2018
Local Services Plan
For Mental Hygiene Services

Onondaga Co Dept of Adult & LTC
October 31, 2017

NEW YORK STATE OF OPPORTUNITY.

Office of Mental Health | Office of Alcoholism and Substance Abuse Services | Office for People With Developmental Disabilities

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2017 Mental Hygiene Executive Summary
Onondaga Co Dept of Adult & LTC
Certified: Roshana Daniel (6/1/17)

Please see the attached Executive Summary.

Attachments

- 2017 Mental Hygiene Executive Summary.docx - Executive Summary
- LGU Goals & Priorities.xlsx - LGU Goals & Priorities
- Onondaga County 2018.xlsx - Onondaga County 2018

Mental Hygiene Goals and Objectives Form
Onondaga Co Dept of Adult & LTC (70200)
Certified: Roshana Daniel (6/1/17)

1. Overall Needs Assessment by Population (Required)

Please explain why or how the overall needs have changed and the results from those changes.

a) Indicate how the level of unmet **mental health service needs**, in general, has changed over the past year: ○ Improved ◉ Stayed the Same ○ Worsened

Please Explain:
It is difficult to make a meaningful assessment of aggregate change in need across such a broad category of services. Targeted analysis of key indicators using data already available to state agencies, completed as a collaboration between county and state resources, would best answer this question.

b) Indicate how the level of unmet **substance use disorder (SUD) needs**, in general, has changed over the past year: ○ Improved ◉ Stayed the Same ○ Worsened

Please Explain:
As indicated above regarding mental health needs, it is difficult to assess such a broad category. Key indicators related to opioid use and overdose woudl reflect and increase need for services, and substantial efforts have been undertaken to address that need. Current planning priorities include additional steps to respond to opioid use, and recent expansions in medication assisted treatment (MAT) in the region have reduced waitlists and wait times at opioid treatment programs (OTPs) and area clinics.

c) Indicate how the level of unmet needs of the **developmentally disabled** population, in general, has changed in the past year: ○ Improved ◉ Stayed the Same ○ Worsened

Please Explain:

The level of communications and coordination between state and county related to services for developmental disabilities remains limited. We are currently unable to assess changes related to need. Onondaga County is c

2. Goals Based On Local Needs

Issue Category	Applicable State Agenc(ies)		
	OASAS	OMH	OPWDD
a) Housing	☑	☑	☐
b) Transportation	☐	☐	☐
c) Crisis Services	☑	☐	☐
d) Workforce Recruitment and Retention (service system)	☑	☑	☑
e) Employment/ Job Opportunities (clients)	☐	☐	☐
f) Prevention	☑	☑	
g) Inpatient Treatment Services	☐	☐	
h) Recovery and Support Services	☐	☐	
i) Reducing Stigma	☐	☐	
j) SUD Outpatient Services	☐		
k) SUD Residential Treatment Services	☐		
l) Heroin and Opioid Programs and Services	☑		
m) Coordination/Integration with Other Systems for SUD clients	☑		
n) Mental Health Clinic		☑	
o) Other Mental Health Outpatient Services (non-clinic)		☐	
p) Mental Health Care Coordination		☑	☐
q) Developmental Disability Clinical Services			☐
r) Developmental Disability Children Services			☐
s) Developmental Disability Adult Services			☐
t) Developmental Disability Student/Transition Services			☐
u) Developmental Disability Respite Services			☐
v) Developmental Disability Family Supports			☐
w) Developmental Disability Self-Directed Services			☐
x) Autism Services			☐
y) Developmental Disability Person Centered Planning			☐
z) Developmental Disability Residential Services			☑
aa) Developmental Disability Front Door			☐

ab) Developmental Disability Service Coordination ☐ ☐ ☐

ac) Other Need (Specify in Background Information) ☐ ☐ ☐

2a. Housing - Background Information

Please see the attachments for background and explainations.

Do you have a Goal related to addressing this need? ○ Yes ◉ No

If "No", Please discuss any challenges that have precluded the development of a goal (e.g. external barriers):
A number of the issue categories above have not been designated in relation to an applicable state agency with a goal/outcome. Some of these categories are umbrella items that are infused in a wide range of projetcts and goals. These include Transporation, Recovery and Support Services, Reducing Stigma, etc. As such, a lack of goals associated with a particular issue category should not be interpreted as an indication that the particular issue category is not actively considered within the planning and actions of the Onondaga County LGU. The Onondaga Plan also does not include goals/outcomes related to the majority of the Issues Categories that are not relevant to the needs of individuals and families with Developmental Disabilities. Rather, this is a reflection of our limited opportunity to engage/partner with OPWDD.

