National Outcome Measures (NOMs) in collaboration with States in order to demonstrate and improve the effectiveness of the Substance Abuse Prevention and Treatment (SAPT) Block Grant and the corresponding Center for Mental Health Services (CMHS) Block Grant, as well as discretionary grant programs. The SAPT Block Grant provides \$115.5 million annually to prevention, treatment, and recovery services in New York.

The ten NOMs domains cut across mental health, substance use treatment, and substance abuse prevention services: reduced morbidity (e.g., abstinence); increased employment and education; decreased criminal justice involvement; stability in housing; social connectedness; access and capacity; retention in care; perception of care; cost effectiveness; and use of evidence-based practices. These domains are intended to represent "meaningful, real life outcomes for people who are striving to attain and sustain recovery; build resilience; and live, work, learn, and participate fully in their communities." For a broad description of NOMs you may access SAMHSA's website at <http://www.nationaloutcomemeasures.samhsa.gov/>.

For treatment services, many of the NOMs use before-and-after measures, specifically, changes in status from admission to discharge. While this may not be a strong design from a research perspective (e.g., no control group), it is an excellent design for managing outcomes and improving performance. In order to implement this measurement design, SAMHSA required states to enhance reporting of client admission and discharge data to the federal Treatment Episode Data Set (TEDS). OASAS began implementing new data items based on NOMs requirements in 2006 and will continue as necessary to augment its Client Data System (CDS). At the same time, OASAS continues to participate in SAMHSA’s technical consultation groups (TCGs) and the Performance Data Work Group of the National Association of State Alcohol and Drug Abuse Directors (NASADAD). OASAS’ purpose is to minimize the reporting burden on service providers while assuring that the NOMs measures developed are useful for performance management at the federal, State, county, and provider levels.

Table 2.1 presents statewide outcomes for chemical dependence treatment in four of the ten domains. In the table, “net improvement” (in the last column) is the percentage point difference between the before and after rates; SAMHSA refers to this as “absolute” change. While NOMs reported to SAMHSA are limited to outcomes for funded programs and exclude methadone treatment services, the statistics reported here include all non-crisis treatment services regardless of funding. Thus the NOMs in Table 2.1 represent outcomes for the entire certified treatment system.

Table 2.1 National Outcome Measures (NOMs) for Non-crisis Chemical Dependence Treatment Services* Based on Persons Discharged in Calendar 2008 ***

National Outcome Measure	At Admission	At Discharge	Net** Improvement
Abstinence in Past 30 Days			
From Alcohol	61.1%	85.7%	24.7%
From Other Drugs	47.5%	75.9%	28.4%
From Alcohol and Other Drugs	32.0%	70.0%	38.0%
Employed or Enrolled in School	31.5%	37.9%	6.5%
Stable Living Situation#	88.8%	91.7%	2.9%
Not Arrested in Past 6 months	75.0%	86.5%	11.5%

* These figures include non-crisis outpatient services, inpatient rehabilitation, residential and methadone services

** Net improvement is simply the percentage point difference between the admission and discharge measures.

*** Total discharges with valid data (the denominator) varies by measure: 210,662 for abstinence measures, 202,828 for employment/enrollment, 202,734 for living situation, and 211,247 for arrest.

Stable living situation includes congregate care residences, but excludes homeless shelters and unsheltered situations.

- Abstinence is measured as frequency of use in the past 30 days (i.e., zero frequency). SAMHSA measures abstinence separately for alcohol and other drugs while OASAS includes abstinence from alcohol and other drugs

combined. *Alcohol and Other Drugs* – Among persons discharged in 2008 from non-crisis treatment services, 32 percent had used neither alcohol nor drugs in the 30 days prior to admission while 70 percent had used neither alcohol nor drugs in the 30 days prior to discharge. Thus abstinence from alcohol and drugs *increased by 38 percentage points*, meaning that 80,000 more persons were alcohol and drug abstinent at discharge than at admission. *Alcohol* – Among persons discharged in 2008 from non-crisis treatment services, 61 percent had not used alcohol in the 30 days prior to admission while 86 percent were not using alcohol in the 30 days prior to discharge. Abstinence from alcohol *increased by 25 percentage points*, meaning that 52,000 more persons were alcohol abstinent at discharge than at admission. *Other Drugs* – Correspondingly, 48 percent of persons discharged had not used other drugs in the 30 days prior to admission while 76 percent were not using other drugs in the 30 days prior to discharge. Abstinence from other drugs *increased 28 percentage points*, meaning that 60,000 more persons were abstinent from other drugs at discharge than at admission.

- **Employment and Education** – Among persons discharged in 2008 from non-crisis treatment services, 32 percent had been employed or enrolled in school at admission while 38 percent were employed or enrolled at discharge. This *increase of six percentage points* means that 13,000 more persons were employed or enrolled at discharge than at admission.
- **Stability in Housing** – Among persons discharged in 2008 from non-crisis treatment services, 89 percent had been in a stable housing situation at admission while 92 percent were in a stable housing situation at discharge. This *increase of three percentage points* in stable housing situation means that 6,000 fewer persons were homeless at discharge than at admission.
- **Criminal Justice Involvement** – Among persons discharged in 2008 from non-crisis treatment services, 75 percent had not been arrested in the 6 months prior to admission while 87 percent had not been arrested in the 6 months prior to discharge. This *increase of 12 percentage points* means that 24,000 fewer persons were arrested in the 6 months prior to discharge than had been arrested prior to admission.

Regarding other NOMs for treatment services, New York treatment providers have started reporting self-help group participation (the social connectedness domain) at admission in addition to at discharge (which was already being collected). OASAS has collected data on the adoption of evidence-based practices through participation of treatment providers in the annual online County Planning System surveys in the Local Planning Guidelines. More limited data on the adoption of evidence-based practices will

be collected by SAMHSA's annual survey of providers. Access/capacity and retention indicators need further testing. SAMHSA may in the future require States to conduct annual client perception of care surveys. Cost-effectiveness measures are still under development.

For prevention NOMs, the first five domains are population-based and epidemiological in nature. Data for these indicators are taken from surveys or collected from administrative sources. Indicators are presented in OASAS' annual State and Regional Epidemiological Profile. Data for access/capacity, retention and use of evidence-based practices is collected in the Prevention Activities and Results Information System (PARIS). Cost-effectiveness measures are under development.

Moving forward, OASAS will continue to analyze and review NOMs and other performance indicators at the State and regional levels to identify trends and develop policies and programs for improving the health and well-being of New Yorkers as well as supporting the recovery of individuals who have experienced substance use disorders. OASAS will continue to enlist counties in performance improvement efforts. In collaboration with the Conference of Local Mental Hygiene Directors (CLMHD), OASAS developed comprehensive county profiles, which include NOMs and other outcomes measures for both prevention and treatment services.

As New York's systems evolve and improve, NOMs are being integrated as appropriate. In most cases, improved performance on the Integrated Program Monitoring and Evaluation System (IPMES)/Workscope Objective Attainment System (WOAS) indicators translates directly into improvement on NOMs indicators. OASAS will not superimpose a new performance monitoring system on top of IPMES/WOAS, but rather will integrate these systems over time.

2009 State and Regional Epidemiological Profile

As part of its epidemiological and needs assessment efforts, and in conjunction with its partners, OASAS has developed a State and Regional Epidemiological Profile. It consists principally of indicators intended to measure the extent of alcohol, other substance, and gambling-related problems. The Profile is published annually to monitor trends and includes the NOMs for prevention services as specified by SAMHSA.

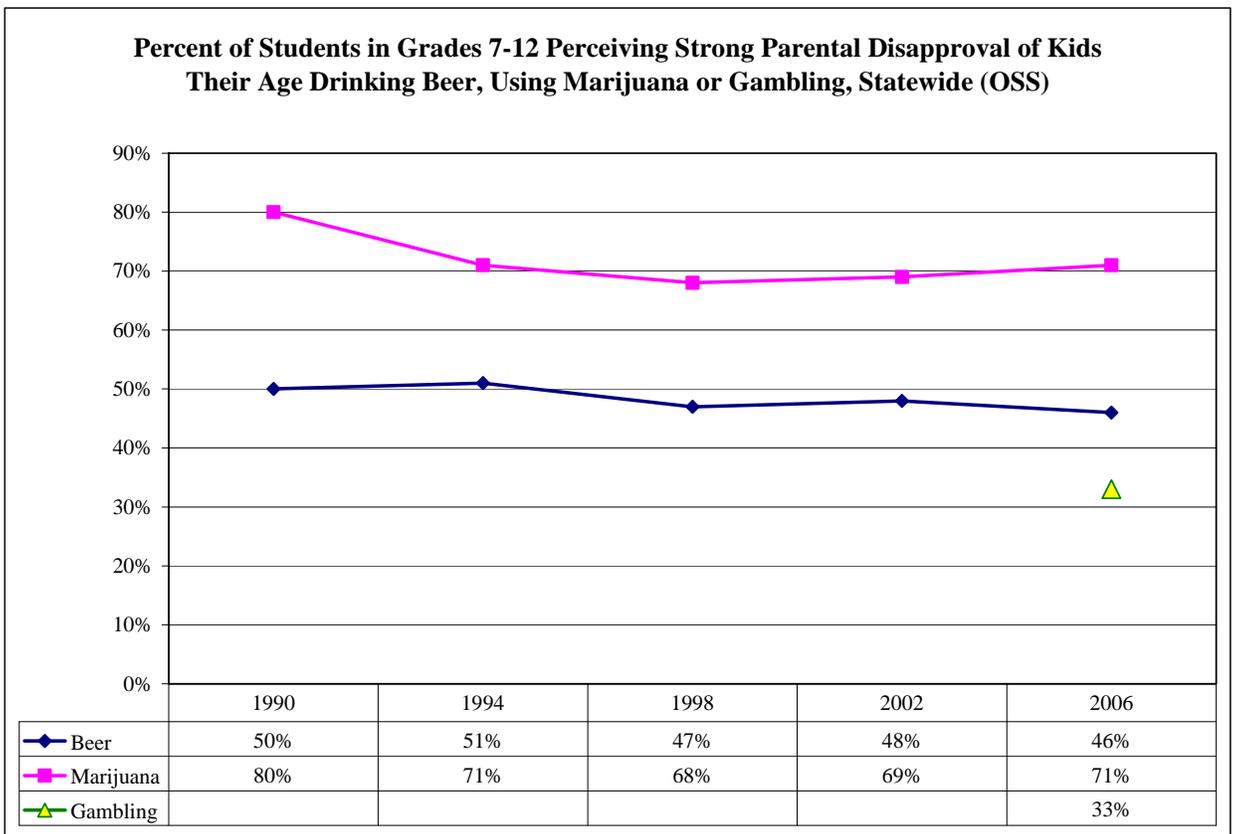
The 2009 Profile documents trends in risk and protective factors, substance use and problems, and resulting negative consequences. For many indicators, the Profile presents data for four epidemiological regions: New York City, New York City Metropolitan Suburban, Upstate Metropolitan, and Rural regions. (Some indicators are only available for New York City and "Rest of State.") In many cases there are substantial differences among regions. The following are highlights from the Profile.

A. Risk and Protective Factors

1. *Change parental behavior to discourage inappropriate and illegal substance use and gambling behavior.*

The 2006 OASAS School Survey indicates that almost three-quarters of students in grades 7-12 *perceive strong parental disapproval* of kids their age smoking marijuana while slightly less than half perceive strong parental disapproval of drinking beer and one-third perceive strong parental disapproval of gambling. Since 1994, there has been no change in students' perception of parental disapproval regarding smoking marijuana; however, over this 12-year period there appears to be a slight downward trend in perceived parental disapproval regarding drinking beer, indicating increasing risk for adolescents. (Trend information is not available for gambling.)

Figure 2.1



Data Source: NYS Office of Alcoholism and Substance Abuse Services School Surveys (OSS).

2. *Change social norms and perceptions to discourage inappropriate and illegal substance use and gambling behavior Change parental behavior to discourage inappropriate and illegal substance use and gambling behavior.*

National Survey on Drug Use and Health (NSDUH) statistics for the nation as a whole in 2005-06 indicate that less than one-third of young adults (ages 18-25) perceive great risk from *binge drinking once or twice a week* while almost one-half of older adults (age 26

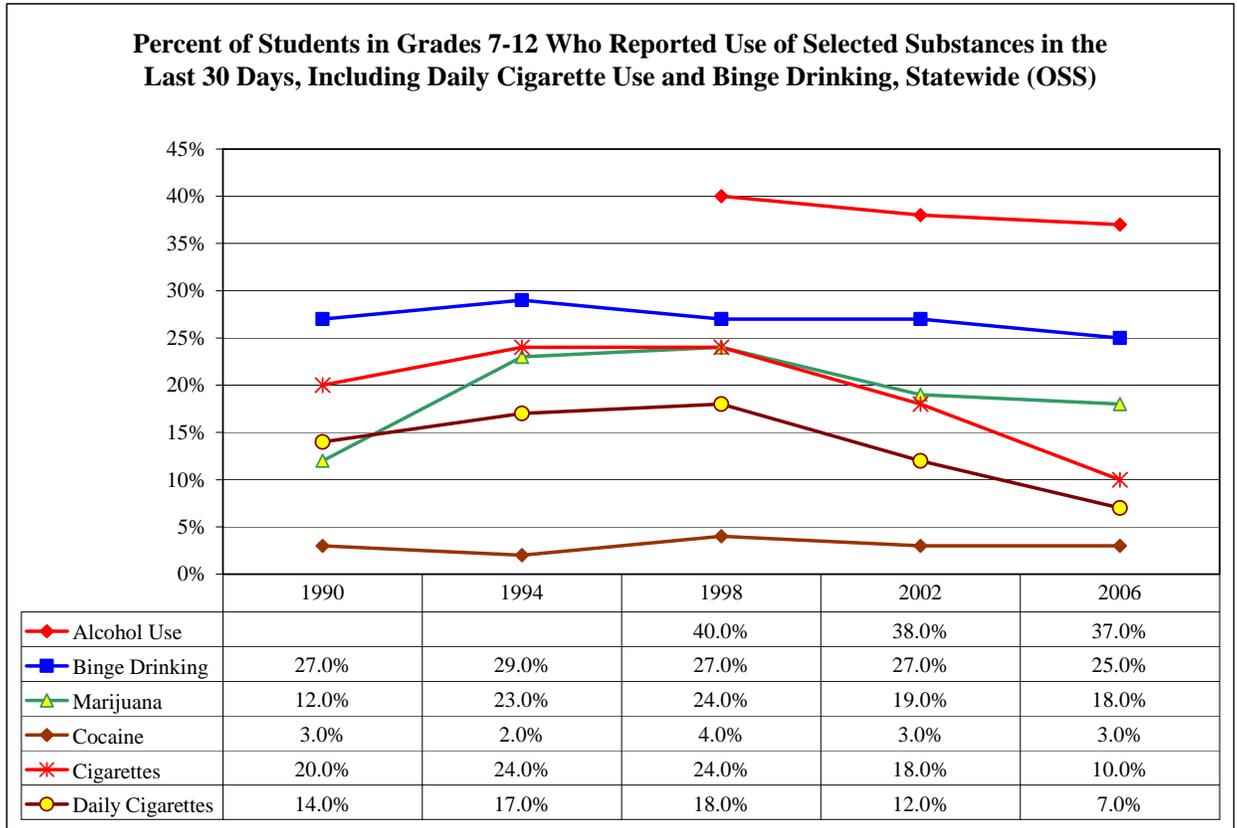
and older) perceive great risk from this level of drinking. Less than one-quarter of young adults (ages 18-25) perceive great risk from *smoking marijuana once a month* while over 40 percent of older adults (age 26 and older) perceive great risk from this level of marijuana use. Close to three-quarters of young adults (ages 18-25) perceive great risk from smoking one or more packs of cigarettes a day while four-in-five older adults (age 26 and older) perceive great risk from smoking one or more packs of cigarettes a day. NSDUH provides short-term trend data from 2002-03 to 2005-06. There were no significant changes in perception of risk among young or older adults during this period, although perception of risk from smoking one or more packs of cigarettes a day appears to be increasing.

B. Substance Use and Gambling Behavior

1. *Reduce the prevalence of substance use in the general population.*

A number of surveys in New York and nationally show a general decline in substance use among adolescents since the late 1990s. The OASAS School Survey of students in grades 7-12 indicates that between 1998 and 2006 current cigarette use (use in the last 30 days) declined by over one-half while current marijuana use declined by one-quarter. Current alcohol use and binge drinking declined only eight percent. Recent data (2006) indicates that one-in-four junior and senior high school students engaged in binge drinking at least once in the past month, one-in-six used marijuana in the past month, and one-in-ten smoked cigarettes in the past month while seven percent smoked daily. One-in-three students in grades 7-12 engaged in some form of gambling in the past month while ten percent met the OASAS criteria for problem gambling. As in previous surveys, New York City students continue to be less likely to engage in binge drinking, marijuana use, and cigarette smoking compared to students in the rest of the State.

Figure 2.2



Data Source: NYS Office of Alcoholism and Substance Abuse Services School Surveys (OSS).

Consistent data for adults in New York is generally limited to periods from 2002 on and these data do not show any noticeable change in adult use. Substance use among young adults (aged 18-25) is substantially higher than for older adults (age 26 and older). The most recent national data (2005-06) from the NSDUH indicate that a little less than half of young adults engaged in binge drinking in the past month while less than one-quarter of older adults did so. One-in-five young adults used marijuana in the past month compared to one-in-twenty older adults. Eight percent of young adults used illicit drugs other than marijuana in the past month compared to three percent of older adults. While two-fifths of young adults smoked cigarettes in the past month, one-quarter of older adults smoked cigarettes in the past month. Analysis based on New York's four epidemiological regions indicates that on average New York City adults are less likely to engage in binge drinking in the past month than adults in other regions. Residents of the Upstate Metropolitan and Rural New York regions are more likely to smoke cigarettes in the past month compared to residents of New York City or the NY Metro Suburban region. No significant difference was found among epidemiological regions in the rate of adults using marijuana or "illicit drugs other than marijuana" in the past month.

2. Delay the initiation of substance use among adolescents and young adults.

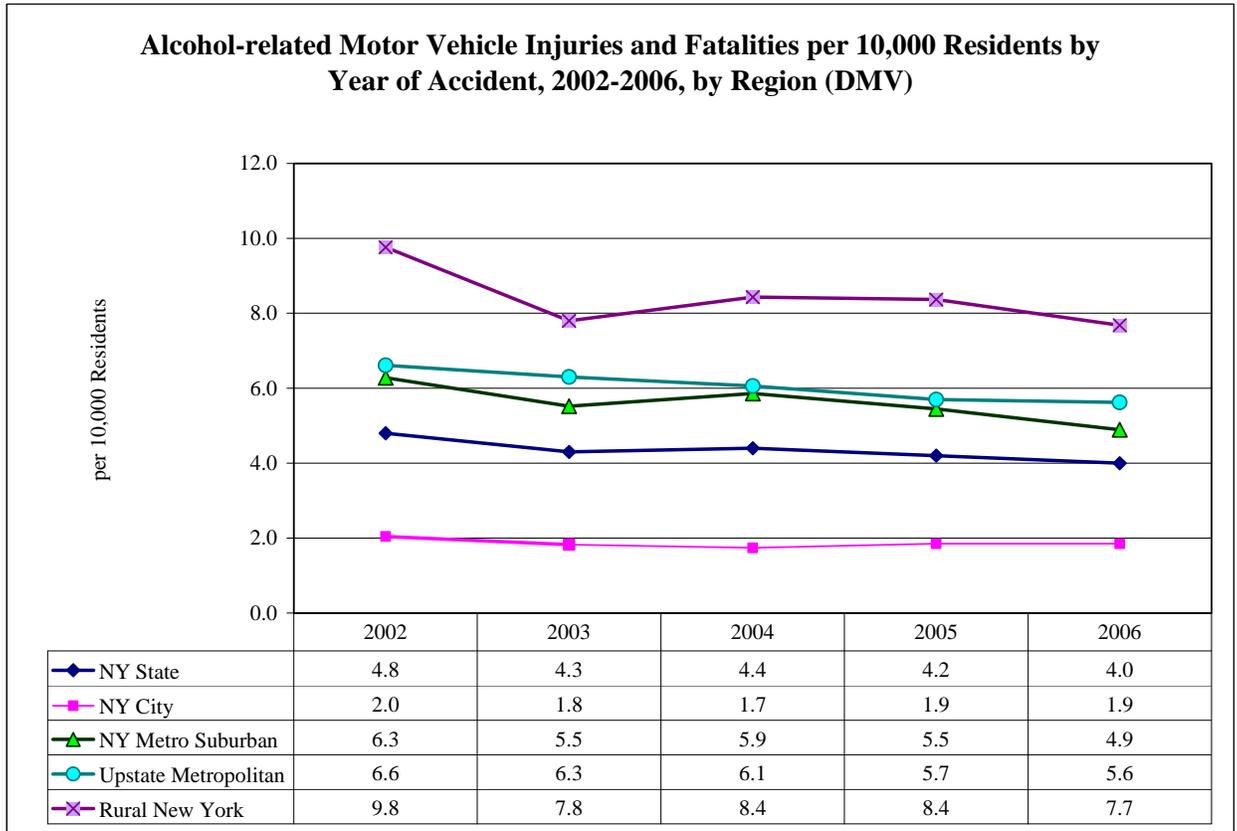
The decline in current use of substances among adolescents has been matched with a decrease in the proportion of students who used a substance before age 15. Based on the OASAS School Survey, between 1998 and 2006, the proportion of students in high school who smoked cigarettes before age 15 decreased by over 40 percent while the proportion who used marijuana before age 15 decreased by one-quarter and the proportion who used alcohol before age 15 decreased by about nine percent. The most recent statistics (2006) indicate that 59 percent of students in grades 9-12 used alcohol before age 15 while 28 percent used cigarettes and 24 percent used marijuana before age 15.

C. Negative Consequences

1. Reduce the prevalence of mortality and morbidity-related negative consequences.

In New York State, 7,548 persons were injured or killed in alcohol-related motor vehicle accidents in 2007, a rate of 3.9 per 10,000 residents (not displayed in Figure 2.3). Among residents of Rural New York, the rate of injury or death in alcohol-related motor vehicle accidents (7.7) is twice the statewide rate while the rate for New York City residents (1.9) is half the statewide rate. It is important to note that from 2002 to 2006 the rate of persons injured and killed in alcohol-related motor vehicle accidents *decreased* by 20 percent.

Figure 2.3



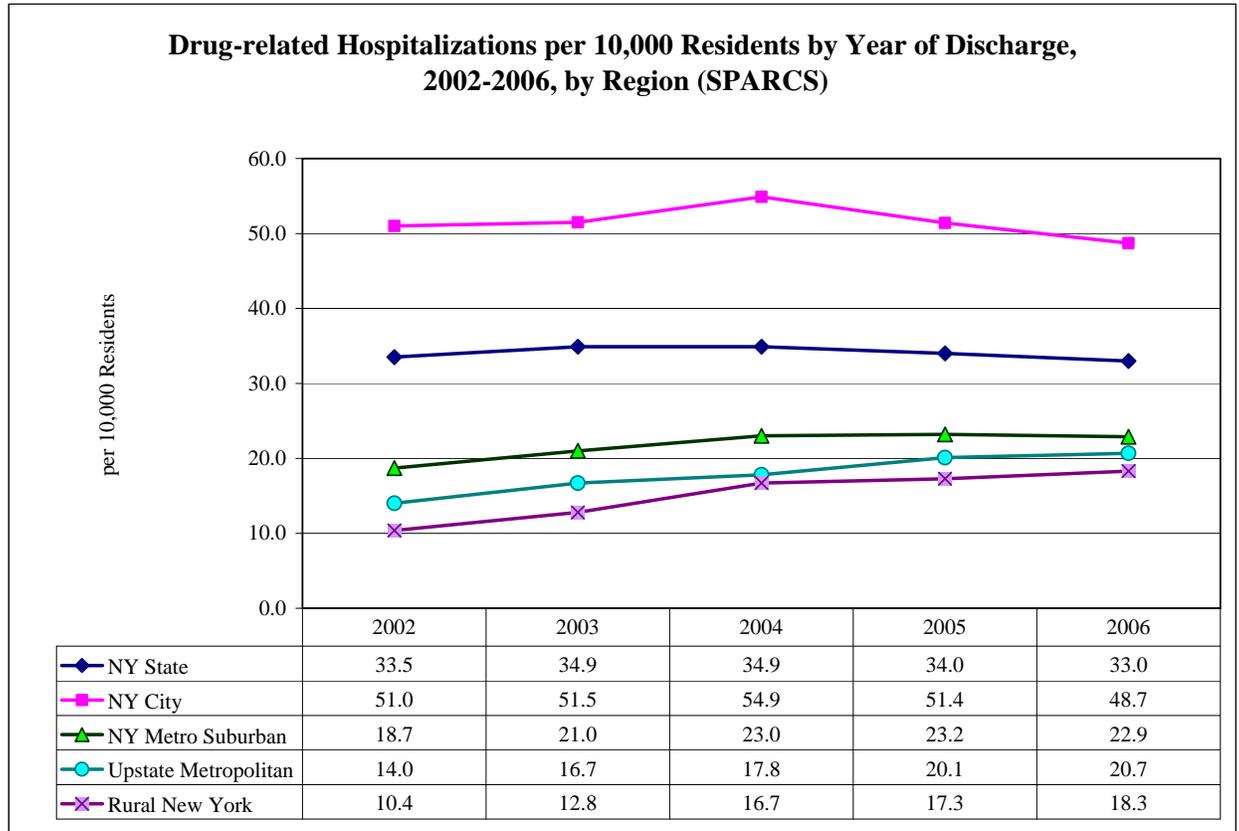
Data Source: NYS Department of Motor Vehicles, NYS Alcohol-Related Accident Data 2002-2006, provided by the NYS DOH, June 2008 (numerator).

<http://www.health.state.ny.us/statistics/chac/general/mvalcohol.htm>

Population estimates from the U.S. Bureau of the Census (denominator).

New York State hospitals recorded 63,723 drug-related hospitalizations in 2006, a rate of 33 per 10,000 residents. From 2002 to 2004, the rate of drug-related hospitalizations *increased* from 33.5 to 34.9 per 10,000 residents; however, since 2004 the rate appears to be *declining*. The drug-related hospitalization rate for New York City residents (48.7) is more than twice the rate in other regions of the state (18.3 – 22.9).

Figure 2.4



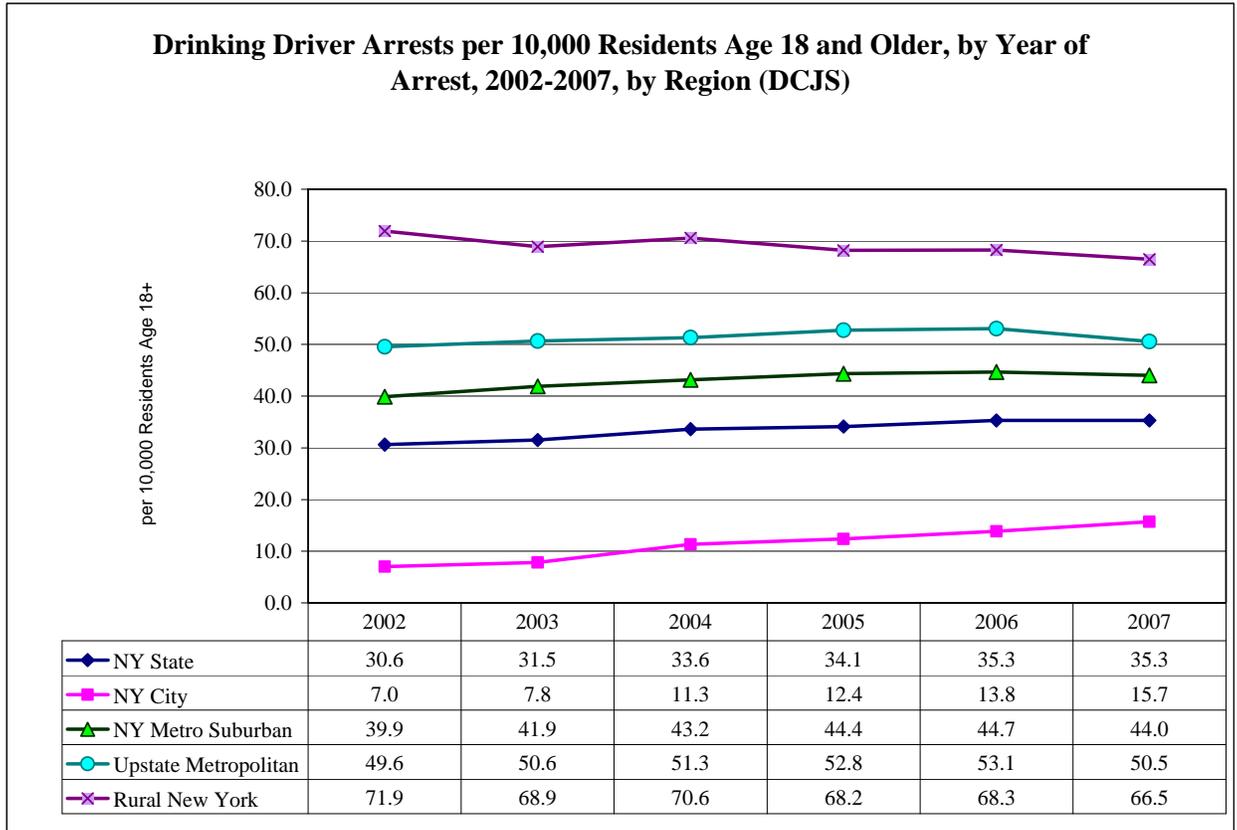
Data Source: NYS Community Health Data Set, 2006. NYS Department of Health, SPARCS (Statewide Planning and Research Cooperative System) data as of March 2008.

<http://www.health.state.ny.us/statistics/chac/hospital/drug.htm>

2. Reduce the prevalence of crime and violence-related negative consequences.

In 2007, law enforcement officials made 52,494 drinking driver arrests in New York State. Since 2001 drinking driver arrest rates have *increased* 16 percent, reaching 35.3 per 10,000 adult residents in 2007. The New York City drinking driver arrest rate doubled since 2002, reaching 15.7 in 2007; however, this is less than half the statewide rate. Although the Rural New York drinking drive arrest rate declined slightly, reaching 66.5, it is still almost double the statewide rate.

Figure 2.5



Data Source: New York State Department of Criminal Justice Services, Computerized Criminal History system as of 02/05/2008 (numerator).

<http://www.criminaljustice.state.ny.us/crimnet/ojsa/arrests/years.htm> Population estimates from the U.S. Bureau of the Census (denominator).

The 2006 OASAS School Survey indicates that one-in-six high school students age 16 and older drove under the influence of alcohol or another drug in the past year. New York City students ages 16 and older were half as likely as students in the rest of the State to have driven under the influence of alcohol or other drugs in the past year (11% vs. 22%). The 2006 OASAS Household Survey indicates that one-in-eight young adults (ages 18-25) drove a vehicle after drinking or using drugs in the past year.

In 2007, there were 145,585 adult arrests for drug offenses in New York State, a rate of 98 arrests per 10,000 adult residents. Between 2000 and 2004, the drug arrest rate decreased by almost one-third, from 115.5 to 79.0 per 10,000 adult residents. Figures for 2005 through 2007 indicate that the drug arrest rates are *increasing* in New York City. The rest of New York State portrays a different trend, with drug arrests *increasing* until 2006, and then *decreasing slightly* in 2007.

The 2006 OASAS School Survey indicates that in the past year more than five percent of students in grades 7-12 physically assaulted someone due to the influence of alcohol or

drugs while a similar number got into trouble with the police due to alcohol or drug use. These rates did not vary significantly between New York City and the rest of the State.

3. Reduce the prevalence of education and employment-related negative consequences.

The 2006 OASAS School Survey also indicates that 20 percent of students in grades 7-12 attended class while intoxicated on alcohol, marijuana, or other drugs in the current school year and four percent of students got into trouble with his or her teachers because of drinking or drug use in the past year. There is no significant difference between New York City and the rest of the State in the percent of students attending class while intoxicated or getting into trouble with teachers due to drinking or drug use.

Youth Development Survey (2008)

Objectives

OASAS conducts the Youth Development Survey (YDS) to support combined efforts to prevent and reduce substance use and problem gambling and improve the State's efforts to promote healthy youth development. In fall 2008, middle and high schools administered the initial baseline survey. OASAS will initiate subsequent surveys on a biannual basis. The survey's objectives are to:

1. Assess risk and protective factors that predict substance use and other problem behaviors such as delinquency;
2. Assess incidence and prevalence of substance use, gambling, and other problem behaviors;
3. Produce data for planning prevention services at the county and school district levels;
4. Produce data for evaluating the population outcomes of prevention services.

Background

The YDS is based on the *Communities That Care Youth Survey*, developed from over two decades of social development research by renowned researchers Dr. J. David Hawkins and Dr. Richard F. Catalano. The survey measures 21 risk and 11 protective factors that predict levels of youth substance use and other problem behaviors such as school drop-outs, delinquency, violence, and teen pregnancy. By measuring levels of risk and protection reported by youth, the YDS identifies the specific risk factors that are elevated and protective factors that are low, so they can be targeted for improvement through effective evidence-based programs and practices.

Survey Methods and Results

Students in grades 7 through 12 took the 2008 YDS using an anonymous, self-administered questionnaire designed to be completed during a single class period. OASAS randomly sampled public and private schools throughout New York State, with the objective of ensuring a representative sample of schools from all counties in the state, including New York City.

Of the 125,000 students sampled to participate in the survey, over 111,000 returned surveys, for an overall response rate of 89 percent. Consistency and validity testing resulted in over 92,000 youth with valid responses. The sample included students enrolled in 409 schools, and provided valid estimates for the State, 23 counties, and the five boroughs of New York City.

Significant findings of the YDS include:

- 49 percent of high school seniors drank alcohol within the past 30 days;
- 31 percent of high school seniors reported binge drinking within the last two weeks;
- 18 percent of high school seniors had abused prescription pain medications;
- 11 percent of all students in grades 7 through 12 reported smoking marijuana within the past 30 days.

The YDS also provided valuable information on statewide Risk and Protection Factors. The survey identified the following noteworthy risk factors:

- Community – Half of New York’s teens (52%) are at-risk for substance use due to crime and drug selling in their neighborhoods;
- School – Forty-six percent of teens are at-risk due to lower academic achievement;
- Family – Forty-nine percent of teens believe that their parents do not think it is wrong for them to engage in behaviors such as stealing and fighting;
- Individual/Peer – Twenty-five percent of teens reported that they began using drugs before age 15, which is a strong risk factor for developing later addictions.

The YDS identified the following key protection factors:

- Community – Two-thirds of teens indicated adults in their neighborhoods disapprove of teen substance use and 59 percent reported that healthy activities are available in their community such as scouting, sports, recreation, and service clubs;
- School – Seventy-nine percent of teens reported having many opportunities for

positive involvement at school, such as individual time with teachers and after-school activities;

- Family – Fifty-three percent of teens were less likely to use substances because they felt rewarded by their parents for good behavior and enjoyed spending more time together;
- Individual/Peer – Sixty-one percent of teens had strong beliefs in what is “right or wrong” and 60 percent were less likely to use drugs due to good social skills.

Use of the Survey Results

The YDS provides an integrated set of reports for the community (school district), county, and State levels, so each community can see how they compare to their county and to the State norms. The report also provides comparisons to a larger normative sample of youth in seven other states for the risk and protection factors. The survey results are not meant to be report cards on school performance, but a reflection of multiple issues that need to be addressed by all members of the community. Monitoring risk and protective factors can guide the State and local communities in developing a package of evidence-based programs and practices that best meets their needs. Measuring the prevalence of youth substance use, gambling, and other adolescent problem behaviors will enable the State and local communities to monitor progress in promoting healthy development for the over 1.5 million New York State youth in grades 7 through 12. Participation in the YDS every two years will provide trend data necessary for monitoring the effectiveness of these efforts.

OASAS will use the survey findings to collaborate with the prevention system in developing a *Strategic Prevention Plan* to guide policy and resource development to reduce the prevalence of substance use and problem gambling. The agency will also share these results with our State partner agencies to coordinate planning for underage drinking, tobacco, school dropout, and violence prevention efforts.

System Facts: Prevention

Prevention Activity and Results Information System (PARIS)

OASAS operates PARIS as the primary data system for funded prevention providers. PARIS is a web-based reporting system that collects and maintains information on prevention activity planning and provider service delivery. There is an annual prevention workplan development and approval process with review at the county and OASAS Field Office levels. Activity data collection templates for the planned services are automatically generated from the approved workplan.

PARIS is an adaptation of a general prevention data system framework developed by KIT Solutions, which operates similar systems for over a dozen states. The KIT framework

offers modules for activity planning, activity data collection, reporting, system administration, and user support within the application. OASAS first made PARIS available to prevention providers in fall 2006 and began collecting activity data in 2007.

A distinguishing feature of PARIS is the emphasis on the Workplan process where each provider conducts an assessment of community needs, describes the population impacted by those concerns, and selects service approaches for a targeted group of at-risk individuals. The OASAS and county review and approval process allows for the coordination of prevention activities on a county and a State basis.

PARIS captures direct service activities reported to OASAS by funded prevention providers and therefore does not encompass all substance use or problem gambling prevention activities in New York State. For example, data is not collected from college prevention providers, coalitions, and OASAS' Regional Prevention Resource Centers. However, OASAS is planning to make modifications to incorporate providers of indirect prevention services such as those of the regional centers and local coalitions.