Change Over Past 12 Months (Optional)

2c. Crisis Services - Background Information

Please see the attachments for background and explainations.

Do you have a Goal related to addressing this need? ○ Yes ○ No

Change Over Past 12 Months (Optional)

2d. Workforce Recruitment and Retention (service system) - Background Information

Please see the attachments for background and explainations.

Do you have a Goal related to addressing this need? ○ Yes ○ No

Change Over Past 12 Months (Optional)

2f. Prevention - Background Information

Please see the attachments for background and explainations.

Do you have a Goal related to addressing this need? ○ Yes ○ No

Change Over Past 12 Months (Optional)

2l. Heroin and Opioid Programs and Services - Background Information

Please see the attachments for background and explainations.

Do you have a Goal related to addressing this need? ○ Yes ○ No

Change Over Past 12 Months (Optional)

2m. Coordination/Integration with Other Systems for SUD clients - Background Information

Please see the attachments for background and explainations.

Do you have a Goal related to addressing this need? ◉ Yes ○ No

Goal Statement- Is this Goal a priority goal (Maximum 5 Objectives per goal)? ○ Yes ○ No

Objective Statement

Change Over Past 12 Months (Optional)

2n. Mental Health Clinic - Background Information

Please see the attachments for background and explainations.

Do you have a Goal related to addressing this need? ○ Yes ○ No

Change Over Past 12 Months (Optional)

2p. Mental Health Care Coordination - Background Information

Please see the attachments for background and explainations.

Do you have a Goal related to addressing this need? ○ Yes ○ No

Change Over Past 12 Months (Optional)

2z. Developmental Disability Residential Services - Background Information

Please see the attachments for background and explainations.

Do you have a Goal related to addressing this need? ○ Yes ○ No

Change Over Past 12 Months (Optional)

3. Goals Based On State Initiatives

State Initiative	Applicable State Agenc(ies)		
	OASAS	OMH	OPWDD
a) Medicaid Redesign	☑	☑	☐
b) Delivery System Reform Incentive Payment (DSRIP) Program	☑	☑	☐
c) Regional Planning Consortiums (RPCs)	☑	☑	☐
d) NYS Department of Health Prevention Agenda	☑	☑	☐

3a. Medicaid Redesign - Background Information

Please see the attachments for background information and additional information.

Do you have a Goal related to addressing this need? ○ Yes ◉ No

If "No", Please discuss any challenges that have precluded the development of a goal (e.g. external barriers):

Change Over Past 12 Months (Optional)

3b. Delivery System Reform Incentive Payment (DSRIP) Program - Background Information

Please see the attachments for background and explainations.

Do you have a Goal related to addressing this need? ○ Yes ◉ No

If "No", Please discuss any challenges that have precluded the development of a goal (e.g. external barriers):

Change Over Past 12 Months (Optional)

3c. Regional Planning Consortiums (RPCs) - Background Information

Please see the attachments for background and explainations.

Do you have a Goal related to addressing this need? ○ Yes ◉ No

If "No", Please discuss any challenges that have precluded the development of a goal (e.g. external barriers):

Change Over Past 12 Months (Optional)

3d. NYS Department of Health Prevention Agenda - Background Information

Please see the attachments for background and explainations.

Do you have a Goal related to addressing this need? ◉ Yes ○ No

Goal Statement- Is this Goal a priority goal? ○ Yes ○ No

Objective Statement

Change Over Past 12 Months (Optional)

4. Other Goals (Optional)

Other Goals - Background Information

The Onondaga County Plan does not include OPWDD as an applicable state agency. That is not because these initiatives are not relevant to the needs of individuals and families with Developmental Disabilities. Rather, this is a reflections of the limited oppoortunities to engage/partner with OPWDD as an LGU. As reflected in the attachments. Onondaga County is currently engaged in activities related to all of the issue categories defined within the Goals and Objectived form, with the exception of some of the Developmental Disabilities related goals areas, given the limited access to relevant data, ant the limited opportunities for partnership with OPWDD.
As reflected on the attached Executive Summary.

Do you have a Goal related to addressing this need? ○ Yes ○ No

Change Over Past 12 Months (Optional)

Office of Mental Health Agency Planning Survey
Onondaga Co Dept of Adult & LTC (70200)
Certified: Roshana Daniel (5/2/17)

Consult the LSP Guidelines for additional guidance on completing this exercise.

1. For Criminal Procedure Law 730 Chargeback Budgeting: Please indicate the department within your county that is responsible for budgeting CPL 730 restoration chargebacks.

- [ ] Mental hygiene/community services
- [x] Sheriff/county law enforcement
- [ ] Other

If "other" please indicate how these charges are budgeted

Questions regarding the above survey item should be directed to Hank Hren at hank.hren@omh.ny.gov or 518-474-2962.

2. For Local Administration of the Assisted Outpatient Treatment Program:
a) Please describe the system used in your locality to ensure that petitions are filed for individuals requiring Assisted Outpatient Treatment.
Referrals are submitted to the AOT Coordinator for review. If it is determined that a person meets the criteria for AOT and an AOT court order is needed, the AOT Coordinator works with the Onondaga County Legal Department to file a petition. Once a petition is granted, the AOT Coordinator monitors the court order, as well as meets with the individual and treatment team to decide if an extension of the AOT order is needed. AOT court orders are also received from Hutchings Psychiatric Center and New York State Prisons. Treatment planning for these individuals is done in collaboration with the AOT Coordinator.
b) Please describe the system used in your locality to ensure that such individuals requiring Assisted Outpatient Treatment receive the services included in the AOT treatment plan.
The AOT Coordinator sets up the services in the treatment plan and monitors the court order for compliance. The AOT Coordinator facilitates team meetings that are held at regular intervals throughout the length of the court order. The AOT Team may consist of all or some of the following: the individual on the AOT court order, case manager or ACT, therapist, psychiatrist, parole or probation officer, housing provider, peer support, substance abuse treatment provider, family members or support person, community service providers and the AOT Coordinator.
c) Please list the Care Management Programs your Single Point of Access (SPOA) uses to assign AOT referrals.
CIrcare: Health Homes Case Management and the ACT Team.
Questions regarding this survey item should be directed to Rebecca Briney at Rebecca.Briney@omh.ny.gov or 518-402-4233.

Thank you for participating in the 2018 Mental Hygiene Local Services Planning Process by completing this survey. Any technical questions regarding the online County Planning System,
please contact the OASAS Planning Unit at 518-457-5989 or by email at oasasplanning@oasas.ny.gov

Community Service Board Roster
Onondaga Co Dept of Adult & LTC (70200)
Certified: Gigi Love (5/15/17)

Consult the LSP Guidelines for additional guidance on completing this exercise.

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

Chairperson	
Name	Timothy Bobo
Physician	No
Psychologist	No
Represents	CNY Health Systems Agency
Term Expires	12/31/2016
eMail	tjbobo2@yahoo.com

Member	
Name	Beth Hurney
Physician	No
Psychologist	No
Represents	Prevention Network
Term Expires	12/31/2019
eMail	bhurny@preventionnetworkcny.org

Member	
Name	Indu Gupta
Physician	Yes
Psychologist	No
Represents	Onondaga County Health Department
Term Expires	12/31/2019
eMail	indugupta@ongov.net

Member	
Name	Jennifer Redmond
Physician	No
Psychologist	No
Represents	OnCare ACCESS Team
Term Expires	12/31/2019
eMail	jenniferredmond@ongov.net

Member	
Name	Monika Taylor
Physician	No
Psychologist	No
Represents	Crouse Chemical Dependency Services
Term Expires	12/31/2019
eMail	monikataylor@crouse.org

Member	
Name	Patricia Reyna
Physician	No
Psychologist	No
Represents	Consumers
Term Expires	12/31/2019
eMail	pattyr@sbh.org

Member	
Name	James Yonai
Physician	No
Psychologist	No
Represents	Retired DCS
Term Expires	12/31/2017
eMail	jyonai01@gmail.com

Member	
Name	Sara Wall-Bollinger
Physician	No
Psychologist	No
Represents	SWB Consulting
Term Expires	12/31/2017
eMail	sarawbollinger@gmail.com