OASAS provides a Help Desk, training, ad hoc analyses, and ongoing system administration support for prevention program and Field Office staff. PARIS maintains an on-line User Manual as well as a Knowledge Base module with various documentation resources and prevention-related web site links.

Providers deliver prevention services through the following service approaches:

1. Classroom Education Evidence-Based (EB) Programs (or “Model” Programs):

These are primarily school-based classroom education programs, which have been extensively researched and shown to reduce youth substance use. These programs use multi-session curricula to increase family and youth understanding of the consequences of substance use, improve drug use and other problem behavior attitudes, and teach drug refusal and other social skills. Examples are LifeSkills Training, Project Success, Project Alert, and Reconnecting Youth programs.

2. Classroom Education Non Evidence-Based (Non-EB) Programs (or “Non-Model” Programs):

These programs are similar to classroom education evidence-based programs described above, but have been modified or locally developed and have not been scientifically evaluated for effectiveness.

3. Prevention Counseling:

This service is for individuals who are considered at highest risk and may require referral to more intensive services. Components of prevention counseling include

assessment and referral, individual counseling, group counseling, and family counseling. “Counseling assessment” data in PARIS is a count of the total number of individuals assessed for alcoholism and substance use risk factors while “counseling session activities” is a summation of the total number of individual, group, and family counseling sessions conducted by a program in a given time period.

4. Positive Alternative Activities/Single Session Continuing:

These programs consist of pro-social, constructive, and healthy activities that provide opportunity for social bonding. These activities buffer the attraction to alcohol, tobacco, and other drugs and decrease the use of these substances. Examples are fitness-sports, arts, and cultural-multicultural activities that help to develop a healthy lifestyle.

5. Information Dissemination:

Information dissemination programs are prevention services directed at improving information to the general and specific populations about the issues of substance use or abuse. It is provided at community meetings and events, or through media technologies such as newsletters, print media, video, radio, television, or internet.

6. Community Capacity Building:

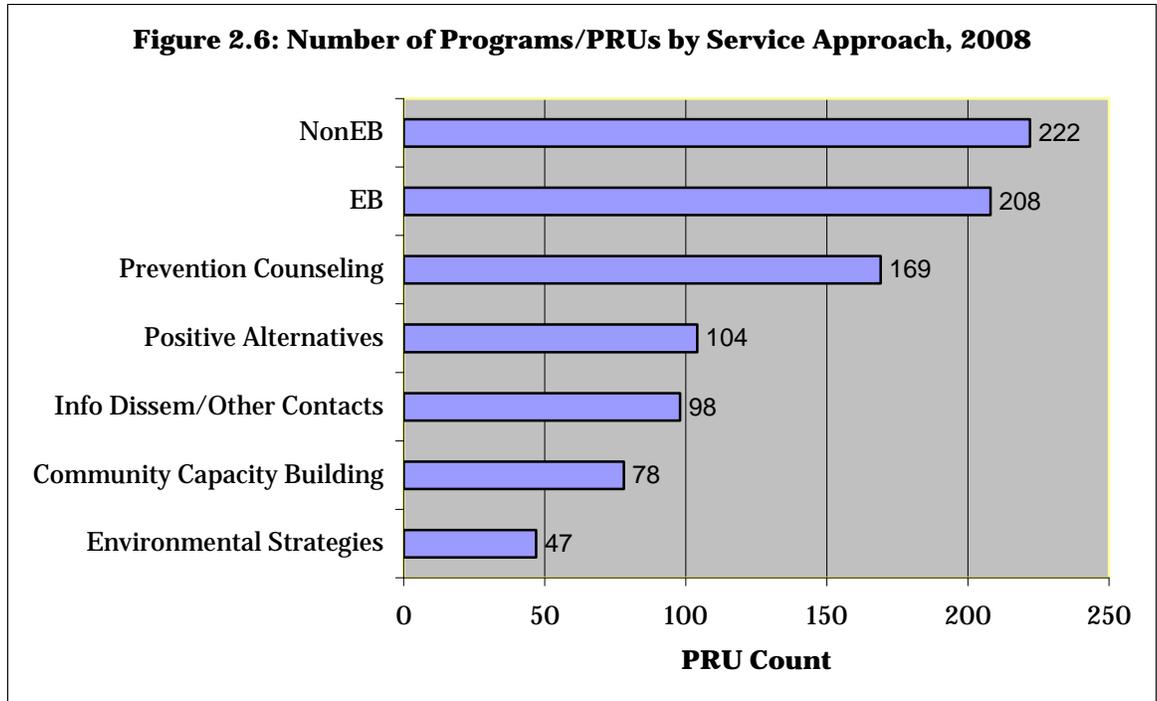
These services aim to enhance the ability to more effectively provide and integrate substance abuse prevention services within the community. Examples of these activities include training, technical assistance for schools and social providers, law enforcement, or other groups.

7. Environmental Strategies:

Environmental strategies are sets of evidence-based and promising substance abuse prevention activities that target community domain factors to decrease levels of substance use. Examples are alcohol outlet compliance checks, advertising restrictions, public alcohol use regulations, and information/warning signs in outlets.

Prevention Data, 2008 Activity Year

- Prevention providers deliver services mainly to youths and young adults in the State through designated Program Reporting Units (PRUs). Individual programs may provide multiple services in a county.
- A total of 298 PRUs delivered prevention services in 2008 with the highest number (222) delivering classroom education Non-EB services and the least (47) delivering environmental strategies. (Figure 2.6)



Note: Total Number of PRU = 298

- There were a total of 484,620 participants served directly during the 2008 activity year (Table 2.2). The participant count captured in PARIS for other population based services such as information dissemination, community capacity building, and environmental strategies was not displayed in these tables because these counts are based on population estimates and are not directly comparable.
- Even though classroom education Non-EB service had the most number of PRUs, the percentage of participants for classroom education EB services was the highest (47%) while positive alternatives was the lowest (5%).

Service Approach	Participant Count	%
Positive Alternatives	25,768	5%
Counseling (at Assessment)	55,700	11%
Classroom Education Non-EBP	173,689	36%
Classroom Education EBP	229,463	47%
Total	484,620	

Note: Because participants could receive multiple services, the total number of participants may be more than the total of unique service recipients.

- There were a total of 467, 120 prevention activities, sessions, and events in 2008 (Table 2.3). Almost half of the total number of activities delivered was prevention counseling sessions (44%), followed by classroom education EB (18%), and classroom education Non-EB (17%).

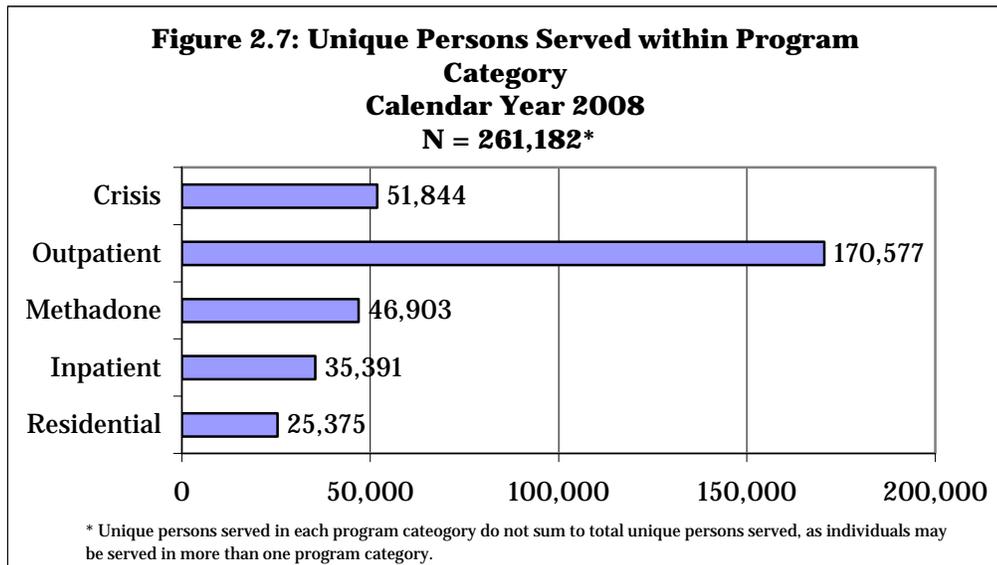
Table 2.3: Activity Count by Service Approach, 2008		
Count of Services	n	%
Classroom Education EBP	83,301	18%
Classroom Education Non-EBP	78,763	17%
Counseling Assessment	55,696	12%
Counseling Session Activities	204,712	44%
Information Dissemination	24,912	5%
Positive Alternatives	11,279	2%
Community Capacity Building	7,351	2%
Environmental Strategies	1,106	0%
Total	467,120	

- There are two major prevention categories considered evidence-based: classroom education EBP and environmental activities (Table 2.4).
- Providers are encouraged to provide evidence-based activities and in 2008, 18 percent of the total output was evidence-based, up from 9 percent in 2007.
- About half (51%) of the total number of classroom education sessions were evidence-based, compared to 2007 when only 32 percent were evidence-based.
- Although the percentage of evidence-based classroom education increased compared to 2007, the percentage of environmental strategies was lower (16%) in 2008 compared to 2007 (27%).

Table 2.4: Prevention Performance Measures, 2008	
% of Total Output that is Classroom Education EBP	18%
% of Classroom Education Sessions that are EBP	51%
% of Programs delivering Classroom Education–EBP	70%
% of Programs delivering Environmental Strategies	16%
Number of NYS Prevention Coalitions	128

System Facts: Treatment

- Each year, across all chemical dependence treatment categories, approximately 261,000 unique individuals are served in an OASAS certified program. Unique individuals served within each chemical dependence treatment program category are displayed in Figure 2.7 below.
- During calendar years 2002 to 2004, the number of unique persons receiving crisis and non-crisis services each year remained steady at around 261,000. The number decreased to around 258,000 from 2005 to 2007. In 2008, the number of unique persons increased to 261,182. Within program categories, there was one notable trend; the number of unique persons in crisis services declined from 57,000 in 2002 to 51,844 in 2008.

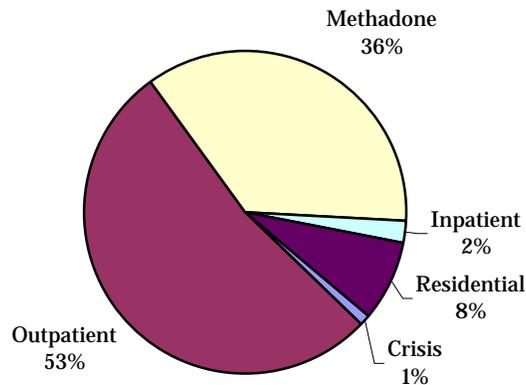


On any given day during 2008, there were nearly 108,000 individuals enrolled in treatment. As shown in Figure 2.8:

- 53 percent were in outpatient programs;
- 36 percent were in methadone programs;
- 8 percent were in residential programs;
- 2 percent were in inpatient programs;
- 1 percent were in crisis programs.

Systemwide, during the period January 2002 to December 2008, the average daily enrollment remained steady at around 107,000. There were changes within program categories: methadone decreased by 2,000, residential decreased by 1,500, and outpatient increased by 4,000.

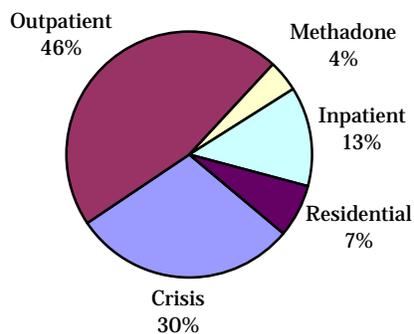
Figure 2.8: Average Daily Enrollment by Program Category Calendar Year 2008
N=107,790



During 2008, there were 311,012 admissions to all chemical dependence treatment categories. Figure 2.9 shows admissions to each program category.

During the period January 2002 to December 2007, the total number of admissions remained constant at around 307,000. In 2008, there was an increase to 311,000 (1.3%). There were trends within program categories: crisis decreased by 11,000, methadone decreased by 3,000, and outpatient increased by 16,000 or 13 percent.

Figure 2.9: Admissions by Program Category Calendar Year 2008



Program Types

OASAS delivers services through more than 1,500 prevention, treatment, and other programs from 685 provider agencies. In 2008 OASAS programs consisted of:

- 1,065 chemical dependence treatment programs;

- 292 chemical dependence prevention programs;
- 25 gambling treatment programs;
- 4 gambling prevention programs.

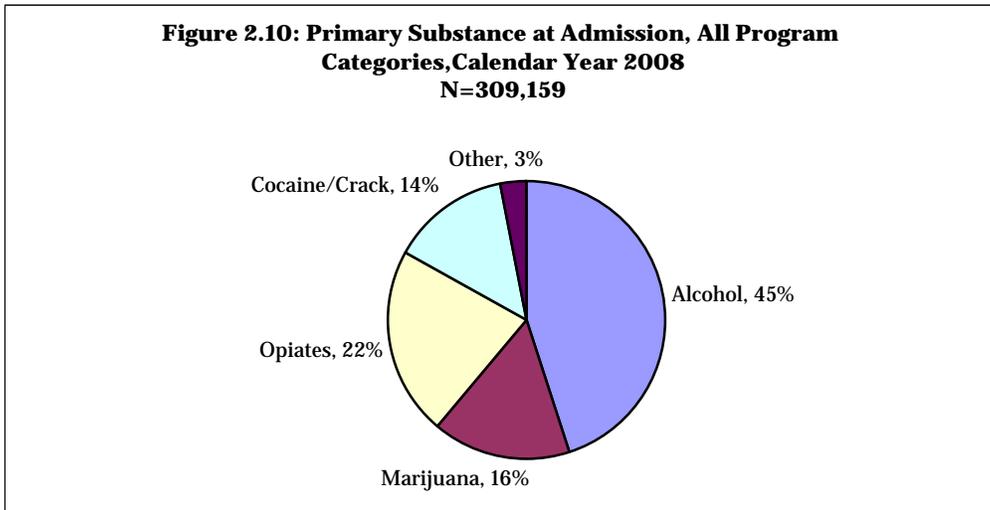
In addition, OASAS funds:

- 38 program support programs (Includes but not limited to County/Program Administration, Criminal Justice Intervention/DWI, Road to Recovery, AIDS Resource);
- 45 permanent supportive housing programs, operated by 39 voluntary agencies (including 25 Shelter Plus Care programs, 13 New York/New York III programs, a 7 upstate permanent supportive housing programs);
- 82 treatment support programs (Includes but not limited to Case Management, Vocational Rehabilitation, Managed Addiction Treatment Services [MATs]).

Substances Used

Figure 2.10 displays the primary substance of abuse at admission. Almost half (45 percent) of those admitted to OASAS treatment programs in 2008 listed alcohol as the primary substance of abuse, followed by opiates (22 percent), marijuana (16 percent), cocaine/crack (14 percent), and other substances (3 percent).

During the period January 2002 to December 2008, alcohol was the dominant primary substance at admission. As a percentage of total, alcohol admissions decreased while opiate and marijuana admissions increased steadily.



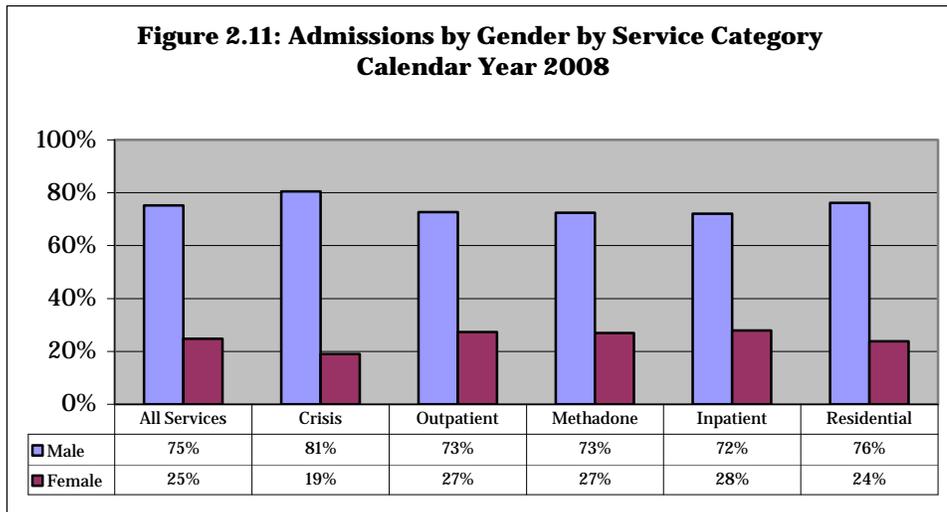
Although alcohol is the primary substance used by adults, for youth, alcohol, marijuana and prescription drugs are also principal concerns.

Treatment Demographics

Gender

Males account for the vast majority of addiction treatment admissions. As shown in Figure 2.11, approximately 75 percent of individuals admitted to all service categories are male, with crisis services having the largest percentage of males (81 percent) and inpatient the lowest (72 percent).

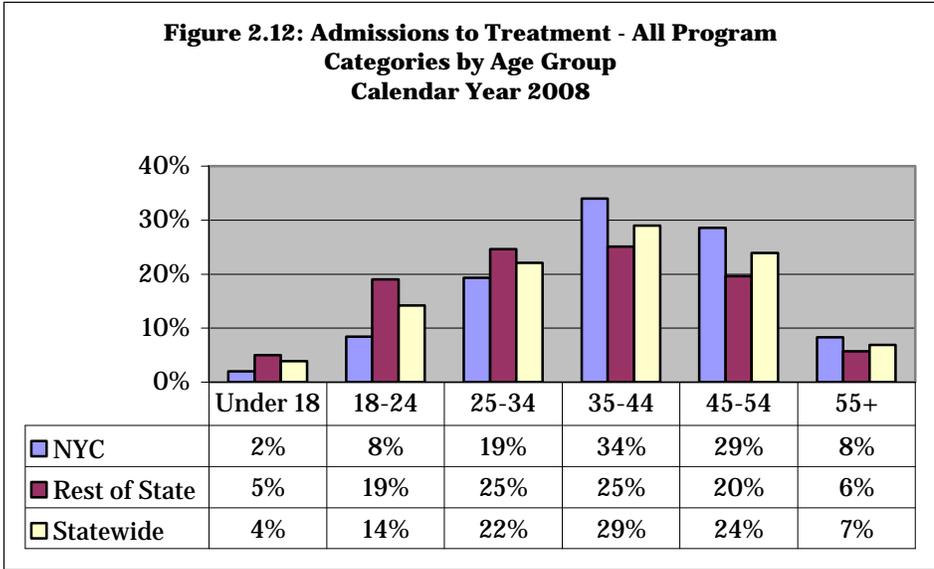
During the period January 2002 to December 2008, the ratio of males to female admissions was 3:1.



Age

People age 35 and over account for 60 percent of admissions to all program categories. Figure 2.12 shows admissions to treatment by age group and program category. People aged 35-44 are the largest age group served in the OASAS treatment system, accounting for 29 percent of all treatment admissions statewide.

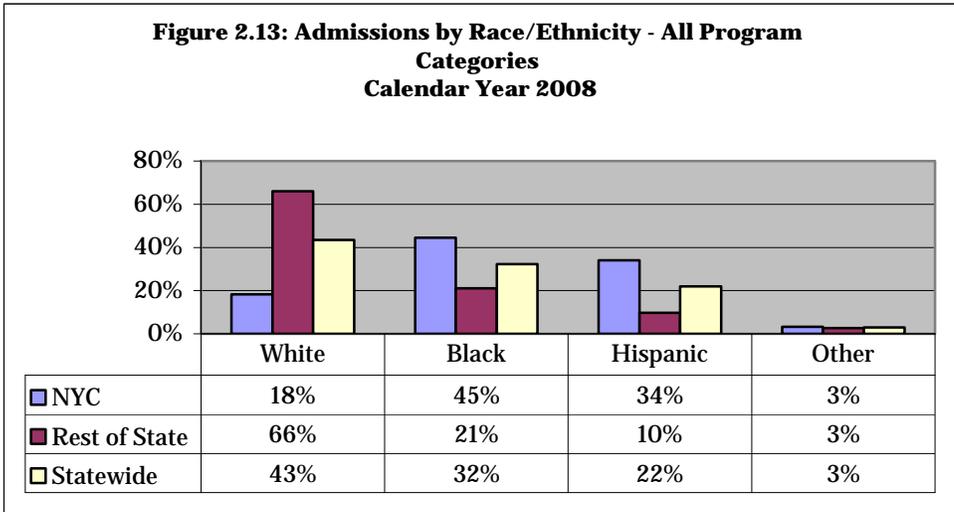
During the period January 2002 to December 2008, admissions in the 35 to 44 age group decreased from 36 percent to 29 percent of the total while the 45 to 54 age group increased from 18 percent to 24 percent and the 55 and older age group increased from 5 percent to 7 percent.



Race

Figure 2.13 shows admissions by race/ethnicity. Over half (57 percent) of admissions to all program categories in 2008 were non-white.

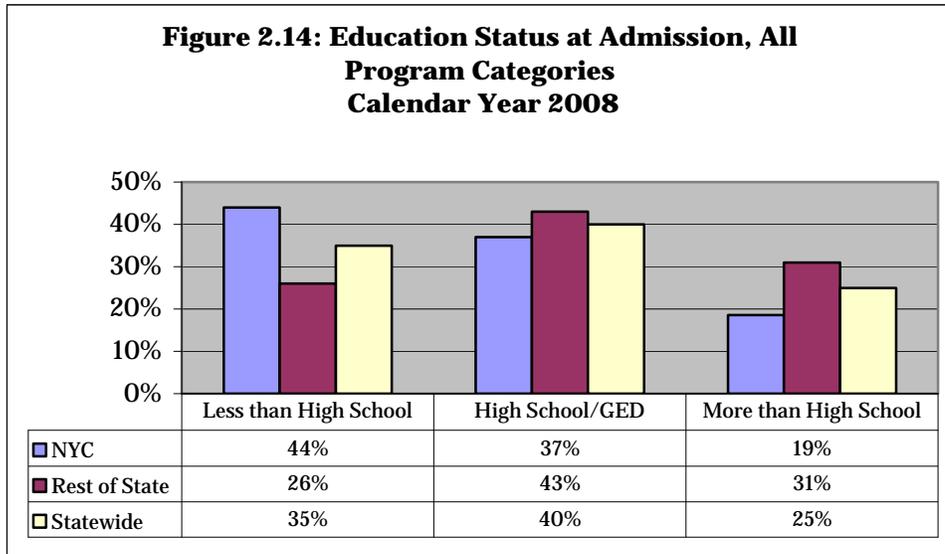
During the period January 2002 to December 2008, Black and Hispanic admissions decreased slightly as a percentage of total admissions by 2 percent and 1 percent respectively while the percentage of white admissions increased by 2 percent. These changes were attributable almost exclusively to programs outside of New York City where Black admissions decreased by 3 percent, Hispanics decreased by 1 percent, and White admissions increased by 5 percent.



Education Status

Figure 2.14 displays the education status at admission for people entering an OASAS treatment facility. More than one third (35 percent) of those admitted to treatment in 2008 had less than a high school education.

During the period January 2002 to December 2008, the percent of admissions with less than a high school education decreased from 38 percent to 35 percent.

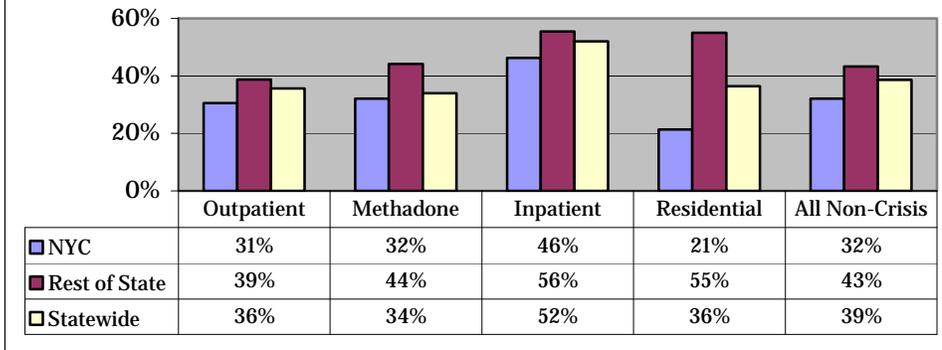


Co-occurring Disorders

Over 35 percent of non-crisis admissions have co-occurring mental health disorders. Figure 2.15 shows the percentage of admissions with a co-occurring disorder by treatment type. As the diagram shows, over half of those admitted to inpatient programs statewide are admitted with a co-occurring mental health disorder.

During the period January 2002 to December 2008, the percentage of non-crisis admissions with co-occurring mental disorders steadily increased from 28 percent to 39 percent.

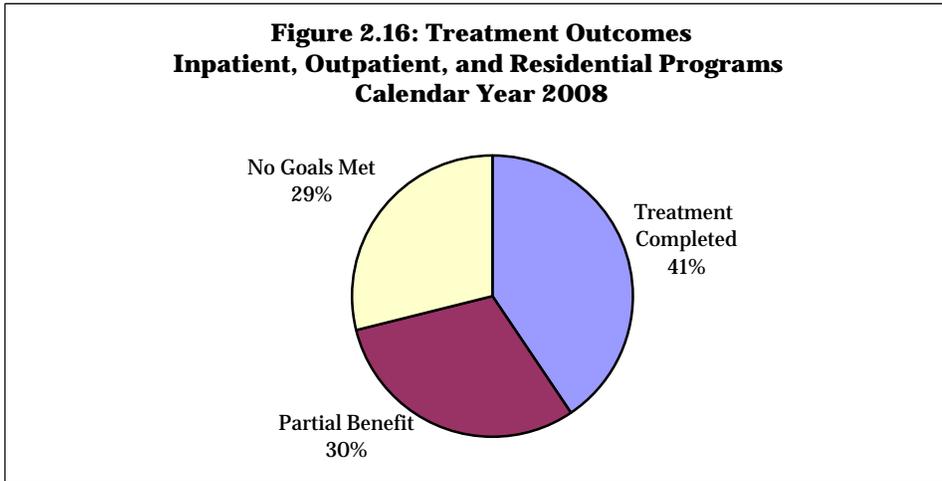
Figure 2.15: Admissions with Co-Occurring Mental Health Disorder (Non-Crisis) Calendar Year 2008



Treatment Outcomes

For 2008, 41 percent of persons discharged from inpatient, outpatient, and residential chemical dependence treatment programs completed treatment, meeting half or more of their treatment goals. Figure 2.16 shows treatment outcomes for 2008.

Figure 2.16: Treatment Outcomes Inpatient, Outpatient, and Residential Programs Calendar Year 2008



IPMES

IPMES monitors the performance of all OASAS-certified treatment programs utilizing demographic (client characteristic) and transactional (i.e., admission, discharge, and transfer) data. IPMES examines performance relative to established minimum standards and/or to that of the performance of similar programs. IPMES Reports on individual programs are presented in graphic formats. Data presented includes prior 12-month performance as well as five years of historical data. The historical performance of similar programs is presented for comparison. The system incorporates procedures for identifying programs that consistently meet or exceed the standards and those that fail to

meet the standards or perform poorly relative to similar programs. The latter are identified and reviewed by OASAS Field Office staff to determine whether technical assistance and/or corrective actions are necessary.

The data in the Table 2.5 below utilizes IPMES measures but are based on the total number of individuals discharged from each of the program types in 2008 and not on program averages.

Table 2.5 Program Category IPMES Performance 2008 Discharges

	Inpatient	Intensive Residential	Outpatient Clinic	Outpatient Rehab	Methadone Clinic	Medically-Managed Detox	Medically-Supervised Withdrawal	Medically-Monitored Withdrawal
Number of Discharges ¹	39,980	12,226	131,132	8,394	12,023	50,333	20,537	19,813
One Week Retention	86	*	*	*	*	*	*	*
One Month Retention	*	74%	78%	73%	90%	*	*	*
IPMES Three Month Retention ²	*	76%	72%	66%	87%	*	*	*
Three Month Retention ⁷	*	56%	56%	48%	79%	*	*	*
IPMES Six Month Retention ²	*	58%	55%	47%	74%	*	*	*
Six-Month Retention ⁷	*	43%	43%	34%	67%	*	*	*
% Completed Treatment	71%	*	*	*	*	72%	78%	63%
%Completing Treatment or Referred	*	54%	44%	47%	*	*	*	*
% Completing Treatment & Admitted into Ambulatory ³	*	55%	*	*	*	*	*	*
% Completing Treatment and Admitted into Amb, IR, or RRSY	52%	*	*	*	*	*	*	*
%Completing Treatment & Admitted Into Any Other Non-Crisis Program ³	*	*	*	*	*	42%	65%	53%
% Maintained or Improved Employment-Related Status ^{4, 5}	*	38%	56%	22%	34%	*	*	*
% Discontinued Use of All Substances	90%	91%	71%	68%	*	*	*	*

¹ Maximum number of discharges used in analysis. Number varies by index.

² Includes only those who were retained at least one month.

³ Within 45 days of discharge date.

⁴ Includes only those in treatment for at least three months.

⁵ Excludes adolescents and females in Intensive Residential-Women and Intensive Residential-Children in Residence programs.

⁶ Calculated using Methadone Client Annual Status Reports for Methadone Clinics

⁷ Includes all individuals discharged.

* Does not apply to this program type.

- Variations of certain performance measures across program types (e.g., retention, treatment completion) are designed to more accurately reflect program operations and performance expectations.
- Program type performance is based on the discharges of people from programs included in that category and not the average of individual program performance.
- All 1 Month Retention Rates were over 70 percent. All 3 Month Retention Rates were greater than 65 percent. All 6 Month Retention Rates were greater than 47 percent. Methadone Clinics at 90 percent, 87 percent, and 74 percent had the largest percentage of people retained for one month, three months, and six months, respectively. Methadone clinics generally are designed to keep people in treatment for long time periods.
- Across all program types, employment rates were relatively low with outpatient clinics having the greatest percentage of individuals maintaining or improving their employment-related status (56 percent). Outpatient clinics generally serve people with the highest level of functioning.
- Inpatient, residential, and crisis programs need to increase the percentage of their completing clients that get admitted into the next level of care. Medically Supervised Withdrawal programs performed the best in this area, but even they had less than two-thirds of their completers getting into the next level of chemical dependence treatment.

Recovery

No conclusive studies exist that can accurately estimate the number of individuals in recovery from addictive disorders. NSDUH routinely provides estimates of the numbers of Americans aged 12 or older who required treatment for an alcohol or illicit drug problem in the past year as well as those who receive treatment; however, this estimation does not provide information about the recovery status of those treated or those who were not. One very recent attempt to estimate the number of people in alcohol recovery in the U.S. population, using data from the 2001-02 National Epidemiologic Survey on Alcohol and Related Conditions (NESARC), looked at respondents who met the criteria for prior to past year Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) alcohol dependence (i.e., respondents who had a lifetime DSM-IV alcohol dependence diagnosis but none in the past year; respondents who had developed alcohol dependence in the year preceding interview were excluded from the analysis since they could not have

had any status in the past year other than still being dependent.). The NESARC study defined being in recovery as those respondents, who had a prior to past year diagnosis and, at the same time, abstained from drinking and/or continuing a "low risk" pattern of alcohol use (Dawson et. al. 2005).

The OASAS Household Survey through its methodology of random digit dialing provides access to a probability sample of persons in households in New York State. The survey also provides estimates of the numbers of New York State adult residents who meet the criteria for lifetime and past year diagnoses of problem gambling as well as substance use disorders (SUDs) along with estimates of incidence and prevalence of lifetime, past year and past month use of various substances and participation in various gambling activities. Thus, drawing upon the methodology of the NESARC study, the next Household Survey, planned for 2010, will now also provide estimates of the numbers of adult residents of New York State in recovery not only from alcohol dependence but other addictive disorders (i.e. illegal drug use, problem gambling) as well. In addition to providing estimates of recovery prevalence, the upcoming survey will also include a recovery module consisting of a limited set of structured questions related to recovery experience and thus generate findings that could permit identification of pathways and barriers to recovery. For policymakers and service providers in New York State, data from this survey will provide accurate information that is needed to make informed funding decisions with regard to recovery-oriented services and supports.

Chapter III: County Planning

The 2010 local services planning process represented the second year of the new collaborative local planning approach adopted by OASAS, OMH, and OMRDD. While preserving the specific mission, characteristics, and constituencies of each disability service system, the *2010 Local Services Plan Guidelines* provided local governmental units (each county and the City of New York) with an enhanced opportunity to address the needs of individuals with co-occurring disorders who require services from multiple systems in a more rational and coordinated manner. The collaborative approach also facilitates more efficient and effective planning for services and supports needed by individuals involved in the three separate systems, such as housing, transportation, and other services.

The local services planning process continues to be guided by the Mental Hygiene Planning Committee, a collaborative effort that includes planning staff from each State Mental Hygiene agency, CLMHD, and several counties. The committee establishes the planning timeline, drafts the integrated portions of the plan guidelines, and develops data and other resources for local planning and needs assessment efforts. The committee also advises on the development of content material, reporting features and other functionality in CPS.

As in the past, Local Governmental Units (LGUs) and OASAS service providers were able to complete and submit their required planning forms directly to the State agencies via CPS, a secure web-based application that registered users can access to enter the required information. The convenience and ease of using CPS, and the State's ability to target follow-up communications to the field, resulted in a 98 percent completion rate for county forms and a 95 percent completion rate for OASAS provider forms during the most recently completed planning cycle. At these rates, the reliability and value of the data collected to support a variety of statewide planning initiatives are significantly improved.

The information gathered through the local planning process provides valuable input that informs OASAS' long-range planning, policy development, and budgeting processes. While the worldwide economic crisis has forced OASAS to make some difficult fiscal decisions, significant initiatives are underway to address many of the priorities identified by counties in their Local Services Plans. The agency continues to aggressively pursue federal grant opportunities for the addiction services system. In addition, OASAS is implementing Communities of Solutions, which builds upon the local planning process and seeks to expand access to services, improve program quality, enhance positive outcomes, and encourage efficiencies in communities across the State.

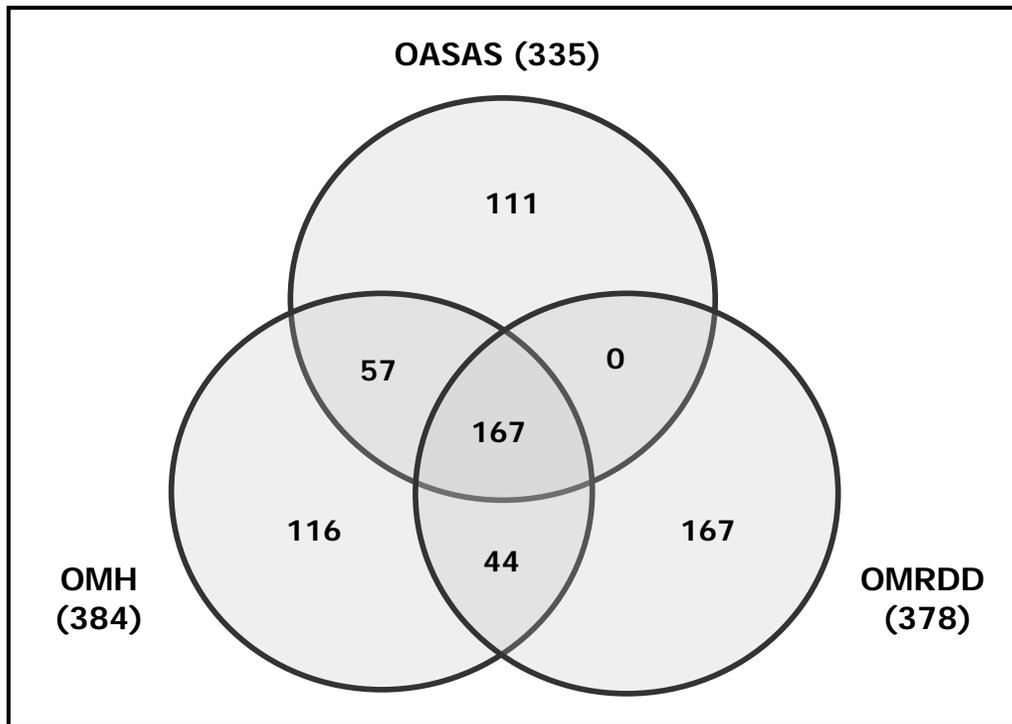
County Priority Outcomes

New York State Mental Hygiene Law (MHL) requires that the statewide comprehensive plan for OASAS, OMH, and OMRDD “...be formulated from local comprehensive plans developed by each local governmental unit...” Section **5.07 (b) (1)**. The local services plan must reflect the requirement of the LGU (each county and the City of New York) to “establish long range goals and objectives consistent with statewide goals and objectives...” Section **41.16 (b) (1)**. Each DMH agency is responsible for providing annual guidance to the counties on the development and submission of separate local services plans.

Last year, the three DMH agencies collaborated on the first ever integrated local services plan guidelines for mental hygiene services. A central component of those guidelines was a new integrated county planning form designed to articulate the county’s long-range goals and objectives in a consistent manner across the three mental hygiene disabilities. The intent of the integrated form was to provide counties with an opportunity to identify and address cross-system issues in a more comprehensive and person-centered manner. The *County Mental Hygiene Priority Outcomes Form* facilitated the development of priority outcomes and associated strategies for each separate disability planning area and for those areas that impact multiple systems. All plans were completed and submitted to each State agency electronically via CPS. A total of 718 separate priority outcomes were submitted in last year’s plans.

This year, counties included a total of 662 priority outcomes, which was down eight percent from last year primarily due to consolidation of like priorities and dropping or accomplishing certain priorities. As the chart below shows, 40 percent of all priorities involved more than one mental hygiene disability, including 25 percent that crossed all three disabilities.

Figure 3.1: County Priority Outcomes by Disability Area (N=662)



In an effort to show the alignment between local and statewide goals, as prescribed in Mental Hygiene Law, counties were asked to categorize each priority outcome based on its relationship to the strategic goals of the relevant State DMH agency. If a priority was identified as relating to more than one State agency, it had to show alignment with a strategic goal for each agency. Counties were asked to only select the one strategic goal most related to its priority and were given the option to select “Other” if they believed their priority did not relate specifically to any of the State strategic goals. An analysis of the 335 county priority outcomes that related to OASAS showed the following distribution against the OASAS strategic goals, or destinations.

Table 3.1: Alignment of County Priorities to OASAS Strategic Destinations (N=335)

OASAS Destination	Initial Percent	Adjusted Percent
Mission Outcomes	55.5%	73.4%
Provider Engagement and Performance	13.4%	11.6%
Talent Management	7.2%	9.0%
Financial Support and Stewardship	6.6%	3.6%
Leadership	1.5%	1.8%
Other	15.8%	0.6%

The “Initial Percent” column shows the distribution of priorities as categorized by the counties in their plans. After an analysis of all priorities, it was determined that many of those priorities more appropriately related to a different OASAS destination and were re-categorized. Most of those changes involved re-categorizing “Other” into one of the five destinations.

Table 3.2 shows the top priority outcome identified by counties in their 2010 Plans categorized by broad focus areas. Like last year, the priorities covered a wide variety of topics with most representing less than ten percent of the total. Again, the most frequently identified topic was priorities related to **Serving Persons with Co-occurring Disabilities**, representing 26.3 percent of the total. This category covers a lot of ground, but priorities addressed improving access to services in a general sense, with specific references made to strategies involving service coordination or integration, case management, cross-system training of clinical staff, developing viable housing options and other support services, and providing more psychiatric crisis services. While 26 percent of priorities specifically address serving persons with co-occurring disorders, persons with multiple disabilities were referenced under many other priority categories, either in an integrated way or separately in the context of needs within each disability system.

Table 3.2: Top County Priority Outcomes by Focus Category (N=335)

Priority Outcome Category	Percent of Total
Serving Persons with Co-occurring Disorders	26.3%
Access to Treatment and Crisis Services	18.2%
Access to Prevention Services	11.3%
Access to Recovery Support Services	8.4%
Access to Safe and Affordable Housing Options	7.8%
Support for Talent Management	7.5%
Serving Other Target Populations	7.5%
All Other Priority Outcome Categories	13.0%

The category with the second most number of priority outcomes was **Access to Treatment and Crisis Services**, representing 18.2 percent of the total. The most frequently mentioned service categories were community residences, outpatient, and crisis services. Priorities related to community residences focused on general expansion of capacity or programs targeting special populations, primarily adolescents and women with children. Priorities related to outpatient services focused on providing off-site visits, general expansion of services, and programs targeting adolescents, youth in transition, families, and problem gamblers. Priorities related to crisis services focused on the development of services where none existed and more effectively responding to psychiatric emergencies. Other treatment priorities focused on implementing evidence-based practices, addiction medications, and quality improvement.

Access to Prevention Services is still a high priority this year, as it was last year, representing 11.3 percent of the total. Beyond a general need to expand prevention services, the greatest number of prevention priorities focused on implementing evidence-based practices or environmental strategies and services that address identified risk and protective factors. A few counties identified a specific programming focus, such as problem gambling, Fetal Alcohol Spectrum Disorders (FASD), students at risk of out of home placement, and family engagement.

Access to Recovery Support Services was identified in 8.4 percent of all county priorities. This category showed the greatest increase in priorities from last year. Several counties talked in general terms about the importance of providing recovery support services, but almost half specifically identified the need for transportation services for people in post-treatment recovery. Nearly all of those were upstate rural counties. Second to transportation, nearly a third of counties identified the need to provide vocational services and job opportunities to people in recovery. Other priorities addressed the need for peer and family support, case management, and educational support.

Providing **Access to Safe and Affordable Housing** continues to be a top priority. While representing only 7.8 percent of all priorities, it ranks third highest among the “top two” priorities identified, behind Serving Persons with Co-occurring Disorders and Access to Prevention Services, at 14.5 percent of the total. While many counties simply identified the need for housing in a general sense, most emphasized the need for safe and affordable housing that is supervised and provides the supports needed to promote recovery, such as case management and employment services. Several county priorities identified the need for supportive and sober housing for individuals transitioning from treatment into the community.

All staffing and workforce development related priorities were grouped together under the category **Support for Talent Management**, which represented 7.5 percent of the total. The majority of these priorities addressed the need to recruit and retain qualified direct care staff. Several counties specifically identified professional staff that is historically difficult to recruit, like psychiatrists, psychologists, physician’s assistants, and nurse practitioners. A few counties also noted that the ability of providers to recruit and retain quality direct care staff is affected by their ability to provide competitive salaries and benefits impacts. The other major priority area addressed the need to maintain a well-trained workforce in general, and more specifically trained in evidence-based practices and cultural and linguistic competence.

In addition to serving persons with co-occurring disorders, priorities related to **Serving Other Target Populations** represented 7.5 percent of the total. The two primary target populations referred to were youth in transition and adolescents. Other target populations included criminal justice or incarcerated populations, followed by the uninsured/underinsured, seniors, homeless, families, veterans, and gay men.

These priority outcome categories represent a general overview of the 335 county priorities identified in this year's local services plans. A more detailed review of the over 600 accompanying strategies will provide OASAS with a clearer understanding of the specific actions counties intend to pursue over the next three-year planning horizon.

County Funding Priorities

OASAS targets available new funding opportunities to initiatives that address top State and local priorities where they will have the greatest impact on outcomes for individuals in recovery. There are many pressing needs and significant demands for limited new resources. The budget decision-making process must involve county and provider input to ensure that all needs and priorities are adequately considered. One of the most important means to achieve this is through the annual local services plan.

To better inform the OASAS budget process, the *2010 Local Services Plan Guidelines* once again asked counties to identify priority initiatives. Specific priorities recommended by the county do not guarantee that funding will follow, but provide a formal mechanism for counties to help influence future OASAS funding priorities.

The OASAS budget development process culminates in the annual submission of the agency's budget request to the Governor in October. Requests for special initiative funding are often included to address gaps in services within the existing addiction service system, to implement innovative or evidence-based programming, or to provide additional support to programs so they may continue to deliver quality services. To improve local input in the development of the OASAS Budget and to better articulate what the greatest local funding priorities are across the State, counties were asked to identify up to three local funding priorities (i.e., an initiative that can only or best be accomplished through a new State funding initiative).

To assist counties in developing their funding priorities, the Local Plan Guidelines asked them to categorize each priority in three different ways: by rank order; by type of service; and by focus area. Counties could select multiple services and focus areas for each priority, as appropriate. This year, a total of 129 priorities were identified statewide, down from the 137 last year.

Table 3.3 shows the distribution of funding priorities based on the type of service. Multiple service types were frequently indicated for specific priorities. Only 43 percent of all priorities identified a single service type, and a third of all priorities identified three or more service types. Outpatient services were the most frequently mentioned service type, identified in about 57 percent of all funding priorities. It was also the service type most frequently mentioned by itself (41%), followed by recovery support (18%), and prevention (16%).

Table 3.3: 2010 County Addiction Funding Priorities by Service Type

Service Type	Count (N=129)	Percent of Total
Outpatient Treatment	73	56.6%
Specialized Services	48	37.2%
Recovery Support Services	47	36.4%
Residential Treatment	35	27.1%
Prevention Services	31	24.0%
Crisis Services	31	24.0%
Inpatient Treatment	18	14.0%
Methadone Treatment	12	9.3%

Counties were also asked to select from a list of focus areas to which the funding priority related. Multiple focus areas could be selected for each priority. Seventy-three percent of all priorities had more than one focus areas selected, with an average of three per priority. Table 3.4 shows a comparison between the focus areas identified this year and last year.

Table 3.4: 2009/2010 County Addiction Funding Priorities

Funding Priority Focus Area	2009 Percent of Total (N=137)	2010 Percent of Total (N=129)
Improved Access to/Availability of Services	68.6%	70.5%
Cross Systems Collaboration/Service Integration	30.7%	41.9%
Expansion of Existing Service Capacity	38.7%	41.1%
Establishment of Services Targeted to Special Populations	38.7%	40.3%
Implementation of Evidence-Based Practices	31.4%	37.2%
Housing	26.3%	28.7%
New Innovative Idea/Demonstration Project, etc.	20.4%	18.6%
Regulatory Relief	8.0%	8.5%
Talent Management/Workforce Recruitment & Retention	11.0%	6.2%
Technology Improvements (EMR, Software/ Computer Upgrades)	4.4%	3.9%

The most notable change from last year is the increase in the number of funding priorities related to cross systems collaboration and service integration, up 11 percent and moving from the fifth most frequently cited focus area to the second most frequent. The focus category that dropped the most from last year was talent management, dropping by about five percent.

Priorities by service categories and broad focus areas provide one perspective on where counties believe new funding should be directed. A closer look at priority descriptions shows another perspective focused on specific actions and programming. While county

priority outcomes are developed to address broader local needs and often do not involve additional funding, there is a general consistency with the more specific funding priorities. Table 3.5 shows the top priority areas based on a review of the priority descriptions and representing at least five percent of the total. Some priorities fell into multiple categories and are reflected in each category.

Table 3.5: County Addiction Funding Priorities by Descriptive Category (N=129)

Funding Priority Descriptive Category	Percent of Total
Improve Access to and Availability of Treatment Services	32.6%
Expand Services to Special Populations	24.8%
Provide More Case Management Services	17.8%
Expand Housing Opportunities	14.7%
Improve Access to and Availability of Prevention Services	10.9%
Implement Evidence-based Practices, Addiction Meds., etc.	6.2%
All Other Categories	14.0%

Improve Access to and Availability of Treatment Services

Counties expressed a general need for additional treatment and crisis services, some where they do not exist and some targeted to specific populations. The most frequently mentioned was **outpatient treatment**, particularly the need to provide off-site visits. Seven counties called for regulatory and reimbursement changes that would allow providers to serve patients away from their clinics. Some counties expressed concern about the need to expand outpatient services as a result of the reform of the Rockefeller Drug Laws. Four counties are looking for additional funding to support the development of problem gambling treatment services.

The second most frequently mentioned treatment service was **community residences**, including six counties identifying the need for a community residence for women or women and their children. Services targeted to adolescents, young adults, and dually diagnosed were also identified. Eight counties identified the need to fund **crisis services**, mostly in counties where certified programs do not currently exist. The need for psychiatric crisis and mobile mental health crisis services were also mentioned. Five counties identified the need for methadone, buprenorphine, or other addiction medication services.

Expand Services to Special Populations

Like last year, the target population most frequently mentioned was persons with **co-occurring disorders** (16). In addition to a general expansion of access to services, a number of different programming strategies were identified, such as case management,

the hiring of a Dual Recovery Coordinator, and service coordination with other systems. Other target populations included **adolescents** (9), **criminal justice clients** (7), **women** (1), and **seniors** (1).

Provide More Case Management Services

Twenty-three counties identified case management services as a funding priority, primarily addressing a general need. Several counties specifically focused on case management services for people in post-treatment supported housing, in crisis, or persons with co-occurring disorders. Two counties specifically identified the need for a MATS-like program.

Expand Housing Opportunities

Safe and affordable housing options continues to be one of the top funding priorities mentioned by counties. The overall lack of housing for people in treatment or leaving treatment is identified as a significant barrier to sustaining recovery and reintegrating into the community. Some counties specifically refer to supportive or transitional housing needs, while others identified the need for rental subsidies, sober homes, and case management.

Improve Access to and Availability of Prevention Services

Most funding priorities for prevention services related to a general expansion of services in the county, or specific programming, like underage drinking, gambling, or implementing environmental strategies or evidence-based practices.

Implement Evidence-Based Practices

Eight counties identified funding priorities related to the implementation of evidence-based practices for treatment (5) and prevention (3), which included Network for the Improvement of Addiction Treatment (NIATx), the use of addiction medications, and the implementation of environmental strategies.

Other Priorities

There were a number of other funding priority categories that totaled less than five percent but should be noted here. Six counties identified specific needs for recruiting and retaining quality clinical staff, with specific mentions of Dual Recovery Coordinators (3), a Child Psychologist, and a CASAC. Five counties identified recovery support services, including the need to establish a Recovery Community Center or provide transportation services. Two counties identified the need for Electronic Medical Records (EMRs), and

three counties would like to see additional funding for facility upgrades or new computers.

Outcomes Management Survey

OASAS is committed to the adoption and use of outcomes management to improve agency performance. Through the use of dashboards and results and learning sessions, OASAS measures progress toward agency goals. Results are shared with managers and staff to inform their work and decision-making.

OASAS also encourages the use of outcomes management in the field through the Outcomes Management Communities of Practice, implementation of the program scorecard, and the Outcomes Management Advisory Group. To better understand the extent to which the outcomes management approach is used in the field, county administrators and providers were asked to complete the Outcomes Management Survey in the *2010 Local Services Plan Guidelines for Mental Hygiene Services*. A similar survey was administered to OASAS staff to better understand and track the use and dissemination of outcomes management internally. OASAS will be able to track changes in use of outcomes management over time against the baseline established in 2009.

The questions contained in the county and provider surveys capture information about length of time using outcomes management, use of data to monitor performance, use of targets to measure progress over time, and how often organizations meet to review outcome information. Finally, respondents were asked about the need for resources to support and encourage the use of outcomes management.

A total of 57 counties and 561 providers completed the survey with response rates of 100 percent and 95 percent respectively. Both counties and providers report similar percentages with regard to using outcomes management for three or more years. For the more specific activities that comprise an outcomes management approach, however, providers report a greater degree of use as compared to county respondents. Providers report using data, monitoring progress, and tracking and review of outcome information to assess performance in larger proportion than counties. Table 3.6 provides a summary of the responses to these and other key items from the county and provider surveys.

Table 3.6: Key Items from the Outcomes Management Survey for Counties and Providers

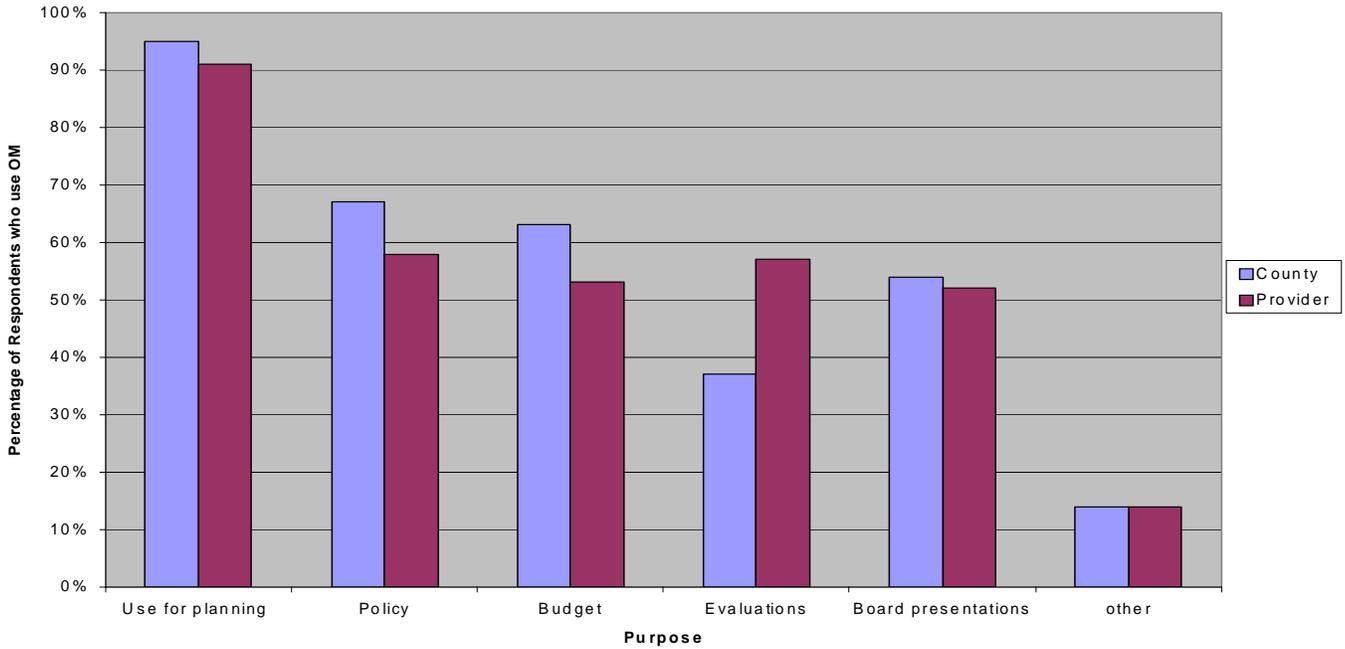
Survey Item	County N=57	Provider N=561
Length of time using Outcomes Management - 3 years or more	68%	73%
Data used to monitor performance (to a high or very high degree)	49%	59%
Set targets and measure progress over time (to a high or very high degree)	47%	61%
Review outcomes at least quarterly	60%	77%
Agency maintains a dashboard, report card, or scorecard	42%	32%

OASAS is encouraged by the number of providers and counties that are using outcomes management. The information from the survey demonstrates that there are a large number of county and provider organizations that report long-standing experience with outcomes management. Clearly, there is a wealth of existing knowledge that can be mobilized to further spread the use of outcomes management to others in the field. The Outcomes Management Communities of Practice offer one opportunity for this type of information sharing, and perhaps peer-to-peer mentoring is another way to capitalize on the field's experience to date. The survey provides OASAS with the means to identify a potential pool of counties and providers most heavily engaged in outcomes management.

One of the most important aspects of the outcomes management model is the use of information gained from tracking measures to assess performance. This enables an organization to monitor progress and set course corrections as needed. While collecting and monitoring data is a good first step, outcomes management calls for the application and use of this information to improve program performance.

The Outcomes Management Survey included a question about the use of information gathered using the outcomes management approach to inform five areas of management practice and program operations. Figure 3.2 illustrates the percentage of counties and providers who reported using outcomes information for planning, policy development, budgeting, staff evaluations, and board presentations. A higher percentage of counties, compared to providers, reported using outcomes information for all the purposes above with the exception of staff evaluation where providers reported much higher use than counties. Providers also reported using this information for program development, community presentations, research articles, grant applications, and to identify areas for training and education.

Figure 3.2: Use of Outcomes Management Information



Key Findings:

- A majority of the counties and providers report a significant involvement with, and utilization of, outcomes management.
- Over half of counties and providers report specific applications of their outcomes management activities.
- The survey provides a baseline and information to identify a pool of potential organizations to promote outcomes management.

Community Coalition Development Survey

OASAS prevention strategies include utilizing community coalitions that engage multiple systems in addressing and promoting prevention at the local level. Community coalitions join together many sectors of the community, including law enforcement, businesses, government, schools, and community prevention providers to raise awareness and serve as a catalyst to address alcohol, other drugs, and problem gambling. Community coalitions, along with local prevention providers, implement environmental strategies to change community norms, reduce availability, and improve enforcement of laws and regulations around substance use and problem gambling.

The Community Coalition Development Survey, conducted through the OASAS 2010 local services planning process, asked prevention providers to identify coalitions in their

county that are addressing alcohol, other drug, and problem gambling prevention. The information obtained from this survey will be used to compile a comprehensive listing of active coalition partnerships statewide and assist OASAS and the regional Prevention Resource Centers in planning training and technical assistance opportunities.

A total of 218 prevention providers were surveyed, with 214 responding (98%). Of the providers that responded, only 68 (32%) identified any active community coalitions (a total of 128 separate coalitions). The following are some of the key findings from those responses:

- 42 providers (62%) identified only one community coalition.
- 19 providers (28%) identified either two or three separate coalitions.
- 7 providers (10%) identified four or more coalitions.
- Westchester and Suffolk counties each had the largest number of coalitions named (12) while 18 counties had no coalitions named.
- The Mid-Hudson region had the most coalitions named (34) and New York City had the fewest (6).

Providers were also asked if their staff needed training or technical assistance on community coalition development. A total of 72 providers (34%) indicated that they needed such training or technical assistance. The greatest number of responses indicated the need for general or basic training on coalition development or training on how to identify and engage partners. Several providers identified specific models or programs, such as the Community Anti-Drug Coalitions of America (CADCA), Community Mobilization, the Strategic Prevention Framework, or environmental strategies that they would like to receive training on. Several more identified the need for training on assessment, evaluation, and sustainability of existing coalitions.

Succession Planning Survey

Chemical dependence service providers in New York State face an aging workforce and continued difficulty recruiting and retaining quality professional staff. Part of this challenge is the need for providers to replace much of its leadership over the next several years as executive directors and other top management staff retires. When top staff leave an agency, whether through anticipated retirement or other unplanned departures, it is important to maintain a continuity of leadership. To ensure that agencies are adequately prepared for the loss of such critical leadership, and that the quality work conducted in their programs is not threatened, it is important to have a plan in place.

During the 2010 local services planning process, all providers were asked to complete a survey on succession planning within their organization. Responses to the survey will give OASAS and the provider community important information on the extent to which adequate preparations are being made and implemented and what actions might be

necessary to ensure the critical continuity of leadership during anticipated times of transition ahead. A total of 594 prevention and treatment providers were surveyed, with 94 percent responding.

Anticipated Departure of Executive and Management Staff

Providers were first asked if they anticipated any top executive or key management staff leaving their agency over the next decade. Overall, 61 percent reported that they did. Prevention and treatment providers responded roughly the same, 63 percent and 56 percent respectively, while 85 percent of providers that operate both prevention and treatment services reported affirmatively. On a regional basis, Upstate providers reported a higher percentage of top staff expected to leave over the next decade (67%) compared to New York City and Long Island providers (55%).

Of those providers reporting the anticipated departure of executive and management staff over the next decade, 42 percent expect departures to occur within the next four years and 20 percent within the next two years. The timeline is roughly the same among prevention and treatment providers, and across all regions, although the Finger Lakes and Mid-Hudson regions appear to be slightly more imminent.

Table 3.7: Anticipated Departure of Leadership Staff Over Next Decade (N=332)

Region of the State	N	5 to 10 Years		3 to 4 Years		Within 2 Years	
		No.	Percent	No.	Percent	No.	Percent
Western	30	19	63.3%	6	20.0%	5	16.7%
Finger Lakes	33	14	42.4%	11	33.3%	8	24.2%
Central	36	25	69.4%	4	11.1%	7	19.4%
Northeastern	37	20	54.1%	9	24.3%	8	21.6%
Mid-Hudson	47	26	55.3%	10	21.3%	11	23.4%
New York City	93	54	58.1%	23	24.7%	16	17.2%
Long Island	56	33	58.9%	11	19.6%	12	21.4%
Statewide	332	191	57.5%	74	22.3%	67	20.2%

Where Will Future Leadership Come From?

All providers were asked where they anticipate their future leadership will come from. Most (60%) believe that future leaders will come from both within and outside their agency, while only nine percent indicated that they will likely come exclusively from outside their agency. That means 91 percent of all providers expect their future leadership could potentially come from within their own organization. There were some notable variations across regions, as 51 percent of Central Region providers anticipate recruiting future leaders exclusively from within their ranks, while only 14 percent of Finger Lakes

providers do. However, 74 percent of providers from both the Finger Lakes and Western Regions reported the likelihood of recruiting future leaders from both within and outside their agency.

Table 3.8: Where Future Leadership Staff Will Come From (N=544)

Region of the State	N	Within Agency		Outside Agency		Both	
		No.	Percent	No.	Percent	No.	Percent
Western	42	11	26.2%	0	0.0%	31	73.8%
Finger Lakes	50	7	14.0%	6	12.0%	37	74.0%
Central	57	29	50.9%	6	10.5%	22	38.6%
Northeastern	53	17	32.1%	7	13.2%	29	54.7%
Mid-Hudson	74	23	31.1%	6	8.1%	45	60.8%
New York City	173	57	32.9%	11	6.4%	105	60.7%
Long Island	95	25	26.3%	13	13.7%	57	60.0%
Statewide	544	169	31.1%	49	9.0%	326	59.9%

How Important is Succession Planning?

Providers were asked to what extent they believed succession planning was necessary in order to ensure a continuity of leadership within their agency. Considering that 91 percent of providers indicated that future leaders could potentially come from within their agency, it is not surprising that 82 percent reported that the need for a succession plan was either a moderate or serious issue. Only six percent responded that a succession plan was “not an issue.” The Mid-Hudson Region had the highest percentage of providers that indicated succession planning was a moderate or serious issue (90%), while the lowest percentage was on Long Island (74%).

Table 3.9: The Seriousness of Succession Planning (N=545)

Region of the State	N	Very Serious		Moderately Serious		Minor Issue or Not an Issue	
		No.	Percent	No.	Percent	No.	Percent
Western	42	22	52.4%	12	28.6%	8	19.0%
Finger Lakes	49	31	63.3%	11	22.4%	7	14.3%
Central	57	25	43.9%	22	38.6%	10	17.5%
Northeastern	53	28	52.8%	18	34.0%	7	13.2%
Mid-Hudson	74	35	47.3%	31	41.9%	8	10.8%
New York City	173	78	45.1%	59	34.1%	36	20.8%
Long Island	97	31	32.0%	41	42.3%	25	25.8%
Statewide	545	250	45.9%	194	35.6%	101	18.5%

Where does the Field Stand with Succession Planning?

While 82 percent of providers believe that succession planning is a moderate or serious issue, only 16 percent of them indicated that a plan currently existed within their agency. Another 16 percent reported that such a plan was in development but not yet in place. Nearly a third of all providers across the State reported that a succession plan was not even under consideration within their organization.

Table 3.10: The Status of Succession Planning (N=547)

Region of the State	N	Plan In Place		Plan In Development		Plan Not Yet In Development	
		No.	Percent	No.	Percent	No.	Percent
Western	42	12	28.6%	3	7.1%	27	64.3%
Finger Lakes	50	10	20.0%	10	20.0%	30	60.0%
Central	57	11	19.3%	5	8.8%	41	71.9%
Northeastern	53	5	9.4%	12	22.6%	36	67.9%
Mid-Hudson	74	10	13.5%	12	16.2%	52	70.3%
New York City	173	29	16.8%	32	18.5%	112	64.7%
Long Island	98	12	12.2%	16	16.3%	70	71.4%
Statewide	547	89	16.3%	90	16.5%	368	67.3%

There are a number of important considerations when developing a successful succession plan, such as the active involvement and support of the Board of Directors and executive management staff. Of the providers that reported having a succession plan in place, 84 percent reported the involvement of the agency’s Board of Directors in the development of the succession plan for the executive director position. Eighty-eight percent reported that their succession plan included management development training and/or mentorship opportunities to develop future leaders. Nearly every provider that reported having a succession plan in place stated that the agency was “generally satisfied” with the plan. When asked about what aspects of their succession plan make it a good one, the following were offered as examples:

- Plan clearly states necessary qualifications, skills, experience, and selection criteria.
- Plan based on model developed by Council of Community Services of New York State (CCSNY).
- Plan developed with active participation of Board of Directors, executive management, counsel’s office, and/or staff team meetings.
- Potential candidates are nominated by management staff.
- Future leaders are brought in on Board activities (e.g., budget reviews, business decisions).

- Plan closely linked to agency’s intermediate and long-range goals.
- Plan develops staff at all levels to “deepen the bench.”
- Plan allows for development of “junior managers” from all ranks.
- Plan undergoes regular monitoring/review.
- The plan is flexible enough to accommodate change and growth.
- Leadership Academy developed incorporating process improvement and strategic planning.
- All professional staff have Professional Development Plans.
- Mentoring and on-going skills development provided to future leaders.
- Leadership development opportunities (real projects) offered to professional staff.

Providers that indicated they were only considering developing a succession plan or have not yet considered developing one were asked if they needed or desired training for their executive management staff or their Board of Directors on developing a succession plan. Only 31 percent responded that they did; only 17 percent of providers from the Northeastern Region.

Recovery-Oriented Support Services Survey

Recovery from addiction has often been viewed as no more than continued abstinence from problem alcohol/drug use or gambling. With the growing acceptance of addiction as a chronic disorder, efforts to integrate recovery management and promote sustained recovery for individuals, families, and communities within prevention, intervention, and treatment require a shift in orientation.

To better assess recovery support service needs statewide and understand the level of integration with addictions treatment and prevention services, the *2010 Local Services Plan Guidelines* included surveys to determine the scope of recovery-oriented services currently taking place among prevention and treatment providers. The provider survey identified:

- Services that are typically available in the community and are accessed while an individual or family is receiving treatment or prevention services;
- Services in the community that are usually accessed after an individual is no longer receiving prevention or treatment or services.

Survey results will serve as a baseline for this information. In future planning cycles, OASAS will measure the implementation of recovery-oriented services.

Similarly, the results of the county survey indicate those recovery-oriented services that are considered most important in helping individuals and families initiate and sustain recovery. In addition, counties were asked which recovery-oriented services should be

considered "billable" when delivered by providers eligible for third party reimbursement. This information will assist OASAS in determining whether amendments to the New York State Medicaid Plan should be considered.

The provider survey was completed by over 95 percent (1290 of 1360) of prevention and treatment providers. Tables 3.11 and 3.12 below detail the percentage of prevention and treatment programs reporting:

- Whether a specific recovery support service was provided by their program;
- If they knew the recovery support service was available in their community;
- If the recovery support service was typically provided concurrently with their respective prevention or treatment services;
- Whether the recovery support service was routinely accessed after a person or family completed the prevention or treatment service.

Table 3.11 Access to Recovery Supports Survey – Prevention Services

Recovery Support Services – Prevention n=291	Provided by Program	Available in Community	Used Concurrently with Program Scvs	Routinely Used Post Services
Recovery Support Groups	11%	8%	76%	39%
Recovery Coaching	10%	7%	67%	16%
Advocacy	72%	56%	36%	26%
Life Skills	62%	48%	31%	13%
Recovery Oriented Health & Wellness	35%	17%	54%	16%
Gender Specific Support Services	33%	18%	51%	15%
Faith-Based Services	5%	2%	80%	32%
Education and Career Planning	48%	29%	51%	19%
Communication Skills Development	62%	47%	28%	11%
Physical Education and Fitness	25%	19%	62%	27%
Cultural Activities	42%	33%	50%	15%
Alc/Drug/Gambling Free Social/Recreational	50%	26%	57%	26%
Family Education (on Addiction)	57%	33%	53%	14%
Parenting Skills in Recovery	34%	17%	62%	14%
FASD Screening for Children	5%	1%	68%	10%
Preventive Counseling for COAs	58%	41%	39%	12%
Primary Healthcare Services	5%	3%	78%	40%

Table 3.12 Access to Recovery Supports Survey – Treatment Services

Recovery Support Services – Treatment n=999	Provided by Program	Available in Community	Used Concurrently with Program Scvs	Routinely Used Post Services
Recovery Support Groups	45%	34%	59%	50%
Recovery Coaching	36%	28%	50%	23%
Advocacy	79%	60%	30%	20%
Life Skills	72%	57%	24%	11%
Recovery Oriented Health & Wellness	73%	51%	35%	17%
Gender Specific Support Services	59%	47%	41%	16%
Faith-Based Services	10%	6%	83%	31%
Education and Career Planning	53%	41%	53%	29%
Communication Skills Development	67%	51%	28%	10%
Physical Education and Fitness	24%	17%	73%	22%
Cultural Activities	30%	22%	69%	21%
Alc/Drug/Gambling Free Social/Recreational	44%	31%	63%	28%
Family Education (on Addiction)	66%	39%	37%	12%
Parenting Skills in Recovery	50%	28%	50%	18%
FASD Screening for Children	5%	2%	75%	14%
Preventive Counseling for COAs	23%	13%	64%	13%
Primary Healthcare Services	27%	23%	65%	44%

The provider survey also gathered information on the relative importance the program ascribed to each of the recovery supports. Providers were asked to assign a rank value between 1 and 5 for each of the recovery support services. Table 3.13 demonstrates strong support for the importance of advocacy, life skills, and primary healthcare by both prevention and treatment providers. It also demonstrates the differences that might be anticipated as a result of providing services at different points of the continuum. For prevention programs, services designed for children of parents with severe alcohol or other drug related problems and alcohol/drug and gambling free social and recreational activities rounded out their top selections. Treatment providers selected peer recovery support groups such as Alcoholics Anonymous (AA), Narcotics Anonymous (NA), Al Anon, and recovery-oriented health and wellness as more valuable.

Table 3.13 Top Five Recovery Support Services

Prevention	Treatment
Advocacy	Peer Recovery Support Groups
Life Skills	Primary Healthcare
Primary Healthcare	Advocacy
COA Services	Life Skills
Social/Recreational Activities	Recovery Health and Wellness

Additional analysis is underway to determine if there are significant regional differences and/or differences in ranking among treatment program types. While it is not surprising that treatment providers rank peer recovery support groups and gender specific recovery supports highly and prevention providers would assign a lower value, it is less clear why there appears to be a substantial discrepancy in the ranking of importance for preventive services for children of people with alcohol/addiction related problems (COA Services) between prevention and treatment services.

Counties assigned a value between low and high for the same recovery support services listed in the provider survey. They were asked to consider to what degree the specific recovery support service would enhance recovery management and result in sustained recovery outcomes if they were available in treatment. Counties were also asked to indicate which of the recovery support services should be included in a revised New York State Medicaid Plan. Table 3.14 portrays the percent of counties who selected each level of importance and who thought the service should be “billable” by a treatment provider.

Table 3.14 Percent of Counties Ranking Recovery Supports and Indicating Billable

Recovery Support Services	Low	Medium	High	Billable	
Recovery Support Groups	2%	5%	19%	72%	21%
Recovery Coaching	4%	21%	37%	39%	25%
Advocacy	2%	25%	40%	33%	35%
Life Skills	0%	26%	35%	39%	70%
Recovery-Oriented Health & Wellness	2%	19%	30%	49%	70%
Gender Specific Support Services	9%	32%	44%	16%	51%
Faith-Based Services	7%	53%	32%	9%	9%
Education and Career Planning	0%	23%	37%	39%	60%
Communication Skills Development	4%	40%	37%	16%	47%
Physical Education and Fitness	16%	35%	32%	16%	18%
Cultural Activities	23%	42%	19%	12%	9%
Alc/Drug/Gambling Free Social/Recreational	2%	26%	40%	32%	5%
Family Education (on Addiction)	2%	11%	40%	47%	74%
Parenting Skills in Recovery	4%	7%	37%	53%	70%
FASD Screening for Children	9%	25%	33%	30%	82%
Preventive Counseling for COAs	12%	26%	30%	30%	65%
Primary Healthcare Services	5%	11%	25%	60%	54%

All of the recovery support services, with the exception of physical education and fitness, faith-based services, and cultural activities were ranked either high or between high and medium by at least 50percent of counties. High ranking based on importance for enhancing recovery maintenance and sustaining recovery outcomes does not directly correspond to whether the service was also recommended to become “billable.” The relatively low ranking for faith-based services bears further investigation as there are

some indications that a significant number of people in recovery report that their faith communities are a major resource for sustaining their recoveries.

Table 3.15 Recovery Support Services Ranked by Higher Value (High or between High and Medium)

Recovery Support Services	Higher Value	Billable
Recovery Support Groups	91.2%	21.1%
Parenting Skills in Recovery	89.5%	70.2%
Family Education (on Addiction)	87.7%	73.7%
Primary Healthcare Services	84.2%	54.4%
Recovery-Oriented Health & Wellness	78.9%	70.2%
Recovery Coaching	75.4%	24.6%
Education and Career Planning	75.4%	59.6%
Advocacy	73.7%	35.1%
Life Skills	73.7%	70.2%
Alc/Drug/Gambling Free		
Social/Recreational	71.9%	5.3%
FASD Screening for Children	63.2%	82.5%
Gender Specific Support Services	59.6%	50.9%
Preventive Counseling for COAs	59.6%	64.9%
Communication Skills Development	52.6%	47.4%
Physical Education and Fitness	47.4%	17.5%
Faith-Based Services	40.4%	8.8%
Cultural Activities	31.6%	8.8%

Chapter IV: 2008 Achievements

Introduction

Under the leadership of Commissioner Karen Carpenter-Palumbo, the OASAS Executive Team launched its Strategic Mapping initiative in June 2007. The purpose was to clarify the agency's *core destinations* for OASAS, county, and provider staff in light of OASAS' Mission: *To improve the lives of all New Yorkers by leading a premier system of addiction services for prevention, treatment, recovery.*

With over 1,500 prevention, treatment, and recovery service providers who annually serve approximately 261,000 individuals, New York has one of the largest addiction services systems in the nation. The Strategic Map clearly defines OASAS and the field's anticipated success across key system dimensions.

As with any map, it is essential to have a clear sense of *destination*. During 2008, OASAS leaders and staff in close partnership with the field defined and conducted 15 outcome driven initiatives aimed at moving toward these defined *destinations*.

- *Mission Outcomes – To establish an effective, science-based program system, which integrates prevention, treatment, and recovery.*
- *Provider Engagement and Performance – To enable everyone the opportunity to achieve the “Gold Standard” as part of our system of service provision.*
- *Leadership – That New York solidifies itself as the State resource on addiction and leads the nation in the field of chemical dependence and problem gambling.*
- *Talent Management – That the addiction field becomes a “Profession of Choice” for attracting, selecting, and developing talent.*
- *Financial Support and Stewardship – To create and put into practice a system with strong return on taxpayer investment and stewardship of resources.*

This chapter summarizes OASAS and provider achievements for 2008 across the 15 metrics under the five *destinations*. This experience has greatly informed our work moving forward and is reflected in the 2009 OASAS Dashboard.

Each Metric identifies the OASAS Team Leader and the specific targets for 2008. These are followed by a summary of team accomplishments.

Metric 1: Improve levels of the substance abuse risk and protective factors in New York State communities in order to reduce the prevalence of substance abuse and problem gambling.

Team Leader: Barry Donovan

2008 Targets:

1. An updated Statewide Epidemiological Profile of Substance Abuse Risk and Protective Factors and Problem Gambling for tracking improvements will be developed and approved by the statewide committee and OASAS Executive Team.

During 2008, OASAS collaborated with the State Epidemiological Outcomes Workgroup (SEOW) to update the State and Community Epidemiological Profile. OASAS analyzed 2007 data from PARIS and developed baseline data on evidence-based prevention approaches for each county. These data were incorporated into the OASAS county profiles, which are being used across the State as part of the Communities of Solution initiative.

2. A Comprehensive Prevention Services Plan will be developed and approved by a provider committee and the Executive Team to prioritize risk-and-protective factor targets and identify the services and resources needed to improve targets for the next two years.

The agency began developing a Strategic Prevention Services Plan to redirect OASAS, State partner, provider, and community resources to reduce prioritized risk and protective factor targets at the local level. The Strategic Prevention Plan will be integrated into the OASAS Statewide Comprehensive Plan. Using data from the State Epidemiological Profile and the 2008 New York State YDS, OASAS and its partners will assess the need for and target prevention services at the local level.

3. Data from the statewide YDS, which assesses the status of community risk and protective factors, will be collected and analyzed by early 2009.

Data collection was completed in December 2008 for the statewide YDS of students in grades 7-12. In addition to information on the prevalence of alcohol and drug use and gambling among adolescents, the survey collected data on 25 risk and protective factors. The data, which has been disseminated to the more than 500 participating school districts across the State, will be used to plan and evaluate prevention services at the school district and county level.

Other Related Results Accomplished:

- Two regional Prevention Resource Centers were established with three more selected for the 2009-2010 fiscal year. The five Regional Prevention Resource Centers will provide training and technical assistance to foster and support community coalitions.
- As part of the implementation of the Prevention Resource Centers, OASAS and CADCA conducted a series of regional training sessions in October, November, and December 2008 for prevention providers and counties. The training was part of a strategy to shift the prevention paradigm from individual services to a regional center concept, establish local community coalitions, and implement evidence-based programming and environmental strategies.
- To support prevention planning and systems change, OASAS submitted an application to the federal Center for Substance Abuse Prevention (CSAP) for the Strategic Prevention Framework – State Incentive Grant (SPF-SIG). In July 2009, OASAS was notified that it will receive \$2.135 million per year for five years to implement a five-step planning process to support positive youth development, reduce risk-taking behaviors, build on assets, and prevent problem behaviors.
- A workgroup composed of agency staff and prevention providers updated the *Prevention Guidelines* to help define strategies and activities necessary to attain comprehensive and effective alcohol, tobacco, substance use, and problem gambling prevention services within the OASAS prevention framework. First established in 1995, these guidelines identify minimum program performance standards, personnel and fiscal practices, recordkeeping, and reporting requirements.

Metric 2: Increase the number of persons served who remain abstinent and successfully manage their addictions throughout recovery.

Team Leader: Steve Hanson

2008 Targets:

1. A definition of "Successful Recovery," along with attendant measures, will be developed and approved by a representative treatment/recovery provider group and the Executive Team.

Based on input from the Recovery Implementation Team (RIT) and attendees at the September 2008 Recovery Conference, OASAS developed a definition of "Successful Recovery." Five definitions were presented at the September 2008 Recovery Conference, with a survey taken as part of the registration process. The RIT reviewed and provided feedback on the definition preferred by survey participants. This feedback was used to

develop the final definition: **“A process of change in which an individual, family member, or family moves from impairment to an enduring and holistic focus on self awareness, understanding of others, and improved quality of life.”**

2. Baseline measures for assessing improvements in community support for recovery will be developed in conjunction with the Recovery Management Support Group using a wide range of data sources, including the CDS, Household Survey Data, Treatment Episode Data, and NOMs.

OASAS developed a list of proxy measures for the overall metric:

- Treatment Admissions;
- Treatment Complete Discharges;
- Successfully making it to aftercare within 60 days;
- Second Time DWI convictions;
- Drug Court Admissions;
- Drug Court Graduations;
- People engaging with Recovery Centers.

In lieu of the immediate incorporation of recovery specific questions in the next Household Survey, OASAS will use other mechanisms to develop baseline measures to assess community support for recovery. For example, the Local Service Plan Guidelines included surveys of counties and prevention and treatment providers regarding the availability of recovery services, and two additional recovery questions were added to the Program Profile and Services Inventory (PPSI).

Other Related Results Accomplished:

- In January 2008, OASAS formed the RIT. Membership of the RIT includes: local recovery communities, individuals in recovery, family members, counties, prevention and treatment providers, OASAS staff, and representatives from the criminal justice, child welfare, and mental health systems. Team members meet quarterly and work collaboratively to develop and improve services for persons in recovery.
- During spring 2008, OASAS conducted a series of focus groups targeted to people in recovery and family members. The issues most commonly noted across the different regions of the State included concerns about access to healthcare, employment, educational opportunities, stigma, and the reintegration of families early in recovery.
- OASAS sponsored a statewide Recovery Conference on September 14-15, 2008. The conference theme was “New York Voices of Recovery: Real People, Real Stories.” The conference also launched *The Stories Campaign* to celebrate recovery; build public awareness that recovery happens; and recognize that thousands of people in New

York are living healthy, responsible, and productive lives in recovery. The conference was coordinated with the celebration of September as National Recovery Month.

- On October 27, 2008, OASAS issued a Request for Proposals (RFP) for organizations to operate Recovery Community Centers. In July 2009, OASAS made awards to Phoenix House, the Center for Community Alternatives, and Friends of Recovery of Delaware and Otsego Counties. The Centers will offer a diverse range of recovery support services that are responsive to the local community. The Recovery Community Centers will offer significant new resources in the four communities where they are operated and serve as a learning laboratory for OASAS to study a variety of recovery support services and strategies. In the long-term, OASAS will provide support and technical assistance to recovery communities across the State based, in part, on the information developed through the Recovery Community Center initiative.
- OASAS believes that safe, affordable housing and stable employment are critical to successful long-term recovery. In accordance with this principle, OASAS created the Bureau of Housing and Employment Services in January 2008. The Bureau coordinates agency housing and employment efforts.
- As part of the New York/New York III Homeless Initiative, OASAS, in collaboration with ten providers and the New York City Departments of Homeless Services (DHS), Health and Mental Hygiene (DOHMH), and Human Resources Administration (HRA), developed apartments that house 250 homeless single adults who have completed chemical dependence treatment. Most of the participants have co-occurring mental health issues as well as addiction problems. The Second Round of New York/New York III funding includes three additional scatter-site programs (75 more apartments).
- On October 24, 2008, OASAS released the *2008 Planning Supplement First Round Upstate Permanent Supportive Housing Initiative*. The initiative mirrors the New York/New York III program model, adjusted for smaller upstate cities and rural communities. It will provide housing for single adults and families in recovery who began a course of treatment and/or recovery when they were homeless.
- In collaboration with DOCS, DOP, and DCJS, OASAS implemented an innovative program for parole violators at Manhattan's Edgecombe Residential Treatment Facility. The program integrates chemical dependence treatment, vocational preparation, parole supervision, and reentry. The program is the first of its kind in New York State. DOCS, DOP, and OASAS regard Edgecombe as a vital new approach to treating parolees, increasing public safety, and preventing relapse and recidivism. It houses up to 100 men for a period of 10 to 30 days. Each parole detainee must have a need for chemical dependence treatment. OASAS employees initially provided

treatment until Odyssey House was selected to operate the chemical dependence treatment program at Edgecombe.

- In October 2007, a reentry unit was established at the Orleans Correctional Facility to facilitate the smooth transition of inmates who are Erie County residents back to the community. It features a pilot program with several well-designed elements, including skill building, parole supervision, chemical dependence treatment, and care coordination based upon close collaboration among OASAS, DOCS, and DOP. Correctional counselors and facility parole officers deliver services such as employability preparation, family reintegration, and cognitive restructuring. An OASAS-funded provider assesses each inmate in the Orleans Reentry Unit for chemical dependence and makes referral to treatment accordingly. This is followed by long-term care coordination and, when needed, supplemental payments to providers to cover special services (e.g., transportation) that may facilitate the parolee's successful return to community life. This program was expanded during 2008 to serve inmates who are Monroe County residents.

Metric 3: Increase the number of persons served who improve their health including engaging in healthy lifestyles.

Team Leader: Peggy Bonneau

2008 Targets:

1. A baseline survey of OASAS programs will be conducted to determine organizational priorities and existing wellness programming to shape future wellness initiatives and metrics.

As part of the local planning process, OASAS conducted the *Tobacco-free and Employee Wellness Survey* to assess the readiness of programs to implement tobacco-free policies and procedures, problems encountered in their implementation, and the extent to which programs needed assistance from the agency. The survey also assessed prevention and treatment program activities related to employee wellness. It was completed in the Online County Planning System by 1,293 prevention and treatment programs, a response rate of 91.2 percent. The surveys provided OASAS with valuable information as it continues to work with counties and providers to promote healthy organizational cultures, work environments, and health and wellness programs.

2. Tobacco Free Regulation becomes effective 7/24/08.

On July 24, 2008, New York became the first State to implement tobacco-free regulations in all prevention and treatment programs. This groundbreaking wellness initiative was enacted on the anniversary of the Clean Indoor Air Act. While the smoking rate in New York State is 18.2 percent, it is as high as 92 percent among the 1.8 million New Yorkers

who are dealing with alcoholism and drug addiction. Tobacco-related disease kills more people each year than all other addictive substances combined. Evidence also shows that tobacco negatively impacts recovery rates from other substances because craving for nicotine increases craving for other drugs. More than 50 percent of the deaths in the chemical dependence treatment population are due to tobacco-related diseases. This is more than the deaths caused by HIV, homicides, suicides, fires, automobile accidents, alcohol, heroin, and cocaine combined.

An \$8 million DOH grant funded the development of tobacco-free curriculum for addictions program staff provided by the University at Albany's Professional Development Program. Over 10,000 individuals received training and assistance, with an additional 5,000 trained via the tobacco workbooks available online. The grant also funded nicotine replacement patches and gum at no cost to patients.

3. Staff participation levels: 15 percent of OASAS staff will participate in three newly formed initiatives (Weight Management, Walking Program, and Health Fair); and 15 percent of employees will participate in other on-site wellness activities.

Approximately 200 OASAS employees (25 percent) participated in the Health Fair, which was held in both Albany and New York City. Almost 250 OASAS staff participated in weight management, walking, and other on-site wellness activities.

Other Related Results Accomplished:

- OASAS began distributing its monthly newsletter "Wellness is For You" to all providers in April 2008. The newsletter provides helpful information about health, wellness, and topics of interest to the addictions field. OASAS created a wellness website as a resource for addictions programs and those dealing with an addiction. It has useful links and valuable information about nutrition, tobacco independence, emotional wellness, and stress management. The website is available at: <http://www.oasas.state.ny.us/wellness>.
- The RIT formed a workgroup to address health and wellness and its role in a recovery-oriented system of care. The workgroup is developing wellness brochures and tools for the addictions field and incorporated health and wellness as major themes of the statewide Recovery Conference in September 2008.
- OASAS established an advisory group to support its Office of Health, Wellness and Medical Direction. This group completed a survey to set priorities among wellness initiatives. Respondents noted they are most interested in:
 1. Self Management Tools
 2. The Importance of Wellness and Recovery
 3. Healthy Leisure Plan

4. Exercise and Movement
 5. Nutrition
- OASAS conducted a Learning Thursday training session on organizational culture as well as a presentation on this at the Alcoholism and Substance Abuse Providers of New York State (ASAP) Talent Pool meeting. The agency is developing a training workbook on organizational culture.

Metric 4: Increase the number of prevention and treatment providers and communities actively implementing evidence-based practices and achieving consumer level outcomes.

Team Leader: Susan Brandau

2008 Targets:

1. Increase of five percent over baseline for prevention programs conducting evidence-based practices.

OASAS used PARIS to obtain baseline data on the status of prevention programs' implementation of evidence-based practices. Nearly three-quarters (74 percent) of prevention programs reported implementation of evidence-based practices defined as either model programs or environmental strategies.

2. Increase of five percent over baseline for treatment providers implementing evidence-based practices.

OASAS conducted a survey of treatment providers in the *2009 Local Services Plan Guidelines* (March 2008) to obtain baseline data regarding the implementation of evidence-based practices. Providers were asked to identify the specific evidence-based practice and stage of implementation. A 90 percent response rate was achieved from providers on the survey. Ninety-five percent of respondents indicated they were at least in the implementation stage for at least one evidence-based practice. OASAS will now be focusing on increasing the percentage of programs that are sustaining the five targeted evidence-based practices.

Providers who indicated that they had achieved the sustainability stage received a follow-up survey to further assess their evidence-based practice adoption strategy and implementation process. OASAS will continue to support the implementation of evidence-based practices and disseminate information to the field regarding the most effective interventions and strategies.

3. Target five evidence-based practices for adoption (Motivational Interviewing [MI], Screening for Co-occurring Disorders, Cognitive Behavioral Therapy, NIATx Process

Improvements, and Medication Assisted Treatment) and develop practice guidelines and practical measures of fidelity for each evidence-based practice.

As part of the survey analysis, baseline data was established for five evidence-based practices:

- Cognitive-Behavioral Therapy (56.5%);
- Motivational Interviewing (54.1%);
- Screening for Co-Occurring Disorders (65.8%);
- Medication Assisted Treatment (Nicotine Replacement Therapy) (46.3%);
- Practice Improvement Administrative Practices (32.4%).

4. Conduct a Train the Trainer (TTT) on Motivational Interviewing (MI) in November 2008 that includes application and implementation guidelines.

With support from the Robert Wood Johnson Foundation, OASAS and ASAP co-sponsored the MI TTT, which was held November 10-13, 2008. Thirty-seven participants, representing all regions of the State, were trained by Dr. William Miller (a nationally recognized expert in this evidence-based treatment approach) and two other national trainers. The goal of this training was to increase the practice of motivational interviewing in addiction treatment programs. The group included two physicians, who will implement training for medical school residents in MI as a part of OASAS' efforts to introduce Screening, Brief Intervention, and Referral to Treatment (SBIRT) as a standard of care. This training was the beginning of an initiative to institutionalize expertise in every region to develop and sustain MI skills to transform the system of care by incorporating evidence-based treatment, clinical supervision, and patient-centered principles. Trainers agreed to participate in a learning community and a quality assurance process to achieve and maintain implementation of this evidence-based practice by using proven implementation strategies.

5. Convene two forums with providers that have fully implemented one of the targeted evidence-based practices to identify facilitators and barriers to adoption.

OASAS conducted two focus groups with providers to gather additional information about their experiences in implementing evidence-based practices.

6. Develop three regional learning collaboratives.

OASAS participated in the NIATx 200 Learning Collaborative held in Syracuse with 17 outpatient providers. The agency also initiated a process to expand the utilization of Strengthening Treatment Access and Retention-State Implementation/Quality Improvement (STAR-SI/QI). OASAS conducted a Learning Thursday webinar "Strategies and Tools to Improve Access and Retention/The NIATx Model" with 300 participants. The agency received national recognition from the Center for Substance Abuse Treatment

(CSAT) for its STAR-QI performance measurement system. It became the standard for other States to model.

Other Related Results Accomplished:

- OASAS conducted six World Cafés to develop a shared vision for improved access to the addiction services system and to elicit feedback from consumers, providers, counties, and agency staff on the identification of barriers that impede access to services and strategies to improve access. The Cafés were held in Albany, Manhattan, Brooklyn, Long Island, Buffalo, and Syracuse. CLMHD assisted OASAS in selecting county and provider representatives to attend these events. OASAS also reached out to recovery organizations and networks to ensure that a range of consumers attended the World Cafés. The goal was to identify key projects for adapting the service system based upon the concerns and ideas identified during the Cafés. Projects were reviewed by the design team for implementation. In July 2009, representatives from the design team will report on their progress at the NIATx/State Associations of Addiction Services (SAAS) Summit in Tucson.
- Four projects are underway to address the vision developed by the team and endorsed by Café participants, “Easy, affordable and welcoming access to client-centered addiction services for all:”
 1. OASAS is developing a campaign to encourage providers to conduct a “walk-through” to simulate the client experience and gain the customer perspective on what it is like for a client to engage in treatment. A walk-through template and recording form will be posted on the OASAS website. In addition, OASAS will offer technical assistance to providers that would like to develop an internal team to try new practices to help create a welcoming, accessible environment and reduce the perceived disconnect between the consumer’s perspective and the vision.
 2. OASAS trained two staff members on the process for developing recovery peer mentors/coaches consistent with a recovery-oriented system of care. Research has demonstrated that long-term treatment outcomes are better for individuals who actively participate in community-based recovery support services while concurrently receiving specialty care. Continued participation in community-based recovery support services is strongly associated with continued abstinence and improved quality of life post treatment. Significantly increasing the availability of recovery coaches and mentors is expected to result in more people engaging with community-based recovery supports.
 3. OASAS will convene at least two medical professional Cafés, one in New York City and one in Albany, to develop relationships with the medical community and introduce screening tools for use within primary care and other medical settings. OASAS data indicates that only two to three percent of clients enter

the addictions treatment system based upon a referral from the healthcare community. The medical professional Cafés will enhance communication to facilitate improved access to the OASAS system of care.

4. An internal OASAS workgroup entitled *Off-Site Services to Increase Access to Care* was developed to explore an issue identified during the Cafés. Providers would like the ability to provide services at non-certified sites and to be reimbursed for those services. The workgroup will identify the current billable status of certain addiction services delivered in select locations; such as assessments and SBIRT, identify at least one area to pursue billing for off-site services, and develop a strategy and timeline for implementation.

Metric 5: Increase service providers' achievement of the OASAS Gold Standard performance approach, which includes consumer outcomes, performance improvement techniques, regulatory compliance and use of evidence-based practices.

Team Leader: Janet Paloski

2008 Targets:

1. Build an Integrated Quality System (IQS) for determining the length of the Operating Certificate in a Certification renewal fully vetted by the Metric 5 team with buy-in from the field.

The agency began development of a new IQS, which will expand on the operating certificate renewal process that is currently in place. During Phase 1, in addition to the recertification review score currently used to determine their certificate term, the new approach will also include facility inspection, fiscal viability, client data reporting, and specific IPMES measures. Integrating these additional elements will allow for a broader vision of a program's performance.

2. Increase by ten percent the number of providers meeting at least one of the IPMES Gold Standard measures.

The baselines for these IPMES Gold Standard measures were developed in April and May 2009.

3. Engage 800 providers in Quality Improvement forums with follow-up on implementation in 2009.

In collaboration with ASAP, OASAS conducted Regional Gold Standard Partnership Dialogue on Treatment Forums in Suffolk, Nassau, Rochester, and New York City that

were attended by staff of 350 providers. The forums focused on the synergy of: full compliance with regulatory, Medicaid audit readiness, ethical, and quality-of-care standards; disciplined use of continuous quality improvement, clinical supervision, and staff development systems; infusion of research tested, evidence-based, and promising practices; wellness; and deliberate attention to patient satisfaction feedback and success indicators. In addition, OASAS staff presented institutes at the last two ASAP Conferences, entitled *Building a Foundation for Excellence and Gold Standard Partnership Models for Success*.

4. 25 Administrative Relief projects will be completed by 12/1/08.

The Administrative/Regulatory Relief Workgroup includes provider representatives and OASAS staff. The workgroup was charged with reducing paperwork and increasing time for individual care. These efforts have resulted in a regulatory guidance document, a new site review instrument that was finalized with providers, model case record forms, and changes to the *Part 822 Chemical Dependence Outpatient Services* regulations, effective February 18, 2009, that reduced paperwork considerably. The workgroup has also been responsible for overall revision of the *Part 822* regulations that will provide for more individualized care. In addition, the workgroup is continuing to develop/refine model case record packages and site review instruments for various OASAS service categories. At the end of 2008, 20 administrative relief projects were completed or nearing completion. Information of these projects can be found on the OASAS website at <http://www.oasas.state.ny.us/workgroup/admin/overview.cfm>.

Other Related Results Accomplished:

- As part of the Gold Standard initiative, OASAS initiated a project to develop program scorecards. The scorecards will help OASAS and the field to communicate their successes and use data to improve the quality of services. During the first phase of this project, OASAS is working with counties and providers to develop scorecards for all intensive residential programs. The scorecards will measure access, quality, outcomes, efficiency, and compliance. Ultimately, OASAS will implement program scorecards for all prevention, treatment, and recovery service types. Pilot scorecards were released on July 1, 2009 for intensive residential programs with scorecards for nearly 1,000 other treatment programs to be released by the end of 2009.
- OASAS delivered regional presentations in September and October 2008 to clarify new *Part 815 Patient Rights* requirements and to explain the clinical basis so that providers have a common understanding of why this is critical to quality services. More than 300 participants attended the presentations conducted in each of the seven regions. A summary of Frequently Asked Questions raised at the *Part 815* presentations was also developed and posted on the OASAS website. This resource provides a framework for providers to enhance their services in support of patient rights.

- OASAS developed a data base to track patient advocacy complaints. One-year of data on patient complaints is now available and reports can be generated by type of complaint, complaints per program, and service type.

Metric 6: Increase recognition of OASAS as a leader and expert, increasing visibility and recognition statewide and nationally.

Team Leader: Dianne Henk

2008 Targets:

1. Rebrand agency with new logo, tag, and descriptive lines.

In June 2008, OASAS rolled out a new logo with online stationery, reports, and supporting materials posted on the agency Intranet for staff use. A new agency folder was created for staff presentations to external audiences. The logo was also posted on the agency's website. To save money, existing brochures are being redone with the logo as supplies run out.

2. Roll out the first phase of the ongoing Your Story Matters campaign including: develop a system to collect 100 recovery stories in a stories bank; highlight 12 stories to be launched at the 2008 Recovery Conference with media coverage in at least 10 newspapers, magazines, and electronic media.

To offer individuals in recovery and their loved ones the opportunity to tell their stories of breaking the cycle of addiction, OASAS launched a stories of recovery campaign at the Recovery Conference in September 2008. The agency created an OASAS mailbox to collect stories from individuals in recovery. During 2008, 50 individuals submitted their stories. Responding to suggestions from the recovery community, OASAS began modifying the campaign in January 2009 to focus on pathways to recovery rather than substances of use. The campaign was branded with graphic design elements and the name was deemed "Your Story Matters." OASAS revised its website to support this campaign. There are 12 Spotlight Stories on the website highlighting the successes of individuals in recovery. These stories of strength and dedication can inspire hope for those still suffering from addiction and encourage others to join in the celebration of recovery. The agency set an ambitious goal of receiving 365 recovery stories during 2009.

3. Conduct scheduled media campaigns resulting in 50 positive stories for the year.

During 2008, OASAS had many noteworthy successes in increasing its local, statewide, and national recognition as a leader in the addictions field. The outcomes achieved in increasing the agency's media visibility exceeded expectations and set a baseline for

substantial growth during 2009. OASAS conducted successful FASD, Gambling, and Recovery Month media campaigns. Media efforts resulted in 48 unique positive stories during 2008. This included a national piece by the Associated Press that was picked up by numerous publications and broadcast media outlets throughout the nation.

4. Develop baseline data on target audience and metrics for assessing impact.

OASAS was unable to develop baseline data on our target audience and metrics for assessing impact due to funding constraints.

5. Redesign the Web site and develop new analytics for tracking Web traffic.

The State's fiscal crisis forced deferral of the project to redesign the agency's website, but modifications are being made to the site on a smaller scale within the existing design, including adding a rotating "advertising" box.

6. Consolidate the 800 numbers for the gambling and chemical dependence helplines and enhance our tracking ability.

OASAS combined and expanded the quality of the two chemical dependence and problem gambling helplines. The new OASAS Hopeline, 1-877-8-HOPENY, which began on February 1, 2009, is operated by the Mental Health Association of New York City. This expanded service provides information and referrals to callers on problem gambling and chemical dependence issues utilizing brief motivational interviewing techniques by Master's-level clinicians. Callers have the option to receive a follow-up call 48 hours after their initial contact to ensure they are getting the services they need. Eight Master's level interns from NYU and Hunter College School of Social Welfare are doing their field placements at the Hopeline. The interns receive training in addiction, assist callers, and participate in supervision as part of an effort to expand the potential talent pool of addiction professionals.

Metric 7: Increase understanding and awareness of addictive illness as a chronic, preventable, and treatable disease.

Team Leader: Steve Kipnis

2008 Targets:

1. Baseline survey completed of Field's understanding of addiction as a chronic disease.

A chronic disease model factsheet was developed and shared with the OASAS Executive Team to start a dialog on the model. A baseline survey was completed to measure understanding of the model. In May 2008, OASAS submitted chronic care information

for inclusion in the new American Society of Addiction Medicine (ASAM) Patient Placement Supplement on Alcohol.

2. Advocates' group will approve final policy statements, educational materials and continuing care regulations.

The agency developed a Chronic Care pamphlet and an aftercare regulation for incorporation into the draft *Part 822 Chemical Dependence Outpatient Services* regulations. OASAS developed a brochure to assist individuals in recovery in communicating with medical professionals and a manual to increase the awareness of medical providers regarding issues confronting those in recovery. The brochure is available on the agency's website at:

http://www.oasas.state.ny.us/pio/documents/HTdoctorvisit_2.pdf.

3. 100 CASACs and program staff will participate in training with 75 indicating an improved understanding of the Chronic Disease Model with 25 having follow-up conversations with coworkers about their learning.

OASAS developed a Chronic Disease and Recovery Workbook that was released in July 2008. Of the 554 individuals completing an evaluation of the Workbook, 96.6 percent understood the concept of addiction as a chronic disease and 91 percent indicated they would discuss the concept at work. Similarly, of staff attending presentations on the chronic disease model of addiction, 100 percent understood the concept of addiction as a chronic disease and 85 percent said they would discuss the concept at work.

Other Related Results Accomplished:

- OASAS focused on educating agency staff, the field, and medical professionals about addiction as a chronic disease and how this fits into a recovery-oriented system of care. On January 24-25, 2008, OASAS conducted a summit at West Point for agency leaders, providers, representative of other State addictions programs, and national experts in the field to consider how New York State's services system could be redesigned to address addiction as a chronic illness. The agency collaborated with the National Center on Addiction and Substance Abuse (CASA) at Columbia University on the development and coordination of this meeting. Presenters from the New Jersey Division of Addiction Services and Connecticut Department of Mental Health and Addictions discussed how they transformed their systems to implement a chronic care model. OASAS and CASA submitted a concept paper to the New York State Health Foundation to support OASAS initiatives to promote a recovery-oriented system of care.
- The OASAS Medical Director delivered presentations on addiction as a chronic disease to:

- National Institute on Drug Abuse (NIDA) Conference (June 2008);
 - DOH Hepatitis C Advisory Council (June 2008);
 - American Psychiatric Association – New York State Chapter (October 2008).
- Although chemical dependence is a leading cause of death, disability, and disease, several surveys have shown that physicians are not adequately trained to recognize and treat addicted individuals or to identify those “at-risk” of addiction. To address this issue, OASAS and Albany Medical College sponsored the Fifth Annual Addiction Medicine Weekend on November 14-15, 2008. Participants included physicians, chemical dependence counselors, and other healthcare workers. Among the areas covered were ethical issues in addiction medicine, addiction medications, and intervening with adolescents regarding substance use issues.
 - On January 23, 2009, OASAS collaborated with Albany Medical College in conducting Addiction Medicine Day for third-year medical students. Over 125 medical students participated in this third annual event. Nationally recognized experts, including OASAS’ Medical Director, delivered presentations on various issues including addiction medications, treatment of patients with pain, signs and symptoms of chemical dependence, impaired physicians, and neurophysiology of addiction. Addiction Medicine Day supplements information students received through an online addiction module that they are required to complete during the first two years of medical school.

Metric 8: Increase influence on State and national policy and practice.

Team Leader: Patricia Zuber-Wilson

2008 Targets:

1. Increase appointments to four positions on substance abuse disorder and problem gambling allied organizations/groups.

OASAS staff received the following appointments:

- Commissioner Carpenter-Palumbo was elected Treasurer of NASADAD Board of Directors.
- Tom Nightingale is co-leader for New York State – SAMHSA Policy Academy on Returning Veterans and Their Families.
- Doug Rosenberry was elected Vice President of the International Certification and Reciprocity Consortium (IC & RC).

- Legislation making Commissioner of OASAS co-chair of the Geriatric Mental Health Council was signed into law as Chapter 203 of Laws of 2008. OASAS will also make recommendation for Governor's appointee to represent the field.

2. Increase by four the participation by OASAS in membership on boards, committees, and panels of stakeholder organizations.

OASAS built partnerships with national and State constituency groups, which led to joint policy initiatives. OASAS held a budget briefing and legislative briefing in 2008 with constituency groups and provided comments on numerous policy papers issued by national and State organizations. As a result, the National Governors Association and the National Association of State Emergency Preparedness Directors included substance abuse prevention and treatment in disaster preparedness policy papers. The agency participates in the National Treatment Network, National Prevention Network, and Women's Services Network. OASAS conducts monthly conference calls with stakeholders and constituency groups on hot topic issues related to federal policy.

The agency developed State level partnerships with constituency groups to support the Social Host bill submitted for consideration by OASAS. Through this effort, a diverse group of stakeholders came together to support the bill. The bill passed the State Senate and, although it did not pass the Assembly, the coming together of these constituency groups was a major accomplishment. OASAS continues to collaborate with these constituency groups on the Social Host bill through conference calls and other mechanisms.

3. Increase reliance on OASAS by federal, State, and local stakeholders by increasing to 25 the number of substantive contacts, meetings, and briefings by senior OASAS leaders.

OASAS made significant strides during 2008 in increasing its influence on State and national policy. The agency accomplished this by educating, through briefings and other correspondence, congressional members, State legislators, and their staff. This effort also extended to the national and State associations and constituency groups. OASAS commented on both legislation and policy matters. The key to the strategy is making sure that addiction prevention, treatment, and recovery services are part of any policy discussions. To provide a more cohesive approach to federal grants management policy and legislative and regulatory issues, the Bureau of Grants Management and Federal Policy was made part of the Office of Government Affairs.

Significant contracts, meetings, and briefings by senior OASAS leaders included the following:

- Commissioner Carpenter-Palumbo provided briefings for congressional staff (2), and a presentation to the Assembly Committee on Alcoholism and Drug Abuse (1) and Legislative Finance Committees (1).

- Substantive meetings with all 24 members of the Senate Mental Health Committee and Assembly Alcohol and Drug Abuse Committee. Of these meetings, 20 were held throughout the State in district offices of the members. Meetings were held with an additional 28 members of the State Legislature on legislation and constituent issues. Overall, there were meetings with 48 members of the Legislature.
- Conducted ten briefings for legislative staff on the budget, agency legislation, and key policy issues. Conducted legislative staff visits to three ATCs and a site visit to the Edgecombe Treatment Facility. The Edgecombe visit included legislative staff who work on criminal justice issues.
- Conducted four constituent group meetings on the budget and agency legislation.
- OASAS receives four to six calls and e-mails per week from elected officials and staff. All calls and e-mails received an initial response within 24 hours. Any additional follow-up was achieved within 48 hours. These included requests for information, assistance with community issues, and constituent assistance in accessing treatment.

Other Related Results Accomplished:

- During 2008, OASAS submitted 15 legislative proposals to the Governor's Office for consideration. Eight proposals were approved for submission and introduced in the Legislature. Six of the eight bills were passed by the Legislature and signed into law by the Governor. Two bills were passed by one house of the Legislature.
- OASAS provided comments on 35 State legislative proposals related to the field of addiction.
- OASAS provided comment and analysis on six congressional or federal regulatory proposals including Centers for Medicare and Medicaid Services (CMS) regulations on upper payment limits (UPL) in collaboration with constituent organizations.
- OASAS participated in NASADAD Policy Committee meetings on a monthly basis and provided information and analysis on federal policy and legislation. Through participation in these calls OASAS staff assisted other substance use authorities on the issue of proposed regulations by CMS, including a devastating proposal related to UPL methodology.

Metric 9: Decrease the number of alcohol, substance abuse, and gambling related consequences to the Public Health, Public Safety, Public Welfare, and Public Education systems.

Team Leader: William Barnette

2008 Targets:

1. All 17 public agencies participating in the ACTION Council will identify their priority alcohol and other drug (AOD) consequences.

The success of OASAS' collaborative efforts was demonstrated on April 15, 2009 when Governor Paterson announced the creation of the ACTION initiative to address alcohol, drug, and gambling addictions that affect nearly 2.5 million New Yorkers. The Governor issued Executive Order No. 16 to direct the partnership of 20 State agencies with non-profits and the private sector and coordinate addiction resources in the areas of public health, safety, welfare, and education.

The Governor appointed a chair of the ACTION Council. The Council, which is coordinated by OASAS, includes commissioners from 20 State agencies. It collaborates with non-governmental stakeholders, community-based organizations, addiction treatment providers, academic institutions, and businesses. The Council focuses on organizing various resources to better develop strategies that improve efforts to identify, treat, and prevent addiction. In addition, the ACTION Council builds upon the recently enacted Rockefeller Drug Law reforms, which emphasize treatment over incarceration for non-violent drug offenders.

2. All 17 public agencies participating will have baseline data for appropriate measurement of change in these consequences.

Existing baseline data developed in 2007 being reviewed and updated and additional data elements being added for discussion at first ACTION Council meeting of 2009.

3. 12 of 17 public agencies participating will launch specific initiatives to improve early identification of people with AOD-related problems in their respective systems.

Completed analysis of more than 70 cross-system initiatives involving two or more agency partners that address consequences of addiction in one or more of the ACTION Council sector domains.

Other Related Results Accomplished:

- As Chair of the IOCC, OASAS collaborated closely with member agencies OMH and OMRDD as well as ad hoc agencies including DOH, SED, OCFS, and DDPC. In August 2008, OASAS, OMH, OMRDD, and DOH published the *People First Progress Report*. The Report summarized progress in implementing the recommendations from the *People First Coordinated Care Listening Forums*. It announced nearly **50** actions that the four agencies had taken in response to input provided and

suggestions made at the *People First Forums*. These actions focused on improving care across multiple systems

- On July 31, 2008, Commissioners Hogan and Carpenter-Palumbo signed a Memorandum of Agreement (MOA), which underscored the shared commitment of OMH and OASAS to the provision of integrated treatment, as well as the shared understanding of the operational flexibility needed to support that goal. In a joint letter, the two commissioners strongly encouraged *OMH and OASAS clinics to screen all clinic recipients for co-occurring substance use or mental health disorders, depending on the setting*. They agreed that integrated treatment is possible within a provider's existing certification. OASAS and OMH collaborated to begin use of the CRAFFT Addiction screening tool at all of OMH's Clinic Plus sites to better identify youth who, in addition to having mental health treatment needs, also have addiction problems.
- As a result of the collaborative initiatives between OASAS and OMH that have resulted from the work of the Task Force on Co-Occurring Disorders, the New York State Health Foundation announced the award of a \$3.2 million grant on January 9, 2009, to fund the first statewide Center of Excellence for the Integration of Care (CEIC) to transform the system of care for 1.4 million New Yorkers suffering from both mental health and substance use conditions. This funding will advance OMH and OASAS initiatives to eliminate barriers to mental health and chemical dependence treatment services.
- OASAS participates in the New York/New York III Homeless Initiative, which has placed 325 homeless single adults in recovery into permanent housing since fiscal year 2008-2009. The Upstate Permanent Supportive Housing (PSH) program has brought access to seven Upstate communities that previously had no OASAS housing options. These are Buffalo, Watertown, Poughkeepsie; and the rural counties of Cortland, Madison, Ontario, and Wayne.
- In March 2008, the commissioners of OASAS and OCFS established a Plan of Cooperation. It outlined eight broad areas where the two systems can work more closely together to address juvenile justice and child welfare issues. During 2008, OASAS certified providers delivered 7,000 units of outpatient services at 16 OCFS sites. This represented an 18 percent increase from 2007. OASAS added two satellite clinics to serve youth in OCFS facilities. Coordination meetings between OASAS and OCFS senior and program staff continue, with a focus on strengthening existing addiction services and establishing new addiction treatment opportunities for youth in the care of OCFS. The two agencies updated the contractual services agreement between OASAS and OCFS facilities. OASAS conducted two demonstrations of its CPS for OCFS Planning and Information Technology staff. The two agencies are exploring the potential for collaboration in local planning and CPS. OASAS surveyed

youth in 27 OCFS facilities as part of the YDS. This will provide information on risk and protective factors for youth in the juvenile detention system.

- OASAS conducted training for AIDS Institute staff on prevention, treatment, and recovery. Approximately 300 staff received training in five locations. The agency also conducted training for Office of Prevention of Domestic Violence staff in prevention, treatment, and recovery. OASAS is a member of the New York State Domestic Violence Advisory Council. While anecdotal evidence over the years has identified the prevalence of domestic violence among people with addictive disorders, no objective prevalence data was available. In 2008, OASAS revised its CDS to collect information on both the victims and perpetrators of domestic violence. When clients are discharged from treatment, information is collected on whether the client was ever a victim or a perpetrator of domestic violence. OASAS treatment providers began reporting this data in April 2009.
- OASAS worked with SED to incorporate its Violent and Disruptive Incidents Reports (VADIR) data into our epidemiological systems.
- OASAS received \$435,000 in funding from the Governor's Traffic Safety Committee (GTSC) to develop an e-data system, which will assist us in implementing DWI screening, assessment, and evaluation.

Metric 10: Increase leadership and promotional opportunities to increase the diversity of the leadership structure in the field.

Team Leader: Loretta Poole

2008 Targets:

1. Increase the number of underrepresented staff engaged in leadership development opportunities.

During 2008, OASAS focused on fostering cultural competency in the agency and the field, and on increasing leadership opportunities for diverse groups. The agency expanded the leadership team by including Open Chair opportunities for Talent Pool members and other staff. OASAS developed selection criteria for the Talent Pool to encourage participation of underrepresented staff in this innovative leadership development opportunity. Of the four selection criteria for the Talent Pool, two related to cultural competency. Talent Pool members are a diverse group with a wide variety of experiences and skills. Their strengths include competencies grounded in diversity, cultural sensitivity, and knowledge of the field.

The agency expanded examination announcement distribution for four titles. These were: Addictions Program Specialist; Secretary 1 and 2; Substance Abuse Traineeship; and Public Administration Transition Traineeship. OASAS conducted study groups for those taking these civil services exams.

2. Collaborate with Metric Team #11 to enhance recruitment of diverse candidates in CASAC initiatives.

OASAS established baseline data on the agency and field to inform hiring and promotional goals and strategies. The data showed that while Blacks and Hispanics comprised about half of statewide treatment admissions, they constitute about 20 percent of OASAS staff.

3. Complete cultural sensitivity training for 2 percent of OASAS staff and 20 percent of providers.

OASAS expanded cultural competency training for agency staff and the field. The goal of the training is to improve employee sensitivity regarding the unique issues affecting diverse groups. The three-day cultural competence awareness workshop for OASAS and provider staff was field tested at six sites. The workshop will be offered to the field in 2009. Over 200 OASAS and provider staff members took the 90-minute cultural competency web-based training. The OASAS Affirmative Action Advisory Committee, OASAS Diversity Committee, and ASAP Cultural Diversity/Competency Committee are developing a plan for completion of the cultural competency curriculum.

Metric 11: Increase the number of credentialed staff and other Qualified Health Professionals working in the field.

Team Leader: Doug Rosenberry

2008 Targets:

1. Expand credentialing course offerings (10,780 in 2007) and student enrollment in Addiction Medicine series (9,300 in 2007) by ten percent in 2008.

Credentialing course offerings increased by 19.9 percent and enrollment in addiction medicine rose by 101 percent.

2. Issue 1,000 new CASAC certificates by 12/31/08. (The 2007 baseline was 350.)

OASAS issued 1,096 new CASAC certificates during 2008. This tripled the number of certificates issued during 2007.

3. Increase by 20 percent the number (5 in 2007) of education and training providers that offer certificate programs for the CPP/CPS credential.

OASAS expanded the number of approved education and training providers by two (40 percent increase) that offer the full 250-hour prevention certificate programs. The new providers were Empire State College and the Alcoholism Council of New York.

4. Issue 50 new Gambling "Stand Alone" and specialty designations by 12/31/08.

Because the newly amended credentialing regulations were not promulgated in 2008, OASAS was unable to meet its goal of issuing credentials to problem gambling counselors; however, the agency did issue 23 gambling specialty designations to currently credentialed CASACs and Credentialed Prevention Professionals (CPPs).

5. Establish four CARN Chapters in New York State to promote CARN certification. (Currently none)

The agency worked with the International Nursing Society on Addictions (IntNSA) to establish the first Certified Addictions Registered Nurse (CARN) Chapter in New York State in September 2008. This Chapter now has three geographic branches: Cheektowaga (September 2008); Latham (January 2009); and New York City (May 2009). The CARN Chapters enable nurses in New York State to be recognized for their specialization in addiction.

CARN Chapters are established under the auspices of IntNSA, which oversees the CARN certification process. IntNSA has, as a primary goal, the furthering of peer collaboration and education in addiction-related nursing services. All CARN Chapter meetings count toward continuing education credits for State and CARN certification requirements.

Other Related Results Accomplished:

- Embracing the concept of making the addictions field a "field of choice," OASAS and its major stakeholders worked collaboratively to develop strategies and implement action steps that would "rebrand" workforce development efforts in a way that encourages innovation and elevates public awareness of the benefits and rewards of a career in the addictions. In support of this, OASAS and its partners have demonstrated significant progress in meeting many Talent Management objectives.
- OASAS introduced a series of procedural and regulatory changes in early 2008 to streamline the credentialing process and eliminate unnecessary barriers for candidates seeking to enter the field. These included eliminating the Case Presentation Method (CPM) oral examination, extending the renewal cycle from two to three years, maintaining the renewal fee at \$150, and broadening the criteria for acceptable continuing education. Revisions to the draft credentialing regulations have

been incorporated since they were completed in December 2008 and OASAS expects to promulgate them, following a period of public comment, in fall 2009.

- Although New York State's fiscal crisis prevented efforts to introduce salary enhancements for the field, the Talent Management Committee, a representative group of about 70 experts, made significant progress during 2008 in developing strategies to address the multitude of issues confronting the addictions workforce. The Committee formed seven workgroups: leadership development; career ladders; organizational culture and best practices; marketing; recruitment, hiring, and retention; compensation; and staff development and training. Among the accomplishments of the Talent Management Committee were:
 - Developed a plan for surveying the service delivery system in 2009 on succession planning, particularly as it relates to individuals and agencies.
 - Presented a proposal for New York State to implement a registration process for direct care workers who are neither credentialed nor have status as Qualified Health Professionals. Such a registry would increase accountability and document the number and composition of this segment of the workforce.
 - Sponsored a May 2008 workshop by Dr. Cheryl Whitley on "Compassion Fatigue and Counselor Wellness: A Staff-Centered Approach to Transform the Work Environment."
 - Purchased a URL domain for a five-year period to serve as the Talent Management Resources Clearinghouse. AddictionsCareerResources.org will serve as the foundation for a "virtual" Talent Management Center and hub for marketing efforts.
 - Developed a plan to launch the Talent Management Center, a web-based virtual resource that will: offer a wide range of resource materials and linkages to organizations that train, hire, or support addictions professionals; operate a toll-free call center to provide information and career guidance to aspiring entry level professionals; and establish a data base of job postings and resumes for employers, professional schools, and prospective employers.
 - Designed a staffing and salary survey and collected data through the Local Services Planning process to establish baseline information on salary and retention issues across job categories.
 - Sponsored regional forums throughout the State in the spring and early summer of 2008 on staff pension and retirement plans.

- Designed and disseminated an *Employee Benefits Questionnaire* to capture a base of qualitative information to enable a standard to be developed for defining basic, adequate health coverage that reflects parity with other systems.
- Designed and incorporated in the existing Independent Peer Review (IPR) process, an evaluation of Clinical Supervision at the agency level. Each of the 21 agencies participating in IPR during 2008 elected to take part in the Clinical Supervision component of the process.

Metric 12: Increase full knowledge, expertise, and retention of high-performing staff throughout the field.

Team Leader: Kathleen Caggiano-Siino

2008 Targets:

1. Employee Engagement data gathered using the Best Places to Work assessment will be used to identify a set of specific actions, selected by 100 OASAS leaders, which will be employed to improve OASAS Best Place to Work (BPTW) score from 63 percent overall.

In 2008, OASAS reapplied to become a “Best Places to Work.” Although the agency did not receive this honor, employee survey results showed significant improvement over those for 2007. Major findings included:

- Positive engagement results increased from 63 percent in 2007 to 74 percent in 2008;
- Positive responses to the statement, “My supervisor treats me fairly,” increased from 50 to 85 percent;
- Positive responses to the statement, “Our rewards and recognition programs are meaningful to me,” increased from 45 to 62 percent;
- Positive responses to the statement, “My supervisor helps me develop my career,” increased from 58 to 72 percent;
- The work environment had the highest level of positive responses at 83 percent.

Survey results also identified areas for improvement including: leadership and planning; organizational culture and communications; and training and development. While some issues identified are outside of OASAS’ control because of civil service law and labor agreements, Executive Team members are gathering suggestions from employees on how the agency can improve in these areas. The Engagement Committee is working on developing supervisory training and expanding the professional development principles of the Talent Pool to additional staff.

Ten addiction providers committed to applying to become a “Best Company to Work For.” Two providers received recognition as “Best Places to Work” – St. Joseph’s Rehabilitation Center in Saranac Lake and Horizon Health Services in Buffalo.

2. Ninety percent of the 120 OASAS Management/Confidential staff along with at least 75 percent of all other OASAS staff represented by other bargaining units will commit to written professional development plans.

OASAS also launched an agency-wide training effort as part of the internal talent management effort. Staff are creating/revising individual development plans to connect their work with the division level metrics and one or more of the agency’s destinations. Two hundred twenty OASAS supervisors were trained in how to develop a professional development plan and all agency employees had the opportunity to receive this training.

3. Through the 26-week Learning Thursday initiative, 22 courses will be offered serving at least 4,400 staff with at least 80 percent rating the sessions as good or excellent.

More than 3,700 OASAS and provider staff participated in the 20 Learning Thursdays held during 2008. These web-based training programs were delivered by OASAS and provider subject matter experts at no cost to participants. They provided OASAS and provider staff with learning and development opportunities that enhance their knowledge, skills, and understanding of the rapidly changing addictions field. The programs encourage learning, teaching others, and practicing concepts at work. Participants receive credentialing hours for CASAC, CPP, and Credentialed Prevention Specialist (CPS) approved courses. Among the 20 courses were: “Understanding Drug Abuse and Addiction,” “Recovery Movement in New York,” “Cultural Competency,” “Co-Occurring Disorders,” “The Outcome Dashboard,” and “Becoming a Profession of Choice: Talent Management for Our Future.”

4. 25 staff at OASAS will be ready for increased responsibility and leadership roles positions through the Talent Pool learning strategy.

OASAS launched the Talent Pool Program as an internal staff development component of our overall talent management strategy. Underlying the Talent Pool is the belief that employees are responsible for their own professional development. The Talent Pool provides centralized learning opportunities to participants, but it is the participant’s efforts that determine the ultimate success of their training and development. Talent Pool components include public speaking, working on teams, readings, assessments, volunteering, rotational assignments, and special projects.

The agency used a peer selection process to choose members of the Talent Pool. As a first step, OASAS formed a Talent Pool Design Team representing all parts of the agency. The Team designed the program, conducted outreach and information sessions, developed selection criteria, and selected Talent Pool members. After a rigorous selection process,

25 OASAS employees were selected for the Talent Pool's initial class in September 2008. Talent Pool members are a very diverse group with a wide-range of backgrounds and experiences.

Each Talent Pool member was given a professional mentor. Mentors include former Chief Executive Officers (CEOs) and high level State government policymakers and managers. Opportunities for Talent Pool members have included shadowing the commissioner, participating in priority workgroups, and attending Leadership Business meetings. The Talent Pool is a model training and development program that has generated significant interest from other State agencies. The program benefits employees, the agency, and the people OASAS serves.

Metric 13: Increase the number and percentage of OASAS and field staff (including both providers and counties) that bring forth innovative ideas and agree to test them through rapid cycle improvement.

Team Leader: Bill Phillips

2008 Targets:

1. Launch at least 45 projects by 40 different staff in three different divisions/units or among providers, with a 75 percent (34) completion rate and 50 percent (23) success rate (defined as substantially achieving the desired project result).

The rapid cycle change approach was introduced during the first OASAS Leadership Business meeting in October 2007. As a result of this session, OASAS Leaders launched 16 projects and completed 14. Overall, staff completed 29 of 32 rapid cycle change projects. Some of the noteworthy projects were:

- Implemented a process to reduce admission time at ATCs to no more than two hours;
- Provided new employees with immediate basic Internet access;
- Developed a co-occurring disorders Listserv to exchange information about these conditions;
- Implemented a new Commissioner's briefing form and a more efficient process for submission;
- OASAS now accepts personal checks for CASAC renewals;
- Reduced the number of IPMES/Workscope manuals mailed to programs and encouraged viewing of the documentation on the website;
- Streamlined the hiring process allowing managers and supervisors to make final decisions for positions below Grade 27.

Rapid cycle change proved to be an effective mechanism for testing ideas and implementing innovative solutions in a timely manner. A key to success is that the

“suggestor” should be willing to do more than have an idea. They need to take ownership of their suggestions and be willing to participate in testing and implementing them. Without this commitment, good suggestions are less likely to be implemented. While some ideas do not lend themselves to rapid cycle change, most do. One of the strengths of this approach is the ability to take large projects and break them down to distinct manageable segments. Our experience demonstrated that rapid cycle change also empowered staff. Employees saw first-hand that ideas were valued and their initiative resulted in improvements. Rapid cycle change also provided another opportunity to recognize staff for their efforts and celebrate their accomplishments.

Rapid cycle change has worked especially well in the ATCs. Several community-based providers have expressed interest in this approach and OASAS staff is delivering technical assistance to them in conjunction with the field offices.

Metric 14: Secure and maintain adequate resources from federal and State governments and private foundations.

Team Leader: Reba Architzel

2008 Targets:

1. Funding for “base” services will be maintained at 2007 levels, as adjusted for increased costs to deliver services. (Baseline: \$563 million in OASAS State Operations and Aid to Localities funding.)

The worldwide economic crisis and its impact on the federal government and New York State presented serious challenges to OASAS’ ability to secure and maintain adequate funding for the addiction service system. Despite these challenges, OASAS continued to move forward aggressively on its agenda to improve the lives of New Yorkers through prevention, treatment, and recovery.

While FY 2008-2009 appropriations were increased over the prior year by \$32 million (total for State Operations and Aid to Localities), OASAS took the following actions to contain and reduce spending:

- Developed its “Program to Eliminate the Gap” (PEG), which was approved by the Governor’s Office and Division of the Budget (DOB). PEG required a 3.35 percent spending reduction in State Operations and a 2 percent reduction in Aid to Localities.
- Prepared a comprehensive inventory of every agency program, dollars spent on these programs, number of employees dedicated to each program, and rated the programs against the agency’s core mission. The inventory was approved and released to the public.

- Implemented a hiring freeze, effective July 30, 2008, in compliance with DOB guidelines. OASAS successfully negotiated waivers/exemptions for health and safety positions at our ATCs.
- Implemented cost control measures, effective November 4, 2008, for all spending not involving federal reimbursement of at least 75 percent or impacting health and/or safety.
- Submitted a "Zero Growth" Budget Request for 2009-2010.
- Negotiated that \$2 million be transferred from DOP to OASAS in 2009-2010 to partially support outpatient and residential treatment programs whose contracts were terminated by Parole. OASAS selected providers for continuation based on performance indicators.

2. Payments for approved local services, based on appropriation restructuring, will be processed on time to be tracked based on agency interest payments.

The State Legislature adopted OASAS' appropriation restructuring proposal. The agency implemented appropriation restructuring without any delays in making payments to providers.

3. Consensus on the following will be achieved for screening, brief intervention, referral and treatment services (SBIRT): Need for screening and brief intervention services; Program model(s) to be used in delivering services; Payment mechanisms; State/local budget implications.

OASAS took a number of steps to access funding and reimbursement to advance the SBIRT initiative. The agency developed a \$12.6 million grant application, which was submitted by the Governor to CSAT. The application scored high enough for final review, but New York was not one of the three States awarded a SBIRT grant.

OASAS assisted Albany Medical College in its successful application for a federal grant to train medical residents in SBIRT. The Commissioner and Medical Director were invited to sit on AMC's advisory committee for this grant. OASAS, in partnership with the Lesbian, Gay, Bisexual, and Transgender Community Center, secured federal grant funding to implement SBIRT services for patients in sexually transmitted disease (STD) clinics in New York City.

The Commissioner participated in the SBIRT summit, convened by the Office of National Drug Control Policy, which provided information and access to national studies on the efficacy of SBIRT. Materials acquired through this summit were shared with DOH in support of a proposed 2009-2010 SBIRT initiative that was enacted as part of the 2009-2010 State Budget. DOH has proposed that Medicaid pay for Screening and Brief

Intervention (SBI) in emergency rooms only. OASAS is working with DOH to assure SBI implementation, including any required amendment of the State's Medicaid Plan, and continues to work with the insurance and business sectors to encourage coverage through healthcare plans.

Medicare and some private insurance plans have approved payment for SBI. OASAS published an "FYI" as part of the Addiction Medicine series that describes SBIRT and alerts healthcare providers that Medicare reimbursement is available for these services.

4. All Federal discretionary and foundation grant funding for prevention, treatment, and recovery-related services awarded to State Agencies and others will be identified by grant purpose, amount of funding and award recipients. (Baseline: 2007 awards from federal and State sources.)

OASAS joined with other State, federal, and local government representatives and veterans in developing a proposal to better address the needs of veterans and their families. This work led to New York's selection (one of only nine States and a territory) for the SAMHSA Policy Academy "Paving the Road Home: The National Behavioral Health Conference and Policy Academy on Returning Veterans and Their Families" and, subsequently, to an Executive Order convening the New York State Council on Returning Veterans and Their Families. Although SAMHSA has yet to make any funding available to policy academy selected states, New York continued to push forward and secured funding from the Health Foundation and others, including a requested congressional earmark for 2010, to address the goals identified by the policy academy team in New York's action plan.

Metric 15: Implement a system that insures a strong return on taxpayer investment.

Team Leader: Michael Lawler

2008 Targets:

1. New York will secure SAMHSA approval of two remaining NOMs, which will complete the State's approval.

OASAS continues to work with SAMHSA and NASADAD to reach consensus on the two remaining NOMs: social connectedness and perception of care. For the social connectedness measure, OASAS implemented reporting changes to its CDS to capture participation in self-help groups at admission and discharge. CSAT is expected to accept OASAS' CDS measure as satisfying this NOM. Consensus has yet to be achieved on the client perception of care NOM.

2. New York's 2009 SAPT Block Grant application will include all NOMs, with full approval by SAMHSA and award of all funds.

The 2009 SAPT Block Grant application and required Annual Synar Report were both submitted by October 1, 2008 (the Synar report was submitted a full three months before the required deadline). The application included reporting on NOMs for all available data. Both the application and report were approved by CSAT and CSAP. The 2009 SAPT Block Grant was awarded with no restrictions or required additional submissions.

3. Performance based contracting options for the field will be identified and approved by Executive Team.

This work has been deferred due to other pressing priorities including the release of numerous Local Planning Supplements.

4. Ambulatory Patient Groups (APGs) for outpatient services will be approved by the Executive Team.

OASAS is developing a new outpatient reimbursement methodology – APGs. It is designed for use as the basis of payment in a visit based ambulatory prospective payment system. The agency expects to begin implementation of this methodology in July 2010 and phase it in over a four-year period. The implementation of APGs is an integral part of the move by the addictions field to one outpatient system of care.

OASAS met regularly with DOH, OMH, and OMRDD to address APG development issues and to develop a coordinated approach. The agency also convened both internal and external APG workgroups. The external workgroup, which includes counties, providers, and hospitals, has provided valuable input on fiscal and programmatic issues.

OASAS developed a draft APG map that it shared with stakeholders. It outlines various aspects of implementation including the development of the pricing structure for evaluation, assessment, individual and group counseling, and medication management. OASAS conducted analysis on base rates and weights associated with APGs to provide a fairer, more equitable payment system that reflects the costs of services provided on the basis of a visit.

5. A fully integrated electronic/web-based State Aid Budgeting and Reporting System (SABRS) will be used by Field Offices.

On March 17, 2008, OASAS provided electronic access to SABRS for use by Field Office staff in determining local funding allocations. In early 2009, the agency implemented a fully integrated, web-based SABRS. The reduction in paperwork has resulted in significant time savings and efficiencies for the Field Offices.

Other Related Results Accomplished:

- Commissioner Carpenter-Palumbo formed a Regulatory Workgroup to revise the *Part 816 Chemical Dependence Withdrawal and Stabilization Services* regulations, as recommended by the Joint Task Force on the Continuum of Care for Alcoholism and Substance Abuse Services. The workgroup, which included representatives from each detoxification level of care, completed draft regulations in February 2008. Additional revisions to these regulations were made to meet the statutory requirements of the 2008-2009 State Budget. The draft regulations were reviewed at the August 20, 2008 meeting of the Governor's Advisory Council on Alcoholism and Substance Abuse Services.

- The *Part 816* regulations were adopted in December 2008. They provide paperwork relief in assessment and treatment planning and better reflect the primary medical and crisis stabilization needs of detoxification patients including: withdrawal, stabilization, and linkage to treatment services. Medical and clinical staff now has increased flexibility and time to develop patient motivation, meet medical needs, and provide individualized case management to improve the rate at which individuals engage in treatment.

Chapter V: Outcomes Management/Statewide Strategic Map

OASAS 2009 Dashboard

One of the major new approaches initiated by OASAS over the past three years is an ongoing effort to integrate outcomes thinking and outcomes management into the day-to-day functioning and operations of OASAS and the field. This approach employs the components of a basic logic model as follows:

Inputs (Resources) – Activities – Outputs – Outcomes

Combining this model with a vision for success helps organizations to structure resources and organize activities to maximize the potential for success through monitoring progress and documenting beneficial outcomes when they are achieved. This approach also is highly efficient in that ongoing monitoring of progress through periodic reviews allows for course corrections if problems arise.

In order to promote this approach, OASAS has followed an “inside-out” strategy that includes modeling the behavior, identifying early adopters, peer learning and exchange, and technical assistance in areas such as metrics and outcomes development, communities of practice, dashboards, learning collaboratives, adoption of evidence-based practices, etc.

Within OASAS, the agency developed a 2008 dashboard, reported on its results (see Chapter IV 2008 Achievements), and developed a 2009 dashboard/strategic map (described in this chapter). Also, all major divisions and offices within OASAS have developed dashboards and are planning results and learning sessions. These division/office level dashboards relate to overall agency work and help individual employees relate their work to the agency destinations and metrics. For example, the Division of Outcome Management and System Information’s dashboard has the following metric for outcomes management: *Increase the number of OASAS staff who regularly use elements of the outcome management approach in conducting their day-to-day business as measured by the percent of staff that report their “supervisor encourages the use of outcomes management” and the percent of staff who agree with the statement “I find the principles of outcome management helpful in conducting my day-to-day business.”*

Secondly, OASAS, in conjunction with approximately 25 other State agencies, has organized an outcomes management community of practice, which meets every other month to share information and ideas in this common area of interest.

In promoting outcomes management within the field, OASAS is assisting the convening of regional communities of practice described below and convened an Outcomes

Management Advisory Group (OMAG), which has been meeting for the past 18 months. This group is currently being reconstituted to consolidate different workgroups related to scorecard development and the IPMES advisory groups.

OASAS has also promoted the integration of outcomes thinking and management into major initiatives within the agency and among counties and providers. Efforts such as tobacco cessation, communities of solution, the world cafés, Rockefeller Drug Law reform, and program scorecards follow the basic principles of outcomes management.

Another feature of OASAS' approach to the integration of outcomes management is multi-level accountability. The agency is developing mechanisms such as scorecards that apply at a system (statewide), county, provider/program and consumer level. Information at the system performance level is contained in the System Overview through IPMES and NOMS. At the service provider level, for over 15 years OASAS has collaborated with treatment providers on the development and utilization of performance management and evaluation systems (i.e., IPMES/WOAS). In continuing collaboration, OASAS is currently developing scorecards providing a single page summary of performance for treatment programs. The scorecards measure access, quality, outcomes, efficiency, and compliance. At the county level, OASAS developed and made available on CPS individual county and regional profiles that contain over 100 key data items from certification, fiscal, planning, and client data systems as well as Medicaid paid claims from emedNY. These data provide the basis for a variety of metrics, which will be utilized for county level scorecards. At the consumer level, OASAS is designing a model patient scorecard to be used by clinicians and their clients to monitor progress.

For 2009, OASAS updated the Agency Dashboard in order to build on prior achievements and focus on areas critical to fulfilling its mission. OASAS uses the Dashboard to operationalize, track, and verify progress towards the destinations on the agency's Strategic Map. The 2009 Strategic Map still contains the five destinations that indicate OASAS' progress on becoming the premier addictions service system in the nation. These five destinations are:

1. **Mission Outcomes:** Establish an effective, science-based program system, which integrates prevention, treatment, and recovery.
2. **Provider Engagement and Performance:** Develop a "Gold Standard" system of service provision.
3. **Leadership:** Be the State resource on addiction and lead the nation in the field of chemical dependence and problem gambling.
4. **Talent Management:** Become a "Profession of Choice" for attracting, selecting, and developing diverse talent.
5. **Financial Support:** A system with strong return on taxpayer investment and stewardship of resources.

On the 2009 Dashboard, OASAS refined the metrics it uses to measure the agency's progress towards each of the five destinations. Using input from OASAS staff and the field, the Executive Team streamlined the metrics, reducing the total number from 15 to ten. In refining and selecting the agency metrics for 2009, OASAS used three criteria to judge the merit of each metric. Each metric on the 2009 OASAS Dashboard must be:

1. Meaningful— generally accepted by those most familiar with them and connected to the agency mission;
2. Measureable— valid, reliable, and associated with a readily available, regularly updated data source;
3. Manageable— able to be affected through agency efforts and vertically integrated at the system, county, provider, and program levels.

OASAS marks progress towards accomplishing each of the ten metrics through a series of milestones. The milestones are short-term goals that OASAS can achieve towards the metric by the end of 2009. There are 42 milestones associated with the ten metrics.

Regional Communities of Practice for Outcomes Management

In addition to implementing outcomes management within the agency, OASAS continues to encourage its use by the field through regional Communities of Practice. Communities of Practice are formed by people who engage in regular interaction over a shared topic of interest. Participants learn and develop skills around a topic either through explicit learning objectives or as a secondary effect of sharing experiences, tools and resources, providing peer support, or problem solving around an issue. The benefits of participating in a Community of Practice include:

- Access to shared resources;
- Insight from others who are trying to do the same or similar things;
- An established support network as you try new approaches to improving performance and individual outcomes.

Part of the success of a Community of Practice lies in participants' interest, commitment, and willingness to try new approaches. OASAS offers the following resources and opportunities to the Regional Communities of Practice for Outcomes Management:

- Regular interaction with other participants, including county administrators, treatment providers, and other service providers working with individuals in the addiction treatment system;
- Exposure to other practitioners engaged in performance improvement and tracking patient outcomes;

- Learning about different tools and mechanisms for collecting data;
- Support and technical assistance.

In exchange for this support OASAS asks that Community of Practice participants:

- Agree to regular, consistent attendance from management level staff;
- Be willing to share their experiences with performance management;
- Be open to new ideas;
- Provide honest feedback on the usefulness of Community of Practice sessions.

Typically, the Communities of Practice meet quarterly with participants volunteering to host the meetings at their respective program site.

In New York State, there are three active Regional Outcomes Management Communities of Practice. They are located in the Capital District, Long Island, and Mid-Hudson Valley. Prevention and treatment providers, as well as county administrators participate in these learning communities. Participants share their experiences with outcomes management, sometimes identified as performance management, and create a learning environment around using data to measure outcomes and improve performance. Topics of discussion at the meetings have included: the use of data to measure outcomes, accessing data available from OASAS, and experiences in using outcomes management. OASAS is encouraged by the number of providers who are interested and engaged in using data to inform their work. As OASAS works to develop tools to provide data on provider performance (such as the program scorecard), it has benefitted from the knowledge that the field is eager to receive performance data, and is interested in accessing more data through the agency. In some areas, the Communities of Practice are growing by word of mouth with participants inviting others to join. This growth demonstrates that the field is embracing the concept, finding value in the process, and wants to share the experience more broadly with others. The ultimate measure of success for the Regional Outcomes Management Communities of Practice will be a field-driven effort to own and maintain the practice.

Destination 1- Mission Outcomes

Establish an effective science-based program system which integrates prevention, treatment, and recovery.

Metric 1: Reduce the levels of substance abuse and gambling risk factors and increase protective factors in New York State communities.

1.1: Issue Prevention Guidelines by 6/30/09; complete implementation training by 8/31/09.

1.2: Three new Prevention Resource Centers will be operational by 9/30/09 bringing the total number of PRCs to five.

1.3: Increase the number of counties with 25 percent or more evidence-based program activities from 38 (2007/08 baseline) to 48 in 2010.

1.4: Develop and implement a Prevention-focused Strategic Plan by 10/31/09.

Status and Discussion

OASAS defines prevention as:

a proactive, evidence-based process, which utilizes effective programs and strategies to prevent or reduce substance use and problem gambling in individuals, families, and communities.

The OASAS prevention framework is based on research that shows substance use is preventable and prevention is the most cost-effective component in the continuum of addiction services. OASAS' prevention efforts are designed to help the field implement and enhance consistent prevention delivery statewide. Focusing prevention resources on lowering risk factors and enhancing protective factors in the population is an essential component of reducing the prevalence of substance use and problem gambling in New York State.

The strategy uses a five-step planning process including:

1. Conducting needs assessments;
2. Building State and local capacity;
3. Developing a comprehensive strategic plan;
4. Implementing evidence-based prevention policies, programs, and practices;
5. Monitoring and evaluating program effectiveness.

OASAS recently updated its prevention guidelines to define and describe the strategies and activities necessary to attain effective alcohol, tobacco, substance use, and problem gambling prevention services. The new guidelines clarify minimum program performance standards regarding service delivery. OASAS issued the new prevention guidelines in June 2009 and they went into effect on September 1, 2009. Agency staff conducted training regarding the guidelines in each region with providers, Field Office staff, and other interested stakeholders.

Research shows that using of evidence-based programs and practices is effective in reducing risk factors and enhancing protective factors that predict problem behaviors including substance use. In accordance with the new guidelines, beginning in 2011, all OASAS funded prevention providers will be required to dedicate a percentage of resources to the delivery of evidence-based practices and programs as follows:

<u>Year</u>	<u>EBP Minimum Standard</u>
2011	35%
2012	40%
2013	45%
2014	50%
2015	55%
2016	60%
2017	65%
2018	70%

The new Regional Prevention Resource Centers supported by OASAS are designed to provide necessary training and technical assistance to prevention providers and local community coalitions to improve planning and build capacity to expand the use of evidence-based practices and programs. In addition to the two existing Regional Prevention Resource Centers (Central and Western), OASAS recently approved three additional Centers via a competitive application process. OASAS expects the three new regional Prevention Resource Centers (Mid Hudson, Finger Lakes, and New York City) to become operational in fall 2009.

OASAS is developing a Prevention Strategic Plan as part of the agency's long-range planning process. The Prevention Strategic Plan will articulate statewide prevention goals and help inform and guide alcohol, other drugs, and problem gambling prevention efforts with providers, counties, coalitions, and other stakeholders. To develop the Plan, OASAS established a project team that includes agency staff, providers, local government representatives, and other stakeholders. The project team convened in June 2009 and formed two workgroups to gather information on needs assessment data and capacity of the prevention system.

Survey data sources identifying risk and protective factors, prevalence, and consequences analyzed by the Data/Assessment Workgroup included the OASAS Household Survey, Behavior Risk Factor Surveillance Survey (BRFSS), NSDUH, OASAS School Survey of 7-12 grades, Youth Risk Behavior Survey of 9-12 grade students, YDS of 7-12 grade students, and the Core Survey of College Students. Numerous archival indicators reviewed by the Workgroup indicating the negative consequences of use include drug and DWI arrests, drug-related hospitalizations, and alcohol-related motor vehicle accidents.

The data reviewed by the Data/Assessment Workgroup indicate that alcohol is the substance most abused by New York State residents. Young adults experience the highest binge drinking rates, followed by youth, and older adults. Marijuana is the most commonly used illicit drug, with prevalence rates highest among young adults and youth. In general, residents of rural areas experience greater alcohol misuse and related negative consequences, while rural and downstate suburban areas are experiencing increases in substance use and related problems, relative to more urban areas of New York State.

The Project Team plans to complete the Statewide Strategic Prevention Plan with recommendations for the Prevention system by late fall 2009. Included in the plan will be measurable statewide priorities that will be used to initiate the process of measuring the impact of the prevention system on statewide priorities. The Plan will also include recommendations for implementation and evaluation of the plan and the statewide prevention priorities.

Metric 2: Increase the number of treatment programs that comprehensively address patient Substance Use Disorders, including the appropriate and medically indicated use of addiction medications, and assisting patients in developing and implementing individualized recovery goals.

2.1: Develop consensus approach and timetable for transforming the State-wide outpatient system (including implementation of Ambulatory Patient Group reimbursement approach).

2.2: Increase the number and type of treatment and re-entry programs designed to serve criminal justice populations (including at Hudson and Bayview Correctional Facilities) by 12/31/09.

2.3: Implement a wide range of drug law reforms in conjunction with DCJS, DOCS, and Office of Court Administration (OCA).

2.4: Design, implement, and monitor the treatment component to the Sentencing Reform with state-wide providers and DOCS facilities.

2.5: Increase by 20 percent the number of certified addiction services receiving training in Post-Traumatic Stress Disorder (PTSD) and TBI among the veteran population.

Status and Discussion

The provision of quality treatment is one of the three core elements of the OASAS mission along with improving access to services and making available a variety of services. These core elements are crucial to helping New Yorkers achieve and maintain recovery.

OASAS and stakeholders work closely to develop and implement plans to improve treatment quality. Stakeholders include:

- Consumers;
- Providers;
- Partner agencies (DCJS, DOH, OMH, OCFS, etc.)
- Payers (Medicaid, Private Insurance, and government funding).

The Rockefeller Drug Law reforms, passed by the New York State Legislature and signed into law by Governor Paterson, have major implications for the OASAS treatment system, especially in terms of treating the criminal justice population. The agency's focus over the next 18 months will be on implementing this significant expansion of our system. At the same time, the establishment of an integrated outpatient system to include the

implementation of the recommendations related to detox reform, methadone, special populations, and the use of the APG funding strategy will continue in 2009.

Criminal Justice

OASAS is working with DCJS, DOCS, DOP), Division of Probation and Correctional Alternatives (DPCA), and the Courts to implement the Rockefeller Drug Law Reforms. This effort includes:

- Expanding outpatient and residential treatment services;
- Enhancing treatment readiness services provided in State correctional facilities;
- Improving re-entry programs for individuals returning to the community.

OASAS is developing procurement procedures for the expansion of outpatient, case management, and residential criminal justice programs. In addition, the agency issued new operating guidelines for the Willard Drug Treatment Campus (DTC). Willard DTC is a drug treatment center operated by DOCS in conjunction with DOP and licensed by OASAS. The new guidelines better match the capacity, utilization, and design of the facility. They also ensure the provision of small group counseling sessions, clarify paperwork requirements, and improve treatment planning.

As required by the sentencing reform legislation, OASAS is responsible for developing guidelines, monitoring, and reporting on the addiction services operated by DOCS. DOCS requested that OASAS certify all of its programs. Planning is underway to review four to five DOCS programs in the coming months as part of DOCS/OASAS Addiction Services Certification Initiative. OASAS will review the curricula, interview inmates and staff, observe the program, review prison advocate reports, and interview former inmates as part of the process. By the end of 2009, OASAS will establish the process to develop new Part 1045 Specialized Services Operating Certificate Guidelines and begin implementation at various correctional facilities.

As part of the agency's criminal justice initiatives, OASAS is implementing re-entry programs at Hudson and Bayview Correctional Facilities. The Hudson program opened in March 2009. OASAS is procuring the services of an outpatient provider to conduct assessments at the facility and to facilitate referrals to aftercare. The Bayview Re-entry program opened in June 2009 and serves women. The program will be longer (six months) than the male programs and is focused on addressing the various special needs of the female population. These include trauma, child care, health, and other issues. OASAS is working with DOCS to develop the specifications of the procurement to ensure that the program is capable of delivering the needed services. The OASAS provider will conduct assessments, make referrals, conduct Cognitive Behavioral Therapy (CBT) sessions in the facility and help with case support upon release

OASAS is working with DCJS, DOCS, and DOP to implement the Transition from Prison to Community (TPC) model. This is a joint venture to improve outcomes (re-arrest, employment, substance use, etc.) for inmates. The program will identify the various needs of the inmates and begin discharge planning from the point of admission into DOCS. The various stakeholders are assigned roles and responsibilities to implement the plan. OASAS' role involves the oversight of DOCS addiction services and provider involvement in post release services.

In the area of criminal justice, OASAS expects to accomplish the following by the end of 2009:

- Expand outpatient services;
- Add 200-300 new residential treatment beds;
- As part of DOCS/OASAS Addiction Services Certification Initiative, review four to five additional DOCS facilities, prepare recommendations, review with DOCS, and submit report to Governor and Legislature.

APGs

OASAS is redesigning its Medicaid payment system for ambulatory services (medically supervised outpatient, methadone) by employing an APG methodology. This process will create a dramatic shift in how OASAS services are reimbursed for Medicaid-eligible patients. Currently, the system is paid a threshold visit rate for medically supervised outpatient services and a weekly fee for methadone services. Working with DOH, OMH, OMRDD and provider agencies, payment will be structured to reflect service categories (APG categories) that more closely reflect actual services and program operations of clinics. While APGs will not directly improve service outcomes, they reflect a payment structure that better support actions such as:

- One Outpatient System of Care;
- Evidence-Based Practices;
- The Gold Standard.

APGs will, among other benefits, allow for multiple billings for service within the same day, which is not supported by the current payment methodology. The goal is to create a fair payment system to better support the delivery of individualized, patient-centered care.

OASAS created a constituency group, co-chaired by the President of the Board of Directors of ASAP. The constituency group works in partnership with OASAS to guide every aspect of the initiative. The group includes representatives from Therapeutic Communities of America (TCA), Greater New York Hospital Association (GNYHA), Hospital Association of New York State (HANYS), CLMHD, Council of Behavioral Health

Care Providers, New York City Health and Hospitals Corporation (HHC), and three OASAS treatment providers.

OASAS, in conjunction with the constituency group, DOH, OMH, and OMRDD, created a draft APG map and submitted it to the 3M Corporation. The 3M Corporation owns the Current Procedural Terminology (CPT)¹ codes used for billing medical and related health services and makes adjustments to the codes and APG categories annually. The map identifies 11 APG categories, and offers opportunities for additional categories as the chemical dependence system evolves. Under certain circumstances, it also allows chemical dependence providers to bill against other agency (especially OMH) categories.

During the spring and summer of 2009, OASAS held 11 community forums across the State (five Upstate, four New York City, and two Long Island). Reaching over 150 providers and local governments, the forums were designed to:

1. Educate the field more fully on APGs and the APG implementation process;
2. Solicit provider recommendations on program and clinical operations that a new pricing system should be able to support in order to achieve quality care.

In addition, OASAS is conducting comprehensive analyses on the different cost components of APG's (i.e., the base rate, category weights, and prices).

By the end of 2009 OASAS expects to:

- Finalize the APG map;
- Develop, in conjunction with a clinical advisory group and the provider constituency group, rules for use and billing of APGs;
- Draft a manual for billing APGs;
- Complete an analysis of software needs and devise a plan to address the needs;
- Develop the weights, base rate, and prices;
- Create a plan and schedule for training providers;
- Hold regional meetings with providers to educate them on APGs and their projected fiscal impact as well as answer provider questions;
- Receive approval of the OASAS APG prices by DOH and DOB;
- Complete Medicaid State Plan amendments and submit them to CMS for approval;
- Amend OASAS regulations to comport with the new payment methodology and billing categories.

¹ “CPT codes are numbers assigned to every task and service a medical practitioner may provide to a patient including medical, surgical and diagnostic services. They are then used by insurers to determine the amount of reimbursement that a practitioner will receive by an insurer”
<http://patients.about.com/od/costsconsumerism/a/cptcodes.htm>

Methadone transformation and one outpatient system of care are two related initiatives designed to improve access to Medication Assisted Treatment as well as broaden the ability of consumers to access all services in one location.

Methadone Transformation

New York State has the largest methadone treatment system in the nation, serving nearly 39,000 individuals in recovery. The system faces numerous challenges including an antiquated regulatory framework, growing siting issues, and a staffing structure that impedes the delivery of comprehensive services for individuals who use drugs in addition to opiates. To address these issues, Commissioner Carpenter-Palumbo created the Methadone Transformation Advisory Group (MTAG), which included patients, opioid treatment providers, coalition groups, and OASAS staff. In October 2008, MTAG submitted its final report to the Commissioner for transforming methadone treatment into an individual-centered, recovery-oriented outpatient service, with a strong capacity for medication-assisted treatment. The recommendations included:

- Incorporating the OASAS methadone regulations into the outpatient regulations as a first step in creating a single outpatient system of care;
- Implementing ambulatory detoxification for uncomplicated opioid detoxifications that do not require hospital stays;
- Introducing more individualized treatment, including buprenorphine treatment and more differentiated phases of treatment.

The MTAG core team met with Commissioner Carpenter-Palumbo to discuss the report and implementation options. Seven workgroups were created to address various aspects of implementation. They are addressing issues such as training, ambulatory detoxification, buprenorphine, community relations, clinical services, and fiscal restructuring. All workgroups have been meeting at least monthly since December 2008. The workgroups will initiate a minimum of 30 demonstrations across New York State. By the end of 2009, the Buprenorphine and Patient CASAC Training workgroups will create guidance documents for use by the field. In addition, OASAS will provide four statewide trainings on MTAG efforts to all Opioid Treatment Providers (OTPs) by December 2009.

One Outpatient System of Care

Based on the MTAG recommendations, OASAS is developing a program model that will integrate and transform opioid, detoxification, and outpatient services into a single comprehensive system of care. This system of care will be person-centered and provide a recovery-oriented and individualized treatment approach to all individuals receiving addiction treatment services. Methadone treatment is an important and stabilizing form of medication-assisted therapy. It is in the best interest of persons in recovery to incorporate methadone and all medication-assisted treatment as part of a recovery-oriented system of care. OASAS is taking the first step by creating a single set of

medically supervised outpatient regulations that will address methadone as part of the outpatient system of care. Although the combined regulation will separately address the needs of outpatient and methadone, it will set a foundation for future discussions on the best way to serve the entire outpatient system of care.

Metric 3: Increase the number of persons successfully managing their addiction within a recovery-oriented system of care.

3.1: Establish three Recovery Centers by 12/31/09 - 1 downstate and 2 upstate (1 rural and 1 urban).

3.2: Increase the number of apartment units in the PSH portfolio from 1,144 in 13 communities (08/09) to at least 1,269 apartment units by 09/10; increase by 125 units or an 11 percent increase; add at least 8 new housing communities (7 from Upstate PSH and one new Shelter Plus Care), which is an increase of 61 percent.

Status and Discussion

OASAS is committed to ensuring that all of its services fully recognize and respond to the needs of those in or seeking recovery. Recovery is a lifelong process of improved health and wellness, quality of life, and a reintegration with family and community. OASAS' major strategies for fostering recovery from addiction include making sure everyone leaving addiction treatment has access to safe and affordable housing and developing Recovery Community Centers (RCCs) where people can receive peer-led services.

Housing

Safe, affordable, permanent housing is fundamental to successful long-term recovery for individuals, families, and communities. Over 4,000 persons who complete long-term residential treatment each year are homeless. In addition, at least 40 percent of all homeless single men, 25 percent of single women, and 25 percent of female-heads-of-household are struggling with alcoholism and substance use. PSH is an evidence-based strategy that effectively addresses this issue.

OASAS intends to:

1. Increase the number of apartments in the OASAS Housing Portfolio by at least ten percent each year;
2. Increase the number of communities that have access to OASAS PSH Programs by ten percent each year.

OASAS participates in three programs that comprise the agency's PSH Approach:

1. Shelter Plus Care, in concert with U.S. Department of Housing and Urban Development (HUD) Homeless efforts;
2. New York/New York III, in concert with our State and New York City sister agencies;

3. The Upstate PSH Program in concert with county mental hygiene and social services departments.

In addition, OASAS also participates in capital funding decisions for permanent housing under development by the Office of Temporary and Disability Assistance's (OTDA's) Homeless Housing and Assistance Program (HHAP) and the Division of Housing and Community Renewal's (DHCR's) Low-Income Housing Tax Credit (LIHTC) and Housing Trust Fund (HTF) programs.

OASAS has successfully:

- Applied for approximately 50 HUD Shelter Plus Care renewal grants each of the past two years;
- Developed and funded two Rounds of New York/New York III funding;
- Developed and funded a first round of the Upstate PSH Initiative.

By April 1, 2010, the OASAS Housing Portfolio will grow from a baseline of 856 apartments in 2007 to 1,276 apartment units (a 49 percent increase); the number of communities with access to OASAS PSH Programs will grow from a baseline of 13 communities in 2007 to 22 communities (a 70 percent increase).

Recovery Community Centers

Recovery Community Centers help prevent relapse and promote sustained recovery for people with addiction problems, their families, and significant others. Each Recovery Community Center will provide a combination of "stage-appropriate" emotional, informational, instrumental, and social supports designed to be responsive to a range of needs from early recovery to long-term sustained recovery. These centers will expand the community's natural recovery support resources and help to create the physical, emotional, and social space within communities where recovery can flourish.

On July 6, 2009 OASAS made three awards as part of the Recovery Community Center initiative. OASAS distributed the awards as a result of a competitive RFP process that focused on three geographic categories - downstate, upstate urban, and upstate rural. The agency expects these three Recovery Centers to be operational in fall 2009. OASAS plans to utilize the Recovery Community Centers as learning laboratories to gather, identify, and share best practices in recovery support services with the field. In support of this initiative, the agency is planning for nine additional centers within the next five years.

Metric 4: Increase the number of persons who improve their health including engaging in healthy lifestyles.

4.1: Of the 488 programs reviewed, 70 percent will be in regulatory compliance; 290 will have taken initial steps to implement acceptable tobacco-free policies and 185 will show positive client health effects with increases in the number of patients who stop smoking.

Status and Discussion

On July 24, 2008, New York became the first State to implement tobacco-free regulations in all addiction prevention and treatment programs. OASAS allowed a one-year implementation period whereby the tobacco-free regulation was not included as a scoring item in the program recertification process. However, OASAS reviewed all programs and provided reviewer notes if the programs were not in compliance. OASAS is supporting providers with guidance and training as they make the field of addiction tobacco-free and integrate the treatment of tobacco dependence into the context of treating all other addictive disorders. This monumental cultural shift will enhance recovery and reduce the single most preventable cause of death – tobacco.

During recertification reviews, OASAS reviewed the tobacco-free policy and gauged the success of implementation. During the first year, programs received reviewers' notes for non-compliance and OASAS required them to submit corrective action plans. Starting in July 2009, the agency began scoring programs on their compliance with the tobacco-free regulations.

OASAS developed a tobacco database for capturing all tobacco related areas of concern including recommendations for training, guidance, and assistance. The agency sends a list of guidance and technical assistance to non-compliant programs following their review. Field Office staff follow-up with non-compliant programs as well and document their efforts and recommendations in the tobacco-free database. OASAS monitors programs to ensure that they submit corrective action plans. Additionally, effective April 1, 2009, programs began completing a tobacco related question upon discharge to determine if people in treatment have used tobacco in the last seven days.

To date, 76.5 percent of programs are compliant with the tobacco-free regulations. During 2009, OASAS will review 488 programs; the agency anticipates that at least 290 will have acceptable tobacco-free policies, 230 will show positive change in the program; and 185 will show positive health effects for individuals in treatment.

Destination 2- Provider Engagement and Performance

Develop a "Gold Standard" system of service provision.

Metric 5: Increase provider engagement in the Gold Standard Initiative.

5.1: Double the number of providers attending in Gold Standard Regional Forums. (08 baseline is 350).

5.2: Establish by 7/1/09 the baseline for providers/coalitions implementing at least one Gold Standard component. Increase by ten percent for Round 2 Gold Standard Regional forums.

5.3: 75% of Train-the-Trainer participants will deliver two or more trainings in their communities within one year of the training date. Baseline will be established by 11/30/09.

5.4: 50% of counties will conduct community of solution conversations using County Profile Data Reports with providers and consumers as a step toward developing local projects.

5.5: World Cafés will launch at least 3 rapid cycle system changes the area of service access.

5.6: Ten additional Administrative/Regulatory Relief projects will be completed (08 baseline= 20 projects.)

Status and Discussion

New York State's addiction services system is the one of the largest in the United States and is poised to also become the nation's premier system, as OASAS partners with the provider community to assure that individuals receive the Gold Standard of care. OASAS works with providers in a comprehensive way to support a fresh vision of person centered addiction services. As partners in this effort, OASAS and the provider community will lead the nation as it pioneers the Gold Standard Initiative.

Gold Standard Initiative

The Gold Standard Initiative will ensure that individual centered addiction services are focused on a blend of:

- Full regulatory compliance;
- Ethical and quality-of-care standards;
- Disciplined use of continuous quality improvement, clinical supervision, and staff development systems;
- Infusion of research tested, evidence-based, and promising practices;
- Wellness;
- Deliberate attention to patient satisfaction feedback and success indicators.

Partnering with providers in this initiative will motivate them to incorporate Gold Standard practices, which will ultimately result in better patient care. As OASAS and the addictions field move forward, a commitment to the Gold Standard will provide a common theme and mission for our work.

Development of the Gold Standard for OASAS services will facilitate a clarification and synthesis of several key regulatory and performance standards, including those that address:

- Patient outcome/performance;
- Regulatory compliance;
- Program management processes;

- Patient health/safety and patient satisfaction.

The new framework will establish consistent performance expectations throughout OASAS that will be clearly communicated to the field. Consistent standards/ratings will serve as the basis for recertification, funding and other key decisions by OASAS

Administrative/Regulatory Relief Workgroup

OASAS established the Administrative/Regulatory Relief Workgroup to reduce paperwork, increase time for patient care, and provide regulatory relief. The Administrative/Regulatory Relief Workgroup includes provider representatives and OASAS staff. The results of the workgroup's efforts include a regulatory guidance document, a new site review instrument, model case record forms, and changes to the *Part 822 Chemical Dependence Outpatient Services* regulations. The *Part 822* changes, effective February 18, 2009, reduced paperwork considerably.

The workgroup is also responsible for overall revision of the *Part 822* regulations that will provide for more individualized patient-centered care. In addition, the workgroup continues to develop/refine model case record packages and site review instruments for various OASAS service categories. In 2008, OASAS completed 20 administrative relief projects. By December 2009, the agency will complete ten additional administrative relief projects.

Recovery Services

OASAS is also committed to investing in the development of recovery services, which will encourage community-based service solutions to the ongoing support needs of persons in recovery from addiction.

Communities of Solution

By the end of 2009, 50 percent of counties will conduct Communities of Solution conversations using County Profile Data Reports with providers and consumers as a step toward developing local projects.

World Cafés will spur three to five rapid cycle system improvements in the area of service access.

Gold Standard Forums

During 2008, OASAS and ASAP jointly planned Regional Gold Standard Partnership and Dialogue on Treatment Forums. Five forums were conducted statewide with more than 350 attendees. At each forum, provider officials had discussions with OASAS and Medicaid Inspector General staff regarding regulatory compliance; Medicaid audit

readiness; quality improvement; clinical supervision; wellness/tobacco-free services; and best, promising, and evidence-based practices.

As a result of the ongoing partnership, OASAS and ASAP have established a model for the Gold Standard of Addiction Treatment Services. The Gold Standard model includes the following elements:

- Talent management;
- Quality improvement;
- Best, promising, and evidence-based practices and programs;
- Recovery support/community partnerships,
- Outcomes management;
- Compliance.

In addition, OASAS continues to partner with the field to plan additional forums, as well as on Phase II of the Gold Standard Partnership, which offers training and regulatory guidance associated with the elements of the Gold Standard. The agency sent the Phase II Gold Standard Follow-Up Survey to forum attendees in June 2009. OASAS is analyzing survey responses. These will frame regional priorities (e.g., regulatory compliance; case records/paperwork reduction; training initiatives; implementing evidence-based practices; scorecard; etc.). OASAS and the provider network will continue to work together to meet the needs of the regions throughout the State.

Metric 6: Increase provider achievement of the Gold Standard of Care.

6.1: Increase by five percent the number of treatment programs implementing evidence-based practices. (08 Baselines: screening for co-occurring disorders -645 programs; Motivational Interviewing 532 programs ; Cognitive behavioral therapy 552 programs ; Contingency management 234 programs; Nicotine replacement therapies 447 programs; and NIATx process improvement 299 programs.)

6.2: Increase by 5 percent the number of prevention programs that allocate at least 20 percent of resources to evidence-based programs (08 baseline-26%)

6.3: Program scorecards distributed to 67 Intensive Residential Providers by 7/1/09 with a provider satisfaction response rate of 70 percent. Scorecards for other treatment programs distributed by 12/31/09 with similar positive response rates.

6.4: Facility Inspection scores will be integrated into the Integrated Quality System (IQS) recertification renewal process by 7/1/09. Analyze Fiscal Viability impact on recertification renewal certificate terms by June 30, 2009. Test IQS scoring mechanism for Intensive Residential programs by August 31, 2009.

6.5: Provide focused regional Technical Assistance Workshops based on Quality Indicator analysis. Quality Indicator analysis baseline to be completed by 12/31/09.

6.6: Decrease the percentage of programs that have initial or recurring Management Plans in annual program review.

6.7: Increase the number of providers over baseline (12) who implement corrective actions based on Quality Service Review /targeted investigation findings.

6.8: Decrease the number of Patient Advocacy complaints related to Patient Rights Violations by 10 percent. (08 baseline-47).

6.9: For cases that find excessive services at second QSR review, increase the number of Operating Certificate revocations completed within six months. (08 Baseline-0).

Status and Discussion

Under this metric, OASAS will develop a comprehensive toolset and performance measurement system to empower the field toward improving access, quality, outcomes, efficiency, and compliance. The ultimate measure of this effort will be the increased number of providers achieving the Gold Standard of care.

Program Scorecards

As part of the Gold Standard initiative, OASAS initiated a project to develop program scorecards. The scorecards will help OASAS and the field to communicate their successes and use data to improve the quality of services. During the first phase of this project, OASAS worked with counties and providers to develop scorecards for all intensive residential programs. The scorecards measure access, quality, outcomes, efficiency, and compliance. Ultimately, OASAS will implement program scorecards for all prevention, treatment, and recovery service types. OASAS released initial scorecards on July 1, 2009 for intensive residential programs and will release scorecards for nearly 1,000 other treatment programs by the end of 2009.

Integrated Quality System (IQS)

OASAS is also developing a new IQS, which will expand on the operating certificate renewal process that the agency currently uses. During Phase 1, OASAS will add a new approach that includes facility inspection, fiscal viability, client data reporting, and specific IPMES measures to the recertification review score that the agency uses to determine the certificate term. Integrating these additional elements will give OASAS a broader vision of a program's performance.

Evidence-Based Programs and Practices

OASAS staff will continue to work with treatment providers to increase their implementation of evidence-based programs and practices. The agency established baselines in such areas as:

- Screening for co-occurring disorders;
- Motivational interviewing;
- Cognitive behavioral therapy;
- Contingency management;
- Nicotine replacement therapies; and
- NIATx process improvement.

Other Gold Standard Initiatives

- OASAS will establish a baseline to track the number of providers that have initial or recurring management plans during their annual program review process.
- OASAS will work with providers to address/correct deficiencies resulting from quality services reviews, targeted investigations and patient advocacy complaints.

Destination 3- Leadership

Be the state resource on addiction and lead the nation in the field of chemical dependence and problem gambling.

Metric 7 Advance and support legislation, regulations and other initiatives that improve access to prevention, treatment and recovery services.

7.1: Strengthen OASAS' State influence through increasing the number of substantive briefings provided for Legislators and other staff to 40 (2008 baseline of 34).

7.2: Strengthen OASAS' federal influence by:

- a. Increase to three from zero the number of federal Technical Assistance grants received by OASAS that directly support agency priorities.
- b. Increase support by five national organizations and federal officials regarding federal law, regulations and policy for the SAPT Block Grant.
- c. Increase OASAS' influence by providing comments on five federal or State laws, regulation, or policy initiatives (2008 baseline of 5).

7.3: Increase OASAS leadership positions to six:

- a. Substance use disorder and problem gambling allied organizations/groups.
- b. The membership of boards, committees and panels of stakeholder organizations.

7.4: Implement the ACTION Interagency Council to formalize current working relationships with 20+ State agencies, influencing agendas in support of increased attention to addiction.

Status and Discussion

OASAS is working at both the federal and State levels to enact policy and secure resources to support addiction treatment, prevention, and recovery. At the federal level OASAS is making its voice heard on national issues such as health care reform and parity for addiction services in insurance coverage. In addition, APGs and SBIRT are important federal initiatives that will greatly affect OASAS services. At the State level, ACTION is unifying many State agencies to address the root causes and combat the destructive consequences of addiction across all systems.

Strengthening OASAS' Federal Influence

Deliberations and legislation enacted at the federal level to strengthen and expand services to prevent substance use, provide treatment for those with a substance use disorder, and support those in recovery present OASAS with unprecedented opportunities for federal support. The two largest initiatives are the President's efforts to secure health care reform and the Wellstone-Domenici Mental Health Parity and Addiction Equity Act of 2008. Additionally, there are also federal initiatives affecting

Medicaid (ambulatory patient groups or APGs), services for criminal justice-involved populations (e.g., the Second Chance Act), and veterans and their families that offer the hope of improved access.

OASAS continues to suggest areas of exploration and offer comments to NASADAD, which has through its Public Policy Committee and staff, continuously monitors federal legislation and proposed legislation. Wherever possible, OASAS comments will reflect outreach to New York constituent and stakeholder groups to assure the most comprehensive, balanced and strategic responses to NASADAD inquiries.

Health Care Reform

In spring 2009, OASAS offered comments on health care reform that have been published on SAMHSA's website. Commissioner Carpenter-Palumbo's letter to SAMHSA regarding health care is available at:

http://dialogue.samhsa.gov/samhsa_communications_dia/new-york-state-office-of-alcoholism-and-substance-abuse-services.html

OASAS additionally has reviewed both the Senate and House bills, providing feedback to the Governor's Office on how this legislation would positively affect access and noting omissions that, if addressed, would strengthen prevention of substance use and early identification of those in need of intervention and/or treatment. The agency will dedicate substantial effort to continuous monitoring of legislative proposals and associated budget enactments to ensure that health care reform is inclusive of substance use issues and critical existing funding – such as the federal SAPT Block Grant -- is not jeopardized.

Through participation in council and advisory groups (e.g., the Governor's Veterans Policy Council), OASAS will assure that provider and constituent concerns are identified and alert the field to opportunities to add their voices to these critical discussions (e.g., responding to the SAMHSA's request for input related to health care reform and substance use).

Wellstone-Domenici Mental Health Parity and Addiction Equity Act

The Wellstone-Domenici Mental Health Parity and Addiction Equity Act of 2008, enacted into law on October 3, 2008, will end health insurance benefits inequity between mental health/substance use disorders and medical/surgical benefits for group health plans with more than 50 employees. States are required to implement the Act's provisions for services delivered on or after January 1, 2010. OASAS will work with DOH and the State Insurance Department to assure that policies issued after that date conform to federal requirements and disseminate information on required changes (e.g., removal of limitations on outpatient visits) to the field.

In February 2009, OASAS joined CSAT and representatives from Connecticut, Maine, Minnesota, North Carolina, South Carolina, and the president of the Drug and Alcohol Service Providers of Pennsylvania, all with some experience in implementing parity, to share their experiences, lessons learned, and recommendations about implementing parity. This led to the release of a CSAT advisory that was made available to NASADAD directors and representatives at the annual meeting held in June 2009 in Syracuse.

Other Federal Initiatives

By securing technical assistance from federal agencies, OASAS is advancing initiatives to improve services (APGs) and access (SBIRT).

APGs

OASAS, in concert with providers and DOH, OMH, and OMRDD, is working on implementing APGs. CSAT has approved OASAS-requested technical assistance for consultant services to assist in the design of a pricing model that will support appropriate ambulatory services in a cost-effective manner, comporting with critical clinical assumptions regarding service delivery (e.g., ratio of individual counseling/group counseling); the technical assistance will also provide modeling strategies to allow OASAS to predict the impact of applying different weights and base rates to assess their effects on the system.

SBIRT

The 2009-2010 State Budget authorized Medicaid payments for SBIRT in emergency departments (under development as an APG payment), effective in 2010.

Addictions Collaborative to Improve Outcomes for New York (ACTION)

The consequences of addiction affect nearly every public system in New York. In recognition of the far-reaching effects of addiction, on April 15, 2009, Governor David A. Paterson issued Executive Order No. 16, creating ACTION. The ACTION initiative directs the partnership of 20 State agencies with nonprofits and the private sector and coordinates addiction resources in the areas of public health, safety, welfare, and education. ACTION is designed to address alcohol, drug, and gambling addictions that affect nearly 2.5 million New Yorkers.

The ACTION Council is coordinated by OASAS and includes the commissioners of:

- OASAS
- Office of Mental Health
- Department of Health
- Office of Mental Retardation and Developmental Disabilities
- Office of Temporary and Disability Assistance

- Division of Criminal Justice Services
- Department of Correctional Services
- Division of Parole
- Office of Children and Family Services
- Council on Children and Families
- Division of Probation and Correctional Alternatives
- Department of Motor Vehicles
- State Education Department
- State University of New York
- Office for the Aging
- Division of Veterans' Affairs
- Division of State Police
- State Liquor Authority
- The Office for the Prevention of Domestic Violence
- The Office of Court Administration

The work of the ACTION Council is carried out through its four committees (Public Health, Welfare, Safety, and Education), with each committee comprising senior staff from member State agencies. The committees are gathering input from various constituent groups, organizations, and individuals from the local and community levels. The Council, through its four major committees, collaborates with non-governmental stakeholders, community-based organizations, addiction treatment providers, academic institutions, and businesses to improve efforts to identify, treat, and prevent addiction. Serving as an umbrella organizing entity, the Council is coordinating work across over 70 multi-system collaborations.

The ACTION Council is building upon the recently enacted Rockefeller Drug Law reforms, which emphasize treatment over incarceration for non-violent drug offenders. This 2009 legislation eliminates mandatory minimum prison sentences and allows judges to divert drug users to treatment instead of prison. To ensure the success of Rockefeller Drug Law reform, the Governor and the Legislature have agreed to invest in drug treatment programs and to expand the number of specialized drug courts. The Council will consult with the National Association of Drug Court Professionals, judges, prosecutors, and defense attorneys, who work in drug courts, to implement Drug Law reforms and assess whether treatment programs for diverted offenders are available and effective.

On July 10, 2009, the ACTION Council held its first meeting at the Edgecombe Residential Treatment Program, a facility that is jointly operated by OASAS, DOCS, and DOP. Edgecombe provides addiction treatment for parole violators who otherwise would be returned to prison and serves as a showcase for the benefits of collaboration in the Public Safety arena. The inaugural meeting included a dialogue with Gil Kerlikowske, Director of the Office of National Drug Control Policy. Each of the four committees is identifying deliverables for 2010 in the areas of public health, safety, welfare, and education.

Metric 8: Generate positive media coverage for the agency and field accomplishments.

8.1: Track at least 100 positive media stories in print, broadcast and online relating to agency initiatives

8.2: Support a statewide consumer movement around Recovery by:

- a. Collecting 300 additional stories (from baseline of 65) for the "Your Story Matters" Campaign;
- b. Increase consumer participation in Recovery Month 2009 events to 10,000 from 5,000 in 2008.

Status and Discussion

Positive media coverage of OASAS and field accomplishments is intended to increase the public's understanding of the chronic illness of addiction, support prevention efforts, direct people to treatment, reduce the stigma of recovery, and support the growing Recovery Movement in New York State. The agency's goal is to have at least 100 positive media stories for 2009.

In order to promote positive media stories, OASAS is generating press releases and events that publicize agency and field accomplishments. Extensive effort is also put into the agency website and there are concerted efforts to promote recovery (such as Recovery Month 2009) and the Your Story Matters campaign.

Recovery Month 2009 included the Sixth Annual Recovery Fine Arts Festival, the Pathways to Recovery Forum, and the Second Annual Recovery Rally, which was also supported by other States, outside organizations, and the A&E television network. OASAS provided marketing support for all recovery month events to providers and on the agency website. As part of Recovery Month, the Second Annual Recovery Rally took place on September 12, 2009. OASAS' goal was 10,000 Rally participants. The agency worked to support this goal through publicity and networking with providers and other organizations to generate support for the event. OASAS achieved this goal when an estimated 10,000 participants celebrated recovery by participating in the walk across the Brooklyn Bridge during the Second Annual Recovery Rally.

Governor David Paterson stood before thousands of recovery supporters at the Rally to show the State's leadership and commitment to recovery. Governor Paterson was joined by the President's Drug Czar, Gil Kerlikowske, and his federal colleagues Nora Volkow of NIDA and Westley Clark of SAMHSA. Other officials included New York State Assemblymen Felix Ortiz and Sam Hoyt and Brooklyn Borough President Marty Markowitz. HLN host Jane Velez-Mitchell and WABC sportscaster Scott Clark, both in recovery, emceed the event that was highlighted by a Smokey Robinson concert.

OASAS kicked off the Recovery Weekend by hosting the Pathways to Recovery Forum on September 11, 2009 for hundreds of recovery supporters at the John Jay College of Criminal Justice. Speakers represented many unique pathways to recovery including: treatment, mutual assistance, medication assisted treatment, drug court, faith-based, harm reduction, national recovery, and friends and family support.

The Your Story Matters campaign was tailored to meet the recovery audience on the OASAS website. People in Recovery are continuing to submit their stories at www.iamrecovery.com with 132 individual stories submitted as of September 15, 2009. By the end of 2009, OASAS intends to have 365 unique stories of recovery on the website. The agency will launch a second campaign to collect additional stories, and OASAS will promote collected recovery stories to the media. OASAS gathered 12 new spotlight stories for the second annual campaign. Commissioner Carpenter-Palumbo introduced the new Your Story Matters campaign spotlight individuals at the Pathways Forum. Five of the 12 individuals were present to receive the Recovery Badge of Honor from the commissioner and also spoke to the audience about the meaning of recovery. Nearly 200 pieces of artwork were submitted for the Sixth Annual Recovery Arts Festival and were displayed at the Empire State Plaza Concourse in Albany.

Destination 4- Talent Management

Become a "Profession of Choice" for attracting, selecting and developing talent.

Metric 9: Increase full knowledge, expertise, and retention of a high-performing, diverse staff throughout the field.

9.1: Implement BPTW findings through 3 new projects (08 baseline- one); increase to 20 the number of agencies voluntarily applying to be a BPTW from the ten that applied in 2008 with two selected.

9.2: Establish an Addiction Career Resources Center by 9/1/09.

9.3: Improve Leadership Competencies: increased use of outcome thinking by OASAS staff from 26 percent to 40 percent; design and deliver customized supervisory learning to ET and Sr. Mgt. Staff with 90 percent participation rate; deliver cultural competencies learning for all leaders; and increase the perceived usefulness of Leadership Business meetings from 70 percent to 80 percent

9.4: Establish loan forgiveness authority and other financial incentives by 12/2010.

9.5: Increase the number of credentialed professionals from 7,149 to 7,506 (+5%); Increase the # of CASAC Trainees from 3,891 to 4,280. (+ 10%). Increase # of CARN certified nurses from 135 to 142. (+5%) Establish a baseline of the number of addiction professionals in the DOCS system.

9.6: Create baseline of medical directors/staff who are American Society of Addiction Medicine (ASAM), American Psychiatric Association (APA), or American Osteopathic Association (AOA) certified; and increase those who are Buprenorphine certified four months after issuing Parts 828, 816, and 822 regulations.

Status and Discussion

Talent Management is an important element of OASAS' Gold Standard system of care. OASAS is focusing significant efforts on making the addictions field a "profession of choice" for attracting and developing talented staff. This will enable New York to lead the nation in the field of addiction services and to provide the best possible services statewide. Increasing full-knowledge, expertise, and retention of a high-performing, diverse staff throughout the field, is a top priority in achieving Gold Standard-level services.

Metric 9 has six specific milestones to mark progress towards achievement. OASAS will accomplish the six milestones of the Talent Management Destination through a multipronged approach whereby five Executive Team members will manage and monitor progress for specific subsets under their purview.

Best Places To Work (BPTW)

The cross-agency Engagement Committee is implementing projects to address improvement opportunities to make the addictions field an employer of choice. The Provider/OASAS Talent Management Committee is promoting the use of BPTW as a source of valuable data to drive improved outcomes.

The Engagement Committee meets regularly to discuss, explore, and determine which topics and line-item elements are within our control (versus under the purview of a control agency or the civil service system) and which are most important to address as OASAS strives to become a “best place to work.” The Committee will release a questionnaire to all staff to garner more in-depth information that will help define the actions OASAS will take. The Provider/OASAS Talent Management Committee has already garnered close to 20 providers who intend to apply for the BPTW this year.

Addiction Career Resource Center

As part of the agency’s commitment to promoting Talent Management and making the addictions field a “profession of choice,” OASAS has partnered with the 70-plus member Talent Management Committee to plan for the implementation of a “virtual” recruitment center that would serve as a central focus for Talent Management. Known as the Addiction Career Resource Center, this new Web resource will provide a vital link between entry level professionals, the schools that train professionals, and the service providers that employ them. This new Center will be supported by start-up funding from OASAS to provide professional assistance to individuals seeking positions in the addictions profession and serve as a resource for posting job openings and resumes and supporting field placements of students who are enrolled in either academic programs or approved community-based training programs.

During 2009, the Addiction Career Resource Center will:

- Develop an independent website containing a wide range of resource materials and linkages to organizations that train, hire, or support addictions professionals;
- Establish a toll-free call center to provide information and guidance on careers and educational/training resources;
- Create a database of job postings and resumes for employers, professional schools, and prospective employees.

In future years, the Addiction Career Resource Center will:

- Continue building and expanding upon its database and resource listing;
- Provide new information on clinical and administrative supervision resources;
- Develop new online marketing strategies to reach job seekers and entry level professionals;
- Access alternative grant/funding opportunities and revenue generating strategies to sustain future expansion beyond the period of OASAS support.

On July 1, 2009, OASAS contracted with the Institute for Professional Development in Addictions to facilitate implementation of the Addictions Career Resource Center.

Leadership Competencies

OASAS continues to promote outcomes thinking as the driving force in all agency initiatives to become the leading addiction authority in the nation. OASAS' broad agency destinations and Strategic Map provide the framework and premise for all work. The agency is designing specific supervisory training opportunities geared towards leadership excellence. OASAS will deliver cultural competency training to help broaden and enrich our diversity awareness, staffing, and beneficial influence. In addition, OASAS plans to deliver timely and useful knowledge and learning opportunities and important topic dialogues with agency leaders.

Outcomes management has evolved through the issuance of our 2009 Priorities distinguished by the overarching five destinations with ten specific agency-level metrics. The Human Resource/Workplace Learning team met with Executive Team members to determine the necessary elements of supervisory learning needed with further meetings planned to frame this important leadership education opportunity. OASAS will hold an informative half-day cultural competency learning program to enhance diversity awareness and practices and the agency has experimented with different Leadership Business meeting formats to obtain the optimum outcomes and impact to maximize usefulness and improvements.

Loan Forgiveness/Financial Incentives

The Provider/OASAS Talent Management Committee is exploring and researching opportunities for loan forgiveness and other financial incentives for direct-care workers with the goal of implementation in 2010. OASAS formed a workgroup that became operational in September 2009.

Addiction Professionals Supply

Addiction professionals are the centerpiece of OASAS Talent Management efforts. These dedicated professionals are vital to the quality and continuing care that is provided in the service delivery system. Much has been written about trends in the addictions services workforce that suggest there will not be a sufficient pool of entry level professionals to replace experienced counselors and prevention professionals when they retire. Many providers report that they are understaffed and unable to recruit sufficient numbers of qualified staff to manage caseloads. This shortfall could potentially have a negative effect on the quality of services provided and patient outcomes.

OASAS, through its collaboration with the Talent Management Committee, has been working to counteract these trends by “rebranding” the addictions profession and focusing attention on the important, life-saving contributions that a career in this field offers. This requires a multifaceted approach, which takes into consideration the major elements of career development and opportunity, including:

- Adequate compensation and benefits;
- Career ladders;
- Personal growth and satisfaction;
- Supportive organizational culture;
- More effective marketing of the field.

Key to these efforts will be achieving greater recognition of the value of addictions professionals both inside and outside of the OASAS service delivery system. Estimates have placed the total number of workers (paid and volunteer) in the OASAS service delivery system at close to 35,000. Whether they are counselors, social workers, prevention practitioners, nurses, clinical supervisors, program directors, or housekeepers, they all play a critical role and need to be supported and valued by the employers in our system.

New York State recognized the “talent” that makes up its workforce when it celebrated Addictions Professionals Day on September 22, 2009. Combining a formal gubernatorial proclamation with local recognition events for the CASAC of the Year, CASAC Trainee of the Year, CPP/CPS of the Year, Addiction Nurse of the Year, and Addiction Physician of the Year helped to elevate the status of the field. Additionally, OASAS efforts have increased public awareness and appreciation of the thousands of health care professionals who have dedicated their lives to helping others.

Certified Professionals

OASAS is establishing a baseline of high-performing, certified professionals through a survey of medical directors and staff who are ASAM, American Psychiatric Association

(APA), or American Osteopathic Association (AOA) certified and who are Buprenorphine certified so that the agency can ensure 100 percent certification compliance. OASAS intends to accomplish the following in this metric by the end of 2009:

- Implement three BPTW projects;
- Increase to 20 the number of provider agencies applying to be a BPTW;
- Establish an Addiction Career Resource Center;
- Improve leadership competencies such as Outcome Thinking, Supervisory and Cultural Competency Training, and increase the effects of the Leadership Business meetings;
- Make progress on establishing loan forgiveness and other financial incentives;
- Increase the supply of and demand for addiction professionals.
- Create a baseline of current medical directors and staff who are certified in ASAM, APA, or AOA.

Destination 5- Financial Support and Stewardship *A system with strong return on taxpayer investment and stewardship of resources.*

Metric 10: Increase or stabilize funding resources while ensuring a strong return on taxpayer investment.

10.1: Secure American Reinvestment & Recovery Act of 2009 (ARRA) funding for OASAS or the Field.

10.2: Secure adequate funding to support treatment for individuals diverted under 2009 Drug Law Reforms (\$4 million in 2009-10) by 10/31/09.

10.3: Submit timely quarterly reports on all financial and performance indicators required to receive Federal Byrne funds; submission of quarterly reports to commence 10/09.

Status and Discussion

At both the federal and State levels, major legislative and policy developments are creating significant opportunities and challenges for OASAS' funding resources. The American Reinvestment and Recovery Act (ARRA) of 2009 is an important federal economic stimulus measure that is creating opportunities for OASAS and the field. In addition to ARRA funding, OASAS is pursuing other federal funding opportunities through agencies such as CSAT, CSAP, and the Center for Mental Health Services (CMHS). One of the most significant State policy changes to affect OASAS has been the Rockefeller Drug Law reforms. As a result of the leadership of Governor David A. Paterson, New York is implementing sweeping reforms of the Rockefeller Drug Laws and recognizing that addiction is a chronic illness that is better addressed through treatment rather than incarceration.

American Reinvestment and Recovery Act of 2009

Given federal and State financial constraints, ARRA funding presents the single most critical opportunity for OASAS and the field to demonstrate through research and program innovation that prevention, treatment, and recovery services are central to the well-being of the nation. ARRA's overall goals are to stimulate the economy in the short-term and invest in essential public services and the workforce to ensure the nation's long-term economic health. The success of ARRA will depend on the shared commitment and responsibility of many partners at the federal, State, and community levels. OASAS is committed to ensuring that any ARRA grant funding that is secured will be invested wisely to improve access, strengthen services, and improve outcomes.

OASAS will expeditiously post all identified ARRA grant funding opportunities to the Grants and Funding Opportunities section of the OASAS website: <http://www.oasas.state.ny.us/hps/grants/indes.cfm>. OASAS added a separate section devoted to ARRA notices of funding availability and news to the website: <http://www.oasas.state.ny.us/hps/grants/ARRAFunding.cfm>. This website also includes guidance and other information to assure that applicants are fully versed in federal requirements related to ARRA funding. While the majority of ARRA grant notices have already been published, there continue to be new announcements that OASAS posts on its website.

Congress did not authorize ARRA funding for SAMHSA. As a result, applicants for ARRA funding, both OASAS and our stakeholders, must learn applicant and submission requirements for other federal agencies. Additional burdens encountered by ARRA applicants include each federal agency's use of different electronic application systems and short timeframes for application submissions.

OASAS, alone or in partnership with others, prepared ARRA applications to NIDA to:

- Increase treatment access and quality for Asian Americans;
- Update and refine its State and county prevalence estimates for individuals with heroin substance use disorders, currently estimated at 200,000 statewide;
- Conduct a pilot study that will build local implementation infrastructure capacity in two counties by utilizing the local governmental unit as purveyors of evidence-based practices (in this case, NIATx);
- Test a chronic care model for offenders who have a substance use disorder.

In addition to the NIDA grant applications, OASAS submitted an application for the Federal Coordinating Council for Comparative Effectiveness Research to:

- In concert with CASA, develop a State-level model to treat addiction as a chronic illness across multiple agencies (e.g., substance use and criminal justice) and

system components (e.g., financing, regulation, service delivery) and to conduct all developmental work necessary to design a rigorous comparative effectiveness research.

OASAS also submitted an ARRA grant application to the National Institutes of Health (NIH) to fund:

- A collaboration with the New York Psychiatric Institute to add a research component to a current project so that factors influencing the “uptake” of the web-based training and its impact can be identified, with adjustments made accordingly.

In partnership with OMH, OASAS has also developed a broadband infrastructure development grant proposal for the U.S. Department of Commerce and, separately, a sustainability application to fund video conferencing that will serve OASAS, OMH, and OMRDD providers and staff.

The competition for ARRA funding has been intense, with over 20,000 applications submitted for NIDA Challenge Grants alone.

Other Federal Grant Applications

As noted above, key federal partners for OASAS and the field (e.g., SAMHSA) did not receive any ARRA funds. OASAS and its providers/stakeholders have, therefore, aggressively pursued other grant funding for a variety of program efforts. These include:

- From CSAT:
 - Local recovery-oriented systems of care
 - Offender re-entry program;
 - Development of comprehensive drug/alcohol and mental health treatment systems for persons who are homeless;
 - Family centered substance use treatment grants for adolescents and their families;
 - Grants to expand substance use treatment capacity for adult drug courts;
 - Juvenile drug courts.
- From CSAP:
 - Knowledge dissemination conference grant;
 - Drug free communities support program;
 - Drug free communities mentoring program; and
 - Sober Truth on Preventing Underage Drinking (STOP grants).
- From NIDA:

- Health services research on the prevention and treatment of drug and alcohol abuse [NIDA and the National Institute on Alcohol Abuse and Alcoholism (NIAAA)];
- Integrated web-based technologies for behavioral couples treatment;
- Web-supported bi-regional dissemination of an evidence-based practice.
- From the Department of Justice:
 - “Second Chance” Act prisoner reentry initiative;
 - Gang prevention coordination assistance program.
- From CMHS:
 - Services in supportive living;
 - Cooperative agreement for linking actions for unmet needs in children’s health (Project Launch).
- Other federal, State, and local sources:
 - HIV/AIDS Health Improvement for Re-entering Ex-Offenders Initiative (HIRE)— Department of Health and Human Services’ Office of Minority Health;
 - Drinking driving program improvements— GTSC;
 - Permanent and transitional supportive congregate housing for persons living with AIDS or advanced HIV illness— New York City Housing Committee;
 - YouthBuild program— U.S Department of Labor;
 - Coalitions to prevent and reduce alcohol abuse at colleges—U.S. Department of Education;
 - Grants for programmatic directives— SAMHSA.

Sentencing Reform

The 2009-2010 Enacted State Budget includes a significant financial investment for chemical dependence residential, outpatient, and case management services as a result of reforms made to the Rockefeller Drug Laws. Approximately \$4 million is available in Fiscal Year 2009-10. The majority of this investment will initially be supported by federal Byrne/Justice Assistance Grant (JAG) ARRA funding. The funding will support residential bed expansion, with the balance for additional outpatient and case management services. During the next two years, it is anticipated that between \$40 and \$50 million could be invested in the OASAS system to provide treatment to individuals being diverted from State prisons.

In order to receive these funds, States and grantees (i.e., OASAS providers) are also required to adhere to significant fiscal and program performance reporting requirements.

OASAS is working collaboratively with DCJS to comply with all ARRA reporting requirements as well as additional requirements imposed by the U.S. Department of Justice as it pertains to utilizing Byrne/JAG funding. OASAS will begin to report on both fiscal and performance elements beginning in October 2009.

It is estimated that over 1,600 individuals will be eligible for treatment as a result of the Rockefeller Drug Law reforms that become effective in October 2009. In order to serve these individuals, OASAS will expand treatment opportunities in both its residential and outpatient systems. The agency is collaborating with its criminal justice partners to identify geographic areas throughout the State that need additional treatment capacity.

OASAS is identifying the additional residential treatment capacity to accommodate offenders who will be diverted from prison to drug treatment as a result of the Drug Law reforms. Between 600 and 700 residential beds will be needed to serve this population. OASAS sent a Request for Information (RFI) to all of its certified residential treatment providers to identify whether additional capacity exists to meet this demand. The agency identified approximately 700 residential beds that can be immediately available in October 2009. Of this amount, nearly 240 beds are in existing certified residential treatment programs and the remaining 460 will be newly established residential beds in the OASAS treatment system and supported by stimulus funding.

OASAS recently issued a Planning Supplement to counties in targeted areas of the State announcing the availability of funding to address anticipated demand for outpatient chemical dependence treatment and assessment services. Counties were asked to identify outpatient treatment providers that can be funded beginning in late 2009 or early 2010. OASAS is developing another Planning Supplement for the provision of clinical case management services to offenders.

Chapter VI: Moving Forward

Underscoring all of the OASAS objectives outlined in this Strategic Plan is our commitment to support the mission:

to improve the lives of New Yorkers by leading a premier system of addiction services through prevention, treatment, recovery.

This Strategic Plan is an important tool in OASAS' efforts to achieve our vision of becoming a premier system of addiction related services and programs for all New Yorkers. Planning at the State and local levels is a critical part of achieving this vision. OASAS regards planning as a continuous process to identify priorities, develop strategies, and measure results for improved outcomes. Over the coming years, OASAS will emphasize the five core planning principles described earlier:

- Planning is an ongoing process that informs policy development, budgeting, and the delivery of services;
- Planning produces documents and reports that are useful and used by Planning focuses on desired system and individual outcomes;
- Planning has “buy in” from all key customers including OASAS leaders and staff, other State agencies, counties, providers, patients/participants, and other stakeholders;
- Planning engages stakeholders in meaningful ways at all levels: federal, State, county, and community.

On February 15, 2010, OASAS will issue the Interim Report on the Strategic Plan. This report will include Executive Budget Highlights, and updates on planning and service system issues.

Moving forward, OASAS' top priorities are:

- Implementing a significant expansion of the addiction treatment system to support Rockefeller Drug Law reforms;
- Developing and implementing a new outpatient reimbursement methodology-APGs, which will support the delivery of individualized, patient-centered care.

APPENDIX I: ACRONYM DEFINITIONS

AA	Alcoholics Anonymous
ACTION	Addictions Collaborative to Improve Outcomes for New Yorkers
AIDS	Acquired Immune Deficiency Syndrome
AMC	Albany Medical College
AOA	American Osteopathic Association
AOD	Alcohol and Other Drug
APA	American Psychiatric Association
APG	Ambulatory Patient Group
ARRA	American Reinvestment and Recovery Act
ASAM	American Society of Addiction Medicine
ASAP	Alcoholism and Substance Abuse Providers of New York State
ATC	Addiction Treatment Center
BPTW	Best Places to Work
BRFSS	Behavior Risk Factor Surveillance Survey
CADCA	Community Anti-Drug Coalitions of America
CARN	Cerfied Addiction Registered Nurse
CASA	National Center on Addiction and Substance Abuse
CASAC	Credentialed Alcoholism and Substance Abuse Counselor
CBT	Cognitive-Behavioral Therapy
CCSNY	Council of Community Services of NYS
CDS	Client Data System
CEIC	Center of Excellence for the Integration of Care
CEO	Chief Executive Officer
CLMHD	Conference of Local Mental Hygiene Directors
CMHS	Center for Mental Health Services
CMS	Centers for Medicare and Medicaid Services
CoS	Communities of Solution
CPLP	Community of Practice for Local Planners
CPM	Case Presentation Method
CPP	Credentialed Prevention Professional
CPS	County Planning System
CPS	Credentialed Prevention Specialist

CPT	Current Procedural Terminology
CSAP	Center for Substance Abuse Prevention
CSAT	Center for Substance Abuse Treatment
DCJS	Division of Criminal Justice Services
DDPC	Developmental Disabilities Planning Council
DHCR	Division of Housing and Community Renewal
DHS	New York City Department of Homeless Services
DMH	Department of Mental Hygiene
DOB	Division of the Budget
DOCS	Department of Correctional Services
DOH	Department of Health
DOHMH	New York City Department of Health and Mental Hygiene
DOP	Division of Parole
DPCA	Division of Probation and Correctional Alternatives
DSM-IV	Diagnostic and Statistic Manual of Mental Disorders, Fourth Edition
DTC	Drug Treatment Campus
DWI	Driving While Intoxicated
FARS	Fatality Analysis Reporting System
FASD	Fetal Alcohol Spectrum Disorders
GNYHA	Greater New York Hospital Association
GORR	Governor's Office of Regulatory Reform
GTSC	Governor's Traffic Safety Committee
HANYS	Healthcare Association of New York State
HHAP	Homeless Housing Assistance Program
HHC	New York City Health and Hospitals Corporation
HIRE	Health Improvement for Re-entering Offenders
HRA	New York City Human Resources Administration
HTF	Housing Trust Fund
HUD	Housing and Urban Development
IC & RC	International Certification and Reciprocity Consortium
IntNSA	International Nurses Society On Addictions
IOCC	Inter-Office Coordinating Council
IOM	Institute of Medicine
IPMES	Integrated Program Monitoring and Evaluation System
IPR	Independent Peer Review
IQS	Integrated Quality System

JAG	Justice Assistance Grant
LGU	Local Governmental Unit
LGBT	Lesbian, Gay, Bisexual and Transgender
LIHTC	Low Income Housing Tax Credit
MATS	Managed Addiction Treatment Services
MI	Motivational Interviewing
MOA	Memorandum of Agreement
MTAG	Methadone Transformation Advisory Group
NA	Narcotics Anonymous
NASADAD	National Association of State Alcohol and Drug Abuse Directors
NCES	National Center for Education Statistics
NESARC	National Epidemiologic Survey on Alcohol and Related Conditions
NIAAA	National Institute on Alcohol Abuse and Alcoholism
NIATx	Network for the Improvement of Addiction Treatment
NIDA	National Institute on Drug Abuse
NIH	National Institutes of Health
NOMs	National Outcome Measures
NSDUH	National Survey on Drug Use and Health
OASAS	Office of Alcoholism and Substance Abuse Services
OCA	Office of Court Administration
OCFS	Office of Children & Family Services
OJJDP	Office of Juvenile Justice and Delinquency Prevention
OMAG	Outcomes Management Advisory Group
OMH	Office of Mental Health
OMRDD	Office of Mental Retardation and Developmental Disabilities
OTDA	Office of Temporary and Disability Assistance
OTP	Opioid Treatment Providers
PARIS	Prevention Activities and Results Information System
PEG	Program to Eliminate the Gap
PPSI	Program Profile and Services Inventory
PRU	Program Reporting Unit
PSH	Permanent Supportive Housing
PTSD	Post-Traumatic Stress Disorder
RCC	Recovery Community Center
RFI	Request for Information

RFP	Request for Proposals
RIT	Recovery Implementation Team
SAAS	State Associations of Addiction Services
SABRS	State Aid Budgeting and Reporting System
SAMHSA	Substance Abuse and Mental Health Services Administration
SAPT	Substance Abuse Prevention and Treatment
SBI	Screening and Brief Intervention
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SED	State Education Department
SEOW	State Epidemiological Outcomes Workgroup
SPARCS	Statewide Planning and Research Cooperative System
SPF-SIG	Strategic Prevention Framework State Incentive Grant
STAR-QI	Strengthening Treatment Access and Retention – Quality Improvement
STAR-SI	Strengthening Treatment Access and Retention – State Implementation
STD	Sexually Transmitted Disease
STOP	Sober Truth on Preventing Underage Drinking
SUD	Substance Use Disorder
TBI	Traumatic Brain Injury
TCA	Therapeutic Communities of America
TCGs	Technical Consultation Groups
TEDS	Treatment Episode Data Set
TPC	Transition from Prison to Community
TTT	Train-the-Trainer
UCR	Uniform Crime Reporting
UPL	Upper Payment Limits
VADIR	Violent and Disruptive Incident Reports
YDS	Youth Development Survey

APPENDIX II: SPECIAL POPULATION FACTS

Fast Facts for Adolescents (Ages 12-17)

Nature of the Problem¹

- OASAS estimates that as many as 160,227 adolescents (10% of adolescents) in New York State (NYS) have a substance use disorder.
- One-quarter of NYS adolescents with a substance use disorder, or 40,065 adolescents, would seek treatment in an OASAS certified program if it was available.
- 43% of adolescent outpatient treatment demand is currently being met. By comparison, 74% of adult outpatient treatment demand is currently being met.

System Capacity

- There were 12,112 adolescent admissions in NYS during 2007, mostly to outpatient programs (80%), followed by residential (13%) and inpatient (7%).
- Adolescents represented 5.7% of total admissions in NYS; nationally, adolescents represented 8% of all admissions.
- Average daily enrollment was 4,366, mostly in outpatient programs (87%), followed by residential (12%) and inpatient (1%).
- 13,673 adolescents were in treatment in NYS during 2007.
- 47 programs treated predominantly adolescents (i.e., 70% or more of their admissions were adolescents).

Trends

- Number of adolescent admissions, as well as percent of adolescent admissions compared to total admissions, decreased between 2000 and 2007 (Figure 1).
- From 2000 to 2007, the percentage who reported marijuana as the primary substance of abuse increased from 62% to 72%, while alcohol decreased from 28% to 17% (Figure 2).

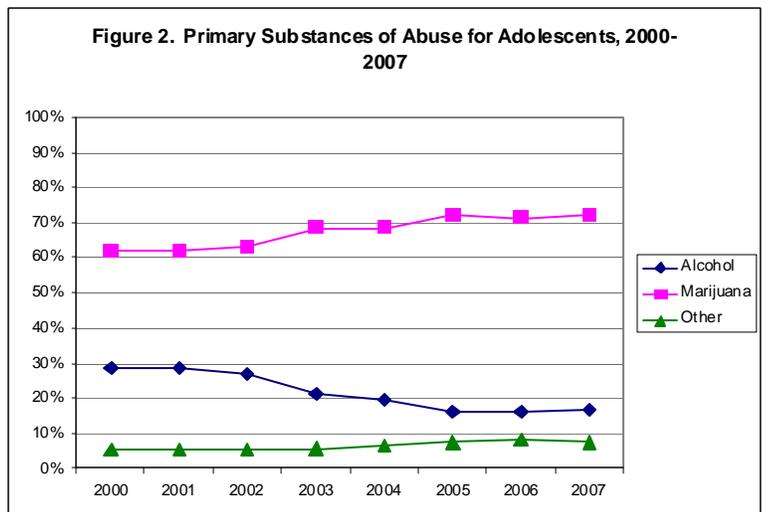
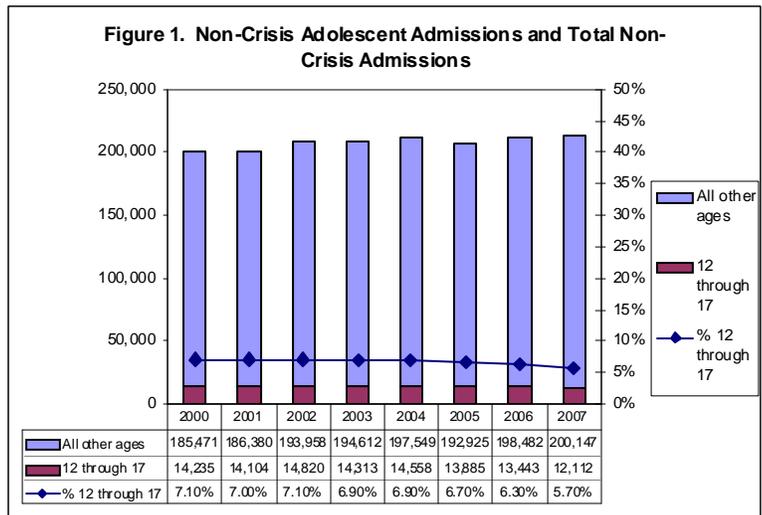
Client Characteristics

- 73% were male
- Primary substances of abuse were marijuana (72%), alcohol (17%), cocaine/crack (3%), opioids (2%), and other (2%)
- 53% were White non-Hispanic, 26% Black non-Hispanic, 18% Hispanic, and 4% other non-Hispanic
- 42% were identified as having a co-existing psychiatric disorder or had ever been treated for a mental illness at either admission or discharge
- Less than 1% were homeless
- Principal referral sources were criminal justice (44%), OASAS treatment system (16%), health care/social services (13%), self (5%), and other (22%)
- 60% had criminal justice involvement
- 5% were identified as having a physical impairment
- Primary payment sources at discharge were public assistance/Medicaid (45%), private insurance (34%), self (8%), none (7%), and other (6%)
- 51% used tobacco or smokeless tobacco in the week prior to admission
- 32% completed treatment

Comparisons

When compared to those who are 18 and older, adolescents were:

- More likely to be admitted to outpatient treatment
- More likely to report marijuana as the primary substance of abuse
- Less likely to be homeless
- Less likely to have a self or OASAS treatment system referral
- More likely to have criminal justice involvement
- Less likely to have a physical impairment
- Less likely to have used tobacco in the week prior to admission



1: From OASAS Service Need Profile, March 2008, Statewide.

Statistics do not include crisis admissions.

Source: NYS OASAS Data Warehouse, for the period January 1, 2007 to December 31, 2007. Last updated March 24, 2009.

Co-Occurring Mental Health Disorder Fast Facts

System Capacity¹

- There were 90,168 non-crisis discharges identified as having a co-occurring mental health disorder² in New York State (NYS) during 2007, mostly from outpatient programs (60%), followed by inpatient (26%), residential (8%), and methadone (6%).
- Those with a co-occurring disorder represented 44% of non-crisis discharges in 2007.
- Average daily enrollment was 35,261, mostly in outpatient programs (63%), followed by methadone (25%), residential (8%), and inpatient (4%).
- In 2007, 64,760 individuals with a co-occurring mental health disorder were in treatment in NYS.
- 148 programs treated predominantly those with a co-occurring disorder (i.e., 70% or more of their discharges in 2007 had a co-occurring disorder).

Trends³

- Both the number of co-occurring admissions and the percent of co-occurring admissions compared to total non-crisis admissions has steadily increased between 2000 and 2007 (Figure 1).

Client Characteristics⁴

- 61% were male
- The most common age group was 35 through 44 (31%), followed by 45 through 54 (22%), 25 through 34 (22%), 18 through 24 (13%), under 18 (6%), and 55 and up (6%).
- Primary substances of abuse were alcohol (40%), crack/cocaine (22%), heroin/opiates (20%), marijuana/hashish (15%), and other (3%)
- 56% were White non-Hispanic, 24% Black non-Hispanic, 17% Hispanic, and 3% other non-Hispanic
- 37% had less than high school education
- 63% were not employed and not looking for work, 23% were employed, and 14% were not employed and looking for work
- 35% resided in New York City
- Principle referral sources were OASAS treatment system (31%), criminal justice (22%), self (19%), health care/social services (19%), and other (9%).
- 38% had criminal justice involvement
- 13% were homeless at admission
- 5% reported veteran status
- 28% had some form of physical impairment
- 73% used smokeless tobacco or smoked tobacco in the week prior to admission
- 50% were the child of an alcoholic and/or substance abuser
- 80% had one or more prior substance treatment episodes
- Primary payment sources at discharge were Medicaid/public assistance (66%), private insurance (15%), self (8%), none (7%), and other (4%).
- 37% completed treatment
- Figure 2 details reported mental health-related characteristics at admission and discharge

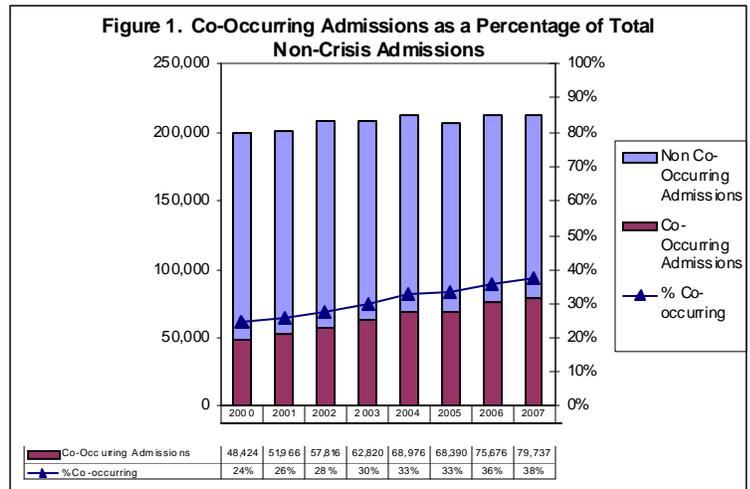
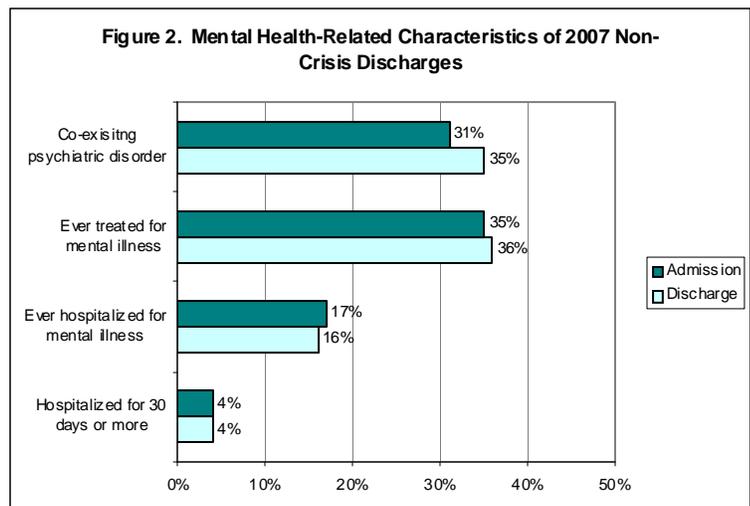


Figure 2. Mental Health-Related Characteristics of 2007 Non-Crisis Discharges



Comparisons

When compared to those who do not have a co-occurring mental health disorder, those with a co-occurring mental health disorder were:

- More likely to be discharged from inpatient treatment
- More likely to be female
- More likely to be White non-Hispanic
- Less likely to be employed
- Less likely to reside in New York City
- More likely to have a OASAS treatment system or health care/social services referral
- Less likely to have criminal justice involvement
- More likely to be identified as having a physical impairment
- More likely to be the child of an alcoholic and/or substance abuser
- More likely to have a prior substance treatment episode
- More likely to pay with Medicaid/public assistance and less likely to self-pay

1: Statistics do not include crisis admissions, as mental health items are not collected on the crisis admission/discharge form.

2: Co-occurring mental health disorder is defined as having a co-existing psychiatric disorder or having ever been treated for a mental illness at either admission or discharge.

3: Trends are based on those who were identified as having a co-existing psychiatric disorder or having ever been treated for a mental illness at admission only, because mental health items first appeared on the discharge form in 2005.

4: Client Characteristics and Comparisons are based on those who were identified as having a co-existing psychiatric disorder or had ever been treated for a mental illness at either admission or discharge.

Source: NYS OASAS Data Warehouse, for the period January 1, 2007 to December 31, 2007. Last updated March 24, 2009.

Fast Facts for Criminal Justice Involvement

System Capacity

- There were 104,376 non-crisis admissions with criminal justice involvement in New York State during 2007, mostly to outpatient programs (75%), followed by inpatient (12%), residential (11%), and methadone (2%).
- Those with criminal justice involvement represented 49% of non-crisis admissions.
- Average daily enrollment was 40,141, mostly in outpatient programs (77%), followed by methadone (12%), residential (9%), and inpatient (2%).
- 109,382 individuals with criminal justice involvement were in treatment in NYS during 2007.
- 224 programs treated predominantly those with criminal justice involvement (i.e., 70% or more of their admissions had criminal justice involvement).

Trends

- The number of admissions with criminal justice involvement increased slightly between 2000 and 2007, while the percent of criminal justice involved compared to total admissions did not change between 2000 and 2007 (Figure 1).

Client Characteristics

- 79% were male
- The most common age group was 25 through 34 (27%), followed by 35 through 44 (25%), 18 through 24 (23%), 45 through 54 (15%), under 18 (7%), and 55 and over (3%)
- Primary substances of abuse were alcohol (39%), marijuana/hashish (29%), crack/cocaine (17%), heroin/opiates (13%), and other (2%)
- 46% were White non-Hispanic, 31% Black non-Hispanic, 20% Hispanic, and 3% Other non-Hispanic
- 40% had less than high school education
- 41% were not employed and not looking for work, 39% were employed, and 20% were not employed and looking for work
- Principle referral sources were criminal justice (71%), OASAS treatment system (13%), other (9%), and self/family (6%). Criminal justice referrals sources are detailed in Figure 2.
- 6% were homeless at admission
- 4% reported veteran status
- 16% had some form of physical impairment
- 34% were identified as having a co-existing psychiatric disorder or had ever been treated for a mental illness at either admission or discharge
- 68% used smokeless tobacco or smoked tobacco in the week prior to admission
- The primary payment sources at discharge were Public Assistance/Medicaid (51%), self (20%), private insurance (13%), none (9%), and other (7%)
- 43% completed treatment

Comparisons

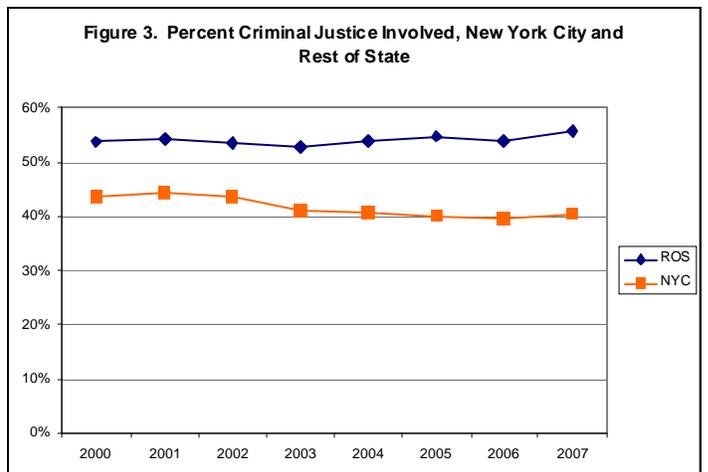
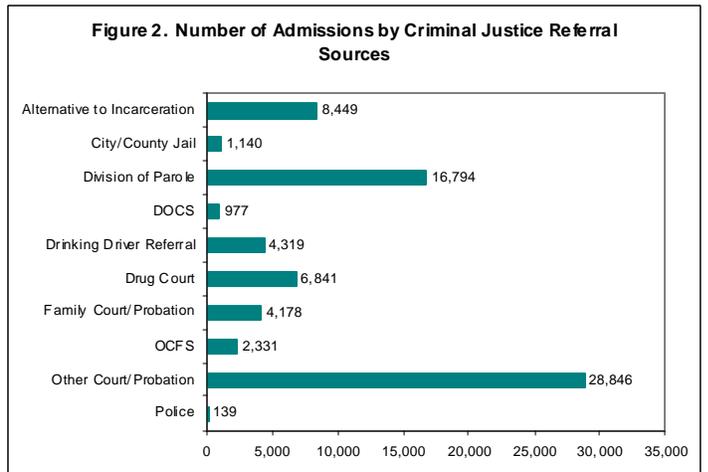
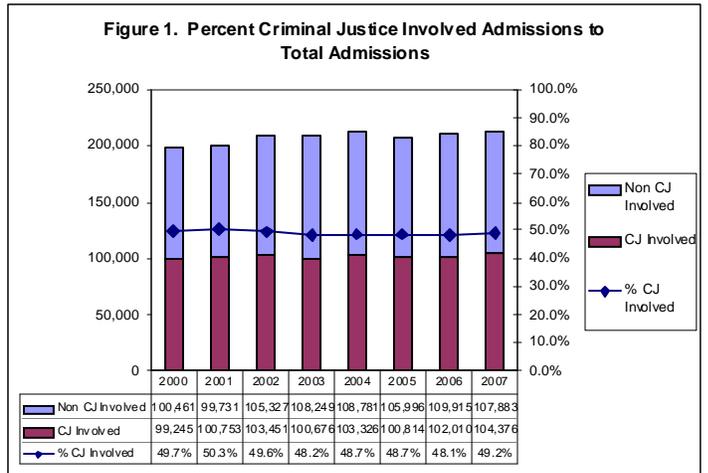
When compared to those who do not have criminal justice involvement, those with criminal justice involvement are:

- More likely to be admitted to outpatient treatment
- More likely to be male
- More likely to be ages 18 through 24
- More likely to report marijuana as the primary substance of abuse, and less likely to report opioids as the primary substance of abuse
- More likely to be employed
- Less likely to be homeless
- Less likely to be identified as having a physical impairment
- Less likely to be identified as having a co-occurring mental illness
- More likely to self-pay and less likely to pay by public assistance/Medicaid

Geographic Differences

The percentage of admissions with criminal justice involvement was lower among New York City residents when compared to residents of the rest of New York State (Figure 3). Those with criminal justice involvement who resided in New York City were:

- More likely to be admitted to residential treatment
- More likely to be Hispanic or Black non-Hispanic
- Less likely to report alcohol and more likely to report marijuana or opioids as the primary substance of abuse
- Less likely to have graduated high school
- Less likely to be employed
- Less likely to be identified as having a co-occurring mental illness
- Less likely to complete treatment



Statistics do not include crisis admissions, as criminal justice items are not collected on the crisis admission/discharge form.

Source: NYS OASAS Data Warehouse, for the period January 1, 2007 to December 31, 2007. Last updated March 24, 2009.

Senior Fast Facts (Age 55 and Older)

System Capacity

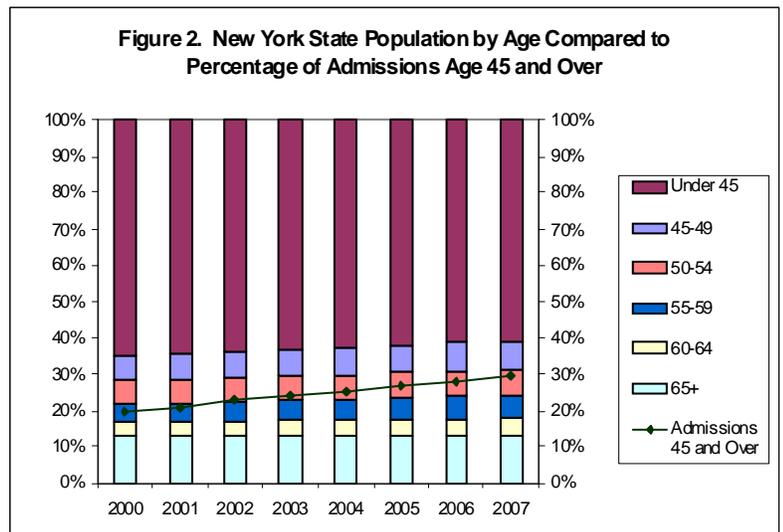
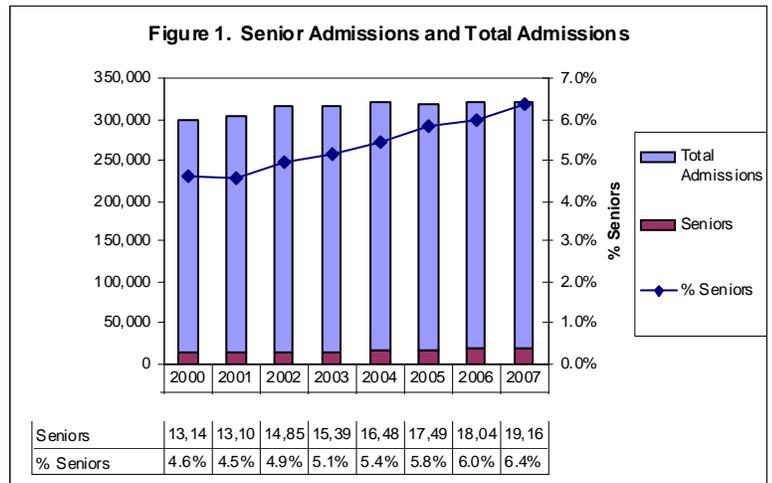
- There were 19,166 senior admissions in New York State during FFY 2006-2007, mostly to crisis programs (40%), followed by outpatient (37%), inpatient (13%), methadone (7%), and residential (3%)
- Seniors represented 6% of total admissions
- Average daily enrollment was 7,583; mostly in outpatient programs (49%), followed by methadone (43%), residential (5%), inpatient (2%), and crisis (1%)
- 18,371 seniors were in treatment in NYS during FFY 2006-2007
- Four programs treated predominantly seniors (i.e., 70% or more of their admissions were seniors)
- Nationally, seniors represent 4% of all admissions

Trends

- Number of senior admissions as well as percent of senior admissions compared to total admissions increased steadily between FFY 1999-2000 and 2006-2007 (Figure 1)
- Over the past eight years, the proportion of admissions over age 45 increased steadily along with the population of this age group, and is approaching one-third of all admissions (Figure 2)

Client Characteristics

- 81% were Male
- Primary substances of abuse were: alcohol (67%), heroin/opiates (19%), crack/cocaine (9%), marijuana/hashish (2%), and other (3%)
- 32% had less than high school education
- 75% were not employed and not looking for work, 16% were employed, and 9% were not employed and looking for work
- Principle referral sources were self/family (40%), other (31%), OASAS treatment system (16%) and criminal justice (13%)
- 43% were White non-Hispanic, 36% Black non-Hispanic, 18% Hispanic, and 3% other non-Hispanic
- 25% had criminal justice involvement¹
- 47% were identified as having a co-existing psychiatric disorder or had ever been treated for a mental illness at either admission or discharge¹
- 19% were homeless at admission
- 13% reported veteran status
- 23% had some form of physical impairment
- 56% used smokeless tobacco or smoked tobacco in the week prior to admission¹
- The primary payment sources at discharge were public assistance/Medicaid (50%), private insurance (16%), other (14%), none (12%) and self (8%)
- 59% completed treatment



Comparisons

When compared to those under age 55, seniors were:

- More likely to report alcohol as the primary substance of abuse and less likely to report marijuana or crack/cocaine as the primary substance of abuse
- Less likely to report any secondary substance of abuse
- More likely to have greater than a high school education
- Less likely to be employed
- More likely to have a physical impairment
- Less likely to use tobacco
- Less likely to have criminal justice involvement
- More likely to complete treatment
- More likely to stay in outpatient and methadone treatment for 3 months or more

1: Criminal justice involvement, mental illness, and tobacco use do not include crisis admissions, as these items are not collected on the crisis admission/discharge form. Source: NYS OASAS Data Warehouse, for the period October 1, 2006 to September 30, 2007. Last updated March 24, 2009.

Veterans Fast Facts

System Capacity

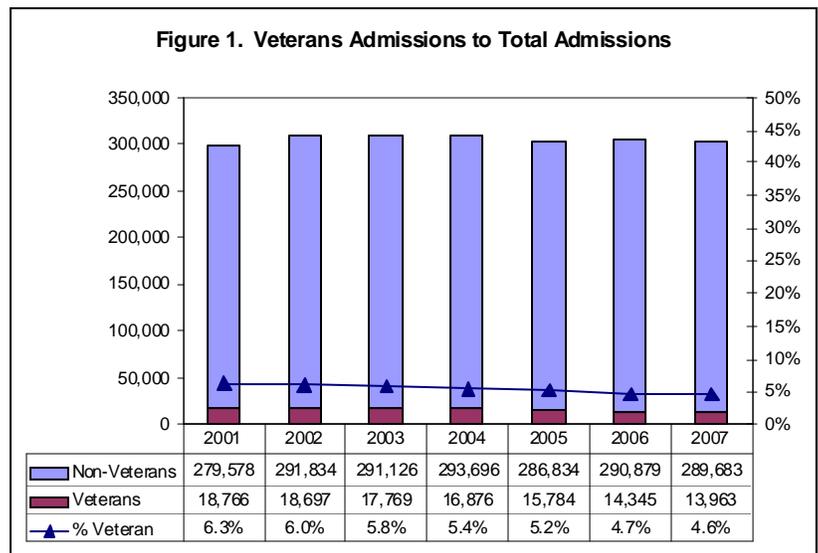
- There were 13,950 veteran admissions to crisis and treatment programs in New York State (NYS) during FFY 2006-2007, mostly to outpatient programs (39%), followed by crisis (35%), inpatient (14%), residential (7%), and methadone (5%)
- Veterans represented 5% of all crisis and treatment admissions in NYS and 5% of all admissions nationally
- The average daily enrollment for veterans was 5,289.
- 11,892 veterans were in treatment in NYS during FFY 2006-2007
- 3 residential programs with a combined bed capacity of 112 beds serve veterans exclusively
- 85% of all substance crisis and treatment programs served some veterans during this period
- 43 veterans were treated for gambling problems, representing 6.3% of all gambling clients

Trends

- The number of veteran admissions as well as the percent of veterans to total admissions decreased from 2000 to 2007

Client Characteristics

- 93% were male
- The most common age group was 45-54 (38%), followed by 35-44 (29%), 55 and over (18%), 25-34 (11%), 19-24 (3%), and 18 and under (1%)
- Primary substances of abuse were: alcohol (58%), crack/cocaine (18%), heroin/opiates (17%), marijuana/hashish (5%), other (2%)
- Secondary substances of abuse were: none (36%), crack/cocaine (27%), alcohol (15%), marijuana/hashish (13%), heroin/opiates (5%), other (4%)
- 17% had less than high school education
- 64% were not employed and not looking for work, 23% were employed, and 13% were not employed and looking for work
- Principle referral sources were: self/family (34%), criminal justice (19%), OASAS treatment system (19%), other (28%)
- 45% were White non-Hispanic, 38% Black non-Hispanic, 15% Hispanic, and 3% other non-Hispanic
- 42% had criminal justice involvement ¹
- 44% were identified as having a co-existing psychiatric disorder or had ever been treated for a mental illness at either admission or discharge ¹
- 24% were homeless
- 71% smoked tobacco or used smokeless tobacco in the week prior to admission ¹
- Primary payment sources at discharge were: public assistance/Medicaid (46%), none (20%), private insurance (15%), self pay (11%), and other (includes VA) (8%)
- 53% completed all or most treatment goals at discharge; this compares favorably to a 48% completion rate for non-veterans
- Lengths of stay at discharge and 1-month and 3-month treatment retention rates are similar to the non-veteran population
- The rates at which veterans are linked to continuing services from crisis and inpatient treatment, are likewise comparable to the non-veteran population



¹: Criminal justice involvement, mental illness, and tobacco use do not include crisis admissions, as these items are not collected on the crisis admission/discharge form.

Source: NYS OASAS Data Warehouse for the period October 1, 2006 to September 30, 2007. Last updated March 24, 2009.

Special Population Report

Women and Children: 2007

Highlights

- In 2007, OASAS treatment programs had 57,040 female primary admissions and 1,145 female significant other admissions.
- Almost two thirds (65%) of females admitted in 2007 reported having children
- More than one quarter (28%) of female admissions reported living with children
- 26 OASAS certified residential treatment programs in NYS will admit children along with their parent

National estimates show that over 6 million (9%) children live with at least one parent who abused or was dependent on alcohol or an illicit drug in the past year¹. More than half (54%) of individuals admitted to OASAS certified treatment programs in 2007 reported having children, and 17% reported living with children. Women admitted to treatment were twice as likely to be living with children as men (28% of women and 13% of men); this is consistent with studies of other populations in treatment, which have found that women in treatment were more likely to be responsible for the care of children, had more children living in their homes, and were more concerned about issues related to children than men in treatment². Responsibility for children, coupled with little access to child care services, is one of the most significant and most frequently cited barriers among females who seek treatment.

All those who are admitted to NYS OASAS certified non-crisis programs are asked if they have children, if they live with children, pregnancy status (if female), whether they have an active case with child protective services, and if they have children in foster care. Information is also gathered on demographic characteristics of clients, such as age and education. This report will summarize client characteristics and system capacity for women by the maternal characteristics listed above.

Figure 1. Non-Crisis Admissions by Sex, 2000-2007

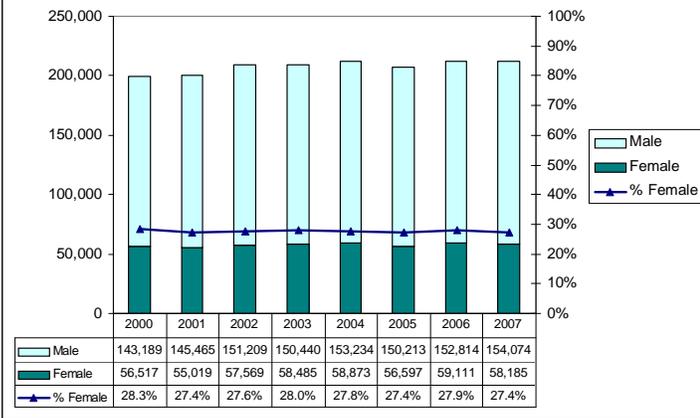
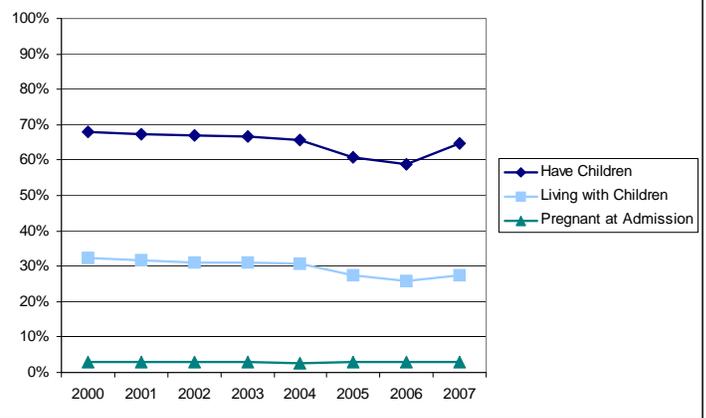


Figure 2. Women and Children Admissions Trends, 2000-2007



Women

In 2007, OASAS treatment programs served 62,438 unique women as primary clients and 2,022 as significant others. There were 58,185 female admissions during this time period (57,040 primary admissions and 1,145 significant other admissions), representing 27% of all non-crisis admissions. The number and percent of female admissions has remained relatively stable since 2000 (Figure 1). Most female admissions were to outpatient programs (65%), followed by inpatient (20%), residential (8%), and methadone (7%). The most frequently reported primary substances of abuse were alcohol (37%), crack/cocaine (25%), opioids (19%), and marijuana (16%). Over two-thirds (68%) of women reported a secondary substance of abuse and 32% reported a tertiary substance. Client characteristics, including demographics, of women admitted in 2007 are shown in Table 1. Select discharge characteristics for women discharged in 2007 are shown in Table 2.

When comparing females admitted to treatment to males admitted to treatment, the two groups appeared fairly similar except that females were less likely to have criminal justice involvement (38% vs. 54%), more likely to have a co-occurring mental health disorder (62% vs. 36%), more likely to be unemployed and not looking for work (59% vs. 48%), and more likely to pay with Medicaid/public assistance (64% vs. 54%). Additionally, females had longer lengths of stay in methadone (median: 405 vs. 295 days) and residential programs (median: 79 vs. 58 days).

Women who have Children

Almost two thirds (65% or 37,682) of females admitted in 2007 reported having children under the age of 19. The percentage of female admissions who have children slightly decreased from 68% in 2000 to 65% in 2007 (Figure 2). The majority of women that have children were admitted to outpatient programs (65%), followed by inpatient (20%), residential (9%), and methadone (7%). As shown in Figure 3, the most frequently reported primary substances of abuse were alcohol (36%), crack/cocaine (28%), opioids (19%), and marijuana/hashish (14%). More than two-thirds (67%) reported a secondary substance of abuse and 31% reported a tertiary substance.

When compared to women who did not report having children, women who had children were more likely to primarily abuse crack/cocaine (28% vs. 18%), more likely to be ages 35-44 (36% vs. 20%) and 45-54 (24% vs. 14%), less likely to be under 18 (0.3% vs. 16%) and 18-24 (9% vs. 27%), less likely to be White non-Hispanic (46% vs. 62%), less likely to be employed (19% vs. 40%), more likely to pay by Medicaid/public assistance (70% vs. 54%) and less likely to pay by private insurance (12% vs. 22%).

Women Living with Children

More than one quarter (28% or 16,073 admissions) of females admitted to treatment in 2007 reported living with children. The percentage of women

Table 1. Admissions by Select Client Characteristics, 2007

	All Women (n=58,185)	Have Children (n=37,682)	Live with Children (n=16,073)	Pregnant Women (n=1,775)	Active Case with CPS (n=8,953)	Child in Foster Care (n=5,325)
Age Group at Admission						
Under 18	6%	<1%	1%	3%	1%	<1%
18-24	15%	9%	12%	34%	17%	14%
25-34	23%	25%	28%	45%	39%	38%
35-44	31%	36%	37%	15%	34%	37%
45-54	20%	24%	20%	2%	9%	11%
55 and Over	5%	6%	3%	-	<1%	<1%
Race						
White non-Hispanic	52%	46%	48%	46%	42%	42%
Black non-Hispanic	30%	35%	31%	33%	36%	34%
Hispanic	15%	17%	18%	19%	20%	21%
Other non-Hispanic	3%	3%	3%	3%	3%	3%
Less than High School Education	38%	39%	36%	48%	48%	53%
Employed	27%	19%	28%	14%	14%	10%
Homeless	10%	11%	5%	15%	12%	17%
Criminal Justice Involvement	38%	37%	38%	44%	44%	43%
Used Tobacco in Week Prior to Admission	74%	76%	71%	71%	81%	83%
Referral Source						
Criminal Justice	25%	24%	27%	31%	30%	29%
Health Care/Social Services	20%	22%	25%	25%	33%	27%
OASAS Treatment System	25%	25%	18%	22%	20%	22%
Self	20%	21%	22%	16%	12%	16%
Other	10%	8%	8%	6%	5%	6%

admitted who reported living with children has decreased from 32% in 2000 to 28% in 2007 (Figure 2). Most of the women were admitted to outpatient programs (76%), followed by inpatient (15%), methadone (7%), and residential (3%). Alcohol was the most frequently reported primary substance of abuse (37%), followed by crack/cocaine (23%), marijuana/hashish (21%), opioids (17%), and other (3%). Over half (60%) reported a secondary substance of abuse and 26% reported a tertiary substance.

When compared to women who were not living with children, the two groups were similar with the exception that women living with children were more likely to be admitted to outpatient programs (76% vs. 61%) and less likely to have a secondary substance of abuse (60% vs. 70%).

Pregnant Women

Three percent of female admissions in 2007 were

pregnant at the time of admission (1,775 admissions). Most were admitted to outpatient programs (62%), followed by residential (14%), inpatient (13%), and methadone (12%). The most frequently reported primary substances of abuse were marijuana (28%), crack/cocaine (27%), alcohol (21%), and opioids (21%). More than two-thirds (69%) reported a secondary substance of abuse, and 31% reported a tertiary substance.

When compared to women who were not pregnant at the time of admission, pregnant women were: more likely to primarily abuse marijuana (28% vs. 16%), less likely to primarily abuse alcohol (21% vs. 37%), more likely to be ages 18-24 (34% vs. 15%) or ages 25-34 (45% vs. 23%), less likely to have education beyond high school (19% vs. 30%), less likely to be employed (14% vs. 27%), more likely to pay by Medicaid/public assistance (83% vs. 64%), and less likely to pay by private insurance (4% vs. 16%). Pregnant women also had shorter lengths of stay in all four program categories (median days: inpatient

Table 2. Select Discharge Characteristics, 2007

	All Women (n=58,317)	Have Children (n=37,260)	Live with Children (n=15,858)	Pregnant Women (n=1,739)	Active Case with CPS (n=8,694)	Child in Foster Care (n=5,380)
Co-Occurring Mental Health Disorder	62%	63%	57%	62%	64%	64%
Payment Source						
Medicaid/Public Assistance	64%	70%	64%	83%	79%	79%
Private Insurance	16%	12%	18%	4%	6%	3%
Self	9%	7%	10%	4%	5%	6%
None	7%	6%	5%	6%	6%	9%
Other	4%	4%	4%	4%	4%	3%
Completed Treatment	36%	36%	35%	29%	33%	32%
Median Length of Stay in Days						
Inpatient	20	20	18	14	22	21
Methadone	405	442	797	316	153	125
Outpatient	87	85	87	78	85	84
Residential	79	80	80	78	76	56

14 vs. 20, methadone 316 vs. 388, outpatient 78 vs. 88, residential 78 vs. 89) when compared to women who were not pregnant at admission.

Social Services Involvement

Almost one-quarter of female admissions who have children had an active case with child protective services (24% or 8,953) at the time of admission. Most were admitted to outpatient programs (72%), followed by inpatient (16%), residential (10%), and methadone (2%). The most frequently reported primary substances of abuse were crack/cocaine (32%), alcohol (27%), marijuana (27%), and opioids (11%). Over two-thirds (69%) reported a secondary substance of abuse and 31% reported a tertiary substance.

Compared to those who did not have an active case with child protective services, those with an active case were: more likely to be admitted to outpatient treatment (72% vs. 62%), more likely to report marijuana as the primary substance of abuse (27% vs. 15%) and less likely to report alcohol (27% vs. 39%) or opioids (11% vs. 21%) as the primary substance of abuse, more likely to be ages 18-24 (17% vs. 7%) or 25-34 (39% vs. 21%), less likely to have a high school or greater education (52% vs. 64%), more likely to have a health care/social services referral source (33% vs. 19%), more likely to have criminal justice involvement (44% vs. 35%), and more likely

to pay by Medicaid/public assistance (79% vs. 67%).

Fourteen percent of female admissions (5,325 admissions) who have children that were admitted in 2007 have one or more children in foster care. Most were admitted to outpatient programs (65%), followed by inpatient (17%), residential (14%), and methadone (4%). The most frequently reported primary substances of abuse were crack/cocaine (40%), alcohol (24%), marijuana (20%), and opioids (14%). Almost three-quarters (74%) reported a secondary substance of abuse and 34% reported a tertiary substance.

When compared to those who did not have children in foster care, those who had children in foster care were: more likely to report crack/cocaine as the primary substance of abuse (40% vs. 23%) and less likely to report alcohol (24% vs. 38%), more likely to have any secondary substance of abuse (74% vs. 67%), more likely to be ages 25-34 (38% vs. 23%), less likely to be White, non-Hispanic (34% vs. 48%), more likely to be homeless (17% vs. 10%), more likely to have less than a high school education (53% vs. 37%), less likely to be employed (10% vs. 21%), more likely to reside in New York City (51% vs. 37%), more likely to pay by Medicaid/public assistance (80% vs. 69%) and less likely to pay by private insurance (14% vs. 3%). Additionally, women who had children in foster care had shorter lengths of stay in residential (median: 56 vs. 89 days) and methadone programs (median: 125 vs. 496 days).

Figure 3. Primary Substances of Abuse, 2007 Admissions

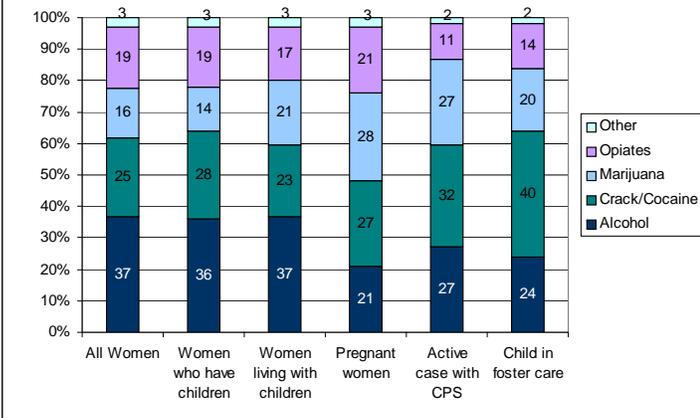
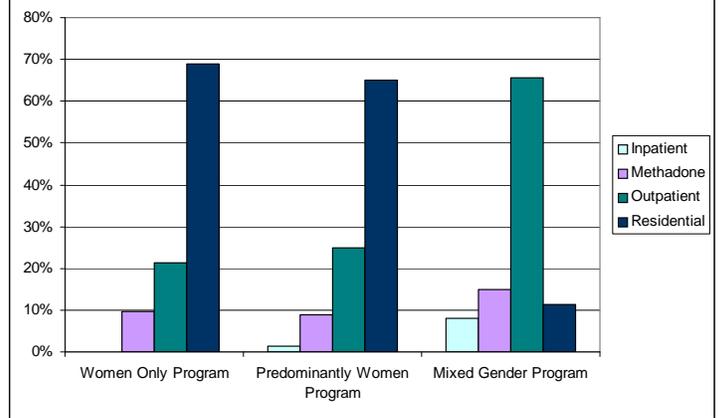


Figure 4. Program Categories by Population Admitted, 2007



Women’s Treatment Programs

Research studies have found differences between the background characteristics, substance abuse patterns, and personal histories of male and female substance users. Treatment programs designed specifically for women can focus on not only women's substance abuse-related problems but also their special needs and barriers to treatment. A recently published literature review found positive treatment outcomes associated with treatment programs for women, including decreased substance use, increased treatment retention, improved perinatal/birth outcomes and prenatal care, and improvements in self-esteem and depression ².

Eighty programs in NYS admitted predominantly women in 2007, meaning that 70% or more of their admissions were women and 61 of these programs served women only, meaning that 100% of their admissions were women. However, only a small percentage (5%) of total female admissions in 2007 were admitted to one of the 80 programs admitting predominantly women. As seen in Figure 4, about two-thirds of the 80 predominantly women’s programs were residential (65%) and more than two-thirds (69%) of the 61 women’s only programs were residential, while the majority of mixed gender programs were outpatient (66%).

Differences in geographic distribution between women-only and mixed gender programs were seen.

A smaller proportion of the women-only programs were located in New York City when compared to the proportion of mixed gender programs located in NYC (34% vs. 43%).

Women and Children Residential Programs

Several OASAS certified residential treatment programs in NYS will admit children along with their parent. Twenty-six residential programs admitted a parent of either gender along with their child in 2007 and seventeen of the programs admitted only women, both with and without children. Almost one-quarter (23%) of the 26 programs and 29% of the 17 programs were located in New York City.

Almost all (97%) of the children admitted to residential programs in 2007 were admitted with their mother. In 2007, 401 children were admitted along with their mothers. The mean age of the children admitted was 2 years and the median age was 10 months. Gender was split fairly evenly between male (53%) and female (47%) children. The majority of the children were Black non-Hispanic (44%), followed by Hispanic (28%), White non-Hispanic (21%), and Other non-Hispanic (6%). The median length of stay for those discharged in 2007 was 163 days.

Sources

1. The NHSDA Report. Children Living with Substance-Abusing or Substance-Dependent Parents. June 2, 2003.
2. Brady, T. M., & Ashley, O. S. (Eds.). (2005). Women in substance abuse treatment: Results from the Alcohol and Drug Services Study (ADSS) (DHHS Publication No. SMA 04-3968, Analytic Series A-26). Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies.

Notes

Statistics do not include crisis admissions, as questions pertaining to having children, living with children, foster care, and child protective services status are not asked on the crisis admission/discharge form.

Number of biological children, stepchildren, adopted children and/or foster children under age 19 is collected for questions pertaining to having children and living with children.

An active CPS case means that the local Department of Social Services, Child Protective Service Division, or in the case of New York City, the NYC Administration for Children's Services, has an open case for one or more of the children associated with this particular parent whether or not the child(ren) is removed.

Children in foster care includes biological and/or adopted children.

Co-occurring mental health disorder was defined as being identified as having a co-existing psychiatric disorder or having ever been treated for mental illness at either admission or discharge.

A mixed gender program was defined as a program whose 2007 admissions were greater than 0% and less than 70% female.

Source: NYS OASAS Data Warehouse, for the period January 1, 2007 to December 31, 2007. Last updated March 31, 2009.

Suggested Citation:

New York State Office of Alcoholism and Substance Abuse Services, Division of Outcome Management and System Investment, Data Analysis and Use Unit. Special Population Report: Women and Children, 2007. March 31, 2009.

Medicaid Fast Facts

Overview

- During SFY 2008, \$884,248,581 was spent to provide chemical dependence (CD) services to 140,592 Medicaid recipients¹. 5,036,507 CD claims were made.
- The greatest number of recipients were served in outpatient programs (96,635), followed by methadone (35,588), crisis (26,224), and inpatient (19,783).
- Total CD dollars spent, cost per recipient, and cost per claim were highest for crisis services (\$289,351,143 total; \$11,034 per recipient; \$1,217 per claim, see Figure 1). Medically managed withdrawal was the most expensive crisis service.
- Over one and a half billion dollars (\$1,631,888,015) were spent to provide non-CD services to recipients of CD services in SFY 2008.
- Of the approximately 2.5 million people in NYS aged 18 and over and eligible for Medicaid, 5.5% received CD services in SFY 2008. OASAS estimates that 11% of this age group has a chemical dependence problem. One percent of the almost 500,000 people ages 12 through 17 who are Medicaid eligible received CD services in SFY 2008. OASAS estimates that 10% of this age group has a chemical dependence problem.
- Looking at eligibility categories, penetration rates (number of recipients receiving CD services divided by total number of recipients) are highest in the 18 and over age group for Safety Net Assistance (33%) and lowest for Medicaid only (3.5%). In the 12 through 17 age category, rates are highest in Temporary Assistance to Needy Families (1.8%) and lowest in Safety Net Assistance. (0.7%).

Trends

- Statewide, the number of recipients for crisis, inpatient, and methadone has been steadily decreasing (Figure 2).
- Trends for dollars spent on CD services are arc-shaped with the amount spent peaking in SFY 2005 and 2006, and decreasing in SFY 2007 and 2008. Dollars spent for non-CD services has increased (Figure 3).
- Claims also followed an arc-shaped trend for non-CD services, all CD services, outpatient, and methadone. Inpatient and crisis claims have steadily decreased.
- Penetration rates in both the 18 and over and 12 to 17 age groups have decreased very slightly since SFY 2003.

Client Characteristics

Close to half (47.9%) of SFY 08 discharges paid with Medicaid. Of those who paid with Medicaid:

- Most were discharged from outpatient programs (45.9%), followed by crisis (29.9%), inpatient (16.9%), and methadone (6.9%).
- The most common primary substance was alcohol (41.5%) followed by opiates (24.7%), cocaine/crack (16.8%), and marijuana (14.3%).
- 70.0% had a secondary or tertiary substance
- 71.3% were male
- 35-44 was the most common age group (33.8%), followed by 45-54 (25.4%), 25-34 (20.5%), 18-24 (10.1%), 55+ (6.6%), and under 18 (3.7%).
- Black, non-Hispanic (39.1%) was the most common ethnicity, followed by White, non-Hispanic (32.9%), Hispanic (25.4%), and other non-Hispanic (2.6%)
- 18.4% were homeless
- 57.1% lived in NYC
- 32.9% had criminal justice involvement
- 43.6% had less than a high school education
- Primary referral sources were self (32.2%), criminal justice (19.9%), other CD (18.7%), health care/social services (15.0%), CD Prevention/Intervention (5.6%), and other (8.5%).
- 3.8% reported being a veteran
- 51.7% had a co-occurring mental health disorder²
- 72.0% used tobacco in the week prior to admission²
- 57.9% have children²
- 46.6% completed treatment

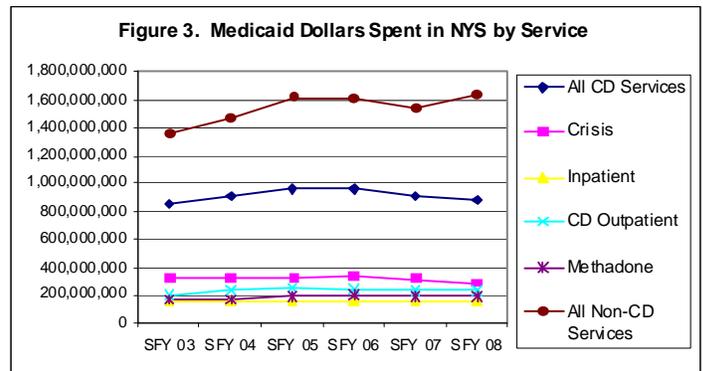
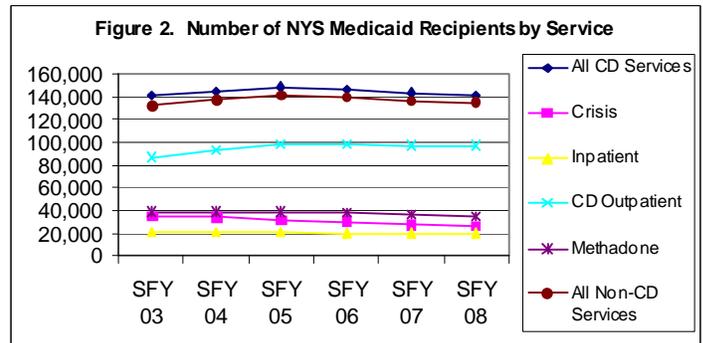
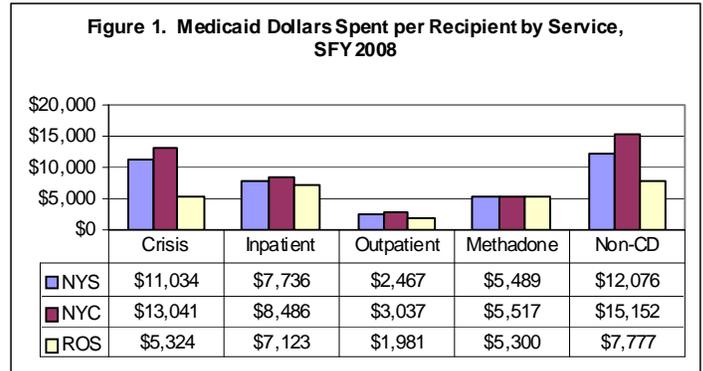
Comparisons

When compared to those who did not pay with Medicaid, those who paid with Medicaid were:

- More likely to be female (28.7% vs. 21.7%)
- More likely to reside in New York City (57.1% vs. 40.1%)
- Less likely to have criminal justice involvement (32.9% vs. 42.2%)
- More likely to have a co-occurring mental health disorder (51.7% vs. 35.9%)
- More likely to be Black, non-Hispanic (39.1% vs. 27.3%)
- Less likely to be employed (13.4% vs. 36.9%)
- More likely to have less than a high school education (43.6% vs. 33.2%)
- More likely to have children (57.9% vs. 49.9%)

Geographic Differences

- Comparing the types of services received, a larger percentage of NYC recipients were served in crisis programs than rest of the state (ROS) recipients (24.0% vs. 11.4%). Additionally, a smaller percentage of NYC recipients were served in outpatient programs (54.9% vs. 87.1%) and a larger percentage of NYC recipients were served in (38.2% vs. 7.8%) in methadone programs.
- Looking at all CD services, the cost per NYC recipient was \$7,893 and \$4,117 per ROS recipient. Geographic cost differences between services types are shown in Figure 1.
- Overall penetration rates are slightly lower in NYC (5.0% 18+, 0.6% 12-17) than in the rest of the state (6.4% 18+, 2.0% 12-17). Rates have decreased slightly since SFY 2003 in both NYC and ROS for those 18 and older, and have decreased for ROS and remained steady for NYC in the 12-17 age group.



1: Data does not include payment made to chemical dependence providers by Medicaid managed care organizations (MCOs). As of SFY 2008, the following services were not eligible for Medicaid reimbursement and, therefore, are not reflected in Medicaid data: medically monitored withdrawal, non-medically supervised outpatient, supportive living, intensive residential, and community residential.

2: Non-crisis admissions

Sources: NYS OASAS Data Warehouse (Client Characteristics and Comparisons sections) and NYSDOH eMedNY Data Warehouse (Overview, Trends, and Geographic Differences sections), for the period March 1, 2007 to April 30, 2008. Document last updated September 10, 2009.

APPENDIX IV: 2009 OASAS DASHBOARD

Mission Outcomes

Establish an effective science-based program system which integrates prevention, treatment and recovery.

Metric 1 - Prevention - Reduce levels of gambling and substance abuse risk factors and increase protective factors in New York State communities.

1.1: Issue Prevention Guidelines by 6/30/09; complete implementation training by 8/31/09.

1.2: Three new Prevention Resource Centers will be operational by 9/30/09 bringing the total number of PRCs to five.

1.3: Increase the number of counties with 25 percent or more evidence-based Program activities from 38 (2007/08 baseline) to 48 in 2010.

1.4: Develop and implement a Prevention-focused Strategic Plan by 10/31/09.

Metric 2 - Treatment - Increase the number of treatment programs comprehensively addressing patient SUDs, including the appropriate use of addiction medications, and assist patients implementing individualized recovery goals.

2.1: Develop consensus approach and timetable for transforming the State-wide outpatient system (including implementation of Ambulatory Patient Group reimbursement approach).

2.2: Increase the number and type of treatment and re-entry programs designed to serve criminal justice populations (including at Hudson and Bayview Correctional Facilities) by 12/31/09.

2.3: Implement a wide range of drug law reforms in conjunction with DCJS, DOC and OCA.

2.4: Design, implement, and monitor the treatment component to the Sentencing Reform with state-wide providers and DOCS facilities.

2.5: Increase by 20% the number of certified addiction services receiving training in PTSD and TBI among the veteran population.

Metric 3 - Recovery - Increase the number of persons successfully managing their addiction within a recovery-oriented system of care.

3.1: Establish three Recovery Centers by 12/31/09 - 1 downstate and 2 upstate (1 rural and 1 urban).

3.2: Increase the number of apartment units in the PSH portfolio from 1,144 in 13 communities (08/09) to at least 1,269 apartment units by 09/10; increase by 125 units or an 11 percent increase; add at least 8 new housing communities (7 from Upstate PSH and one new Shelter Plus Care), which is an increase of 61 percent.

Metric 4 - Increase the number of persons served who improve their health including engaging in healthy lifestyles.

4.1: Of the 488 programs reviewed, 70 percent will be in regulatory compliance; 290 will have taken initial steps to implement acceptable tobacco-free policies and 185 will show positive client health effects with increases in the number of patients who stop smoking.

Provider Engagement and Performance

Realize the Gold Standard of care through the OASAS/Provider Partnership

Metric 5 - Increase provider engagement in the Gold Standard Initiative.

5.1: Double the number of providers attending in Gold Standard Regional Forums. (08 baseline is 350).

5.2: Establish by 7/1/09 the baseline for providers/coalitions implementing at least one Gold Standard component. Increase by 10 percent for Round 2 Gold Standard Regional forums.

5.3: Seventy-five percent of Train-the-Trainer participants will deliver two or more trainings in their communities within one year of the training date. Baseline will be established by 11/30/09.

5.4: Fifty percent of counties will conduct community of solution conversations using County Profile

Data Reports with providers and consumers as a step toward developing local projects.

5.5: World Cafes will launch at least 3 rapid cycle system changes the area of service access.

5.6: 10 additional Administrative/Regulatory Relief projects will be completed (08 baseline= 20 projects.)

Metric 6 - Increase providers achievement of the Gold Standard of Care.

6.1: Increase by five percent the number of Treatment Programs implementing evidence-based practices. (08 Baselines: screening for co-occurring disorders -645 programs; Motivational Interviewing 532 programs ; Cognitive behavioral therapy 532 programs ; Contingency management 234 programs; Nicotine replacement therapies 447 programs; and NIATx process improvement 299 programs.)

6.2: Increase by 5 percent the number of Prevention Programs that allocate at least 20 percent of resources to evidence-based programs (08 baseline-26%)

6.3: Program scorecards distributed to 67 Intensive Residential Providers by 7/1/09 with a provider satisfaction response rate of 70 percent. Scorecards for other treatment programs distributed by 12/31/09 with similar positive response rates.

6.4: Facility Inspection scores will be integrated into the Integrated Quality System (IQS) recertification renewal process by 7/1/09. Analyze Fiscal Viability impact on recertification renewal certificate terms by June 30, 2009. Test IQS scoring mechanism for Intensive Residential programs August 31, 2009.

6.5: Provide focused regional Technical Assistance Workshops based on Quality Indicator analysis. Quality Indicator analysis baseline to be completed by 12/31/09.

6.6: Decrease the percentage of programs that have initial or recurring Management Plans in annual program review.

6.7: Increase the number of providers over baseline (12) who implement corrective actions based on Quality Service Review /targeted investigation findings.

6.8: Decrease the number of Patient Advocacy complaints related to Patient Rights Violations by ten percent (08 baseline-47).

6.9: For cases that find excessive services at 2nd QSR review, increase the # of OC revocations completed within 6 months. (08 Baseline-0).

Leadership

Be the state resource on addiction and lead the nation in the field of chemical dependence and problem gambling.

Metric 7 - Advance and support legislation, regulations and other initiatives that improve access to prevention, treatment and recovery services.

7.1: Strengthen OASAS' State influence through:

a. Governor's approval to proceed with at least 50percent of OASAS' proposed legislative agenda for current year.

b. Increase the percentage of approved bills passed and signed into law. (2008 baseline—08- # of 15; 09 # of 5)

c. Increase the number of substantive briefings provided for Legislators and other staff to 40 (2008 baseline of 34).

7.2: Strengthen OASAS' Federal influence by:

a. Increase three from zero the number of federal Technical Assistance grants received by OASAS that directly support agency priorities.

b. Increase support by five national orgs and federal officials regarding federal law, regulations and policy for the SAPT Block Grant.

c. Increase OASAS' influence by providing comments on five federal or State laws, regulation or policy initiatives (2008 baseline of 1).

7.3: Increase OASAS leadership positions to six:

a. Substance use disorder and problem gambling allied organizations/groups.

b. The membership of boards, committees and panels of stakeholder organizations.

7.4: Implement the ACTION Interagency Council to formalize current working relationships with 20+ State agencies, influencing

agendas in support of increased attention to Addiction.

Metric 8 - Generate positive media coverage for agency and field accomplishments.

8.1: Track at least 100 positive media stories in print, broadcast and online relating to agency initiatives

8.2: Support a statewide consumer movement around Recovery by:

a. Collecting 300 additional stories (from baseline of 65) for the "Your Story Matters" Campaign, and;

b. Increase consumer participation in Recovery Month 2009 events to 10,000 from 5,000 in 2008.

Talent Management

Become a "Profession of Choice" for attracting, selecting and developing talent.

Metric 9 - Increase full knowledge, expertise and retention of a high-performing diverse staff throughout the field.

9.1: Implement BPTW findings through 3 new projects (08 baseline-one); increase to 20 the number of agencies voluntarily applying to be a BPTW from the ten that applied in 2008 with two selected.

9.2: Establish an Addiction Career Resources Center by 9/1/09.

9.3: Improve Leadership Competencies: increased use of outcome thinking by OASAS staff from 26 percent to 40 percent; design and deliver customized supervisory learning to ET and Sr. Mgt. Staff with 90 percent participation rate; deliver cultural competencies learning for all leaders; and increase the perceived usefulness of Leadership Business meetings from 70 percent to 80 percent

9.4: Establish loan forgiveness authority and other financial incentives by 12/2010.

9.5: Increase the # of credentialed professionals from 7,149 to 7,506 (+5%); Increase the # of CASAC Trainees from 3,891 to 4,280. (+ 10%). Increase # of CARN certified nurses from 135 to 142.

(+5%) Establish a baseline of the # of addiction professionals in the DOCS system.

9.6: Create baseline re medical directors/staff who are American Society of Addiction Medicine (ASAM), American Psychiatric Association (APA), or American Osteopathic Association (AOA) certified; and increase those who are Buprenorphine certified 4 months after issuing 828, 816, and 822 regulations.

Financial Support

A system with strong return on taxpayer investment and stewardship of resources.

Metric 10 - Increase or stabilize funding resources while insuring a strong return on taxpayer investment.

10.1: Secure American Reinvestment & Recovery Act of 2009 (ARRA) funding for OASAS or the Field.

10.2: Secure adequate funding to support treatment for individuals diverted under 2009 Drug Law Reforms (\$4 million in 2009-10) by 10/31/09.

10.3: Submit timely quarterly reports on all financial and performance indicators required to receive Federal Byrne funds; submission of quarterly reports to commence 10/09.