Member	
Name	Karen Virginia
Physician	No
Psychologist	No
Represents	Onondaga Case Management
Term Expires	12/31/2016
eMail	kvirginia@ocmsinc.org

Member	
Name	Elizabeth Nolan
Physician	No
Psychologist	No
Represents	Hillside Children & Family
Term Expires	12/31/2016
eMail	enolan@hillside.com

Member	
Name	Mary Beth Frey
Physician	No
Psychologist	No
Represents	The Samaritan Center
Term Expires	12/31/2016
eMail	director@samcenter.org

Member	
Name	Sarah Merrick
Physician	No
Psychologist	No
Represents	Onondaga County DSS: Economic Security
Term Expires	12/31/2016
eMail	sarah.merrick@dfa.state.ny.us

Member	
Name	Rosalee Jenkins
Physician	No

Member	
Name	Tania S. Anderson
Physician	No

Psychologist	No
Represents	Consumers
Term Expires	12/31/2019
eMail	evg.rosalee@gmail.com

Psychologist	No
Represents	Appointment Pending
Term Expires	12/31/2020
eMail	

Member

Name	Diane Nappa
Physician	No
Psychologist	No
Represents	Appointment Pending / Elmcrest Children's Center
Term Expires	12/31/2020
eMail	dnappa@elmcrest.org

Member

Name	Juhanna Rogers
Physician	No
Psychologist	No
Represents	Appointment Pending
Term Expires	12/31/2020
eMail	

Member

Name	Regina L. Reese-Young
Physician	No
Psychologist	No
Represents	Appointment Pending
Term Expires	12/31/2020
eMail	

Alcoholism and Substance Abuse Subcommittee Roster
Onondaga Co Dept of Adult & LTC (70200)
Certified: Gigi Love (5/12/17)

Consult the LSP Guidelines for additional guidance on completing this exercise.

Note: The subcommittee shall have no more than nine members. Three subcommittee members must be members of the board; those members should be identified here. Under item labeled "Represents", enter the name of the member's organization or enter "Consumer", "Family", "Public Representitive", etc. to indicate the perspective the member brings to the subcommittee.

Chairperson	
Name	Monika Taylor
Represents	Crouse Health
eMail	monikataylor@crouse.org
Is CSB Member	Yes

Member	
Name	Paula Cerio
Represents	Salvation Army
eMail	paula.cerio@use.salvationarmy.org
Is CSB Member	No

Member	
Name	Penny Williams
Represents	OCM BOCES
eMail	pwilliams@ocmboces.org
Is CSB Member	No

Member	
Name	Patricia Reyna
Represents	Community
eMail	preyna027@gmail.com
Is CSB Member	Yes

Member	
Name	Kathi Meadows
Represents	Syracuse Behavioral Healthcare
eMail	kathim@sbh.org
Is CSB Member	No

Member	
Name	Beth Hurny
Represents	Prevention Network
eMail	bhurny@preventionnetworkcny.org
Is CSB Member	Yes

Member	
Name	Jeri Bond Arcuri
Represents	Community / Catholic Charities
eMail	jarcuri@ccoc.us
Is CSB Member	No

Member	
Name	James Yonai
Represents	Former DCS
eMail	jyonai01@gmail.com
Is CSB Member	Yes

Member	
Name	Lisa Forshee
Represents	Syracuse Recovery Services
eMail	Lforshee@syrrec.com
Is CSB Member	No

Mental Health Subcommittee Roster
Onondaga Co Dept of Adult & LTC (70200)
Certified: Gigi Love (5/24/17)

Consult the LSP Guidelines for additional guidance on completing this exercise.

Note: The subcommittee shall have no more than eleven members. Three subcommittee members must be members of the board; those members should be identified here. Under item labeled "Represents", enter the name of the member's organization or enter "Consumer", "Family", "Public Representitive", etc. to indicate the perspective the member brings to the subcommittee.

Chairperson	
Name	James Yonai
Represents	Former DCS
eMail	jyonai01@gmail.com
Is CSB Member	Yes

Member	
Name	Margaret Fontenot
Represents	Circare
eMail	mfontenot@cir.care
Is CSB Member	No

Member	
Name	Marylou Sayles
Represents	Huntington Family Centers
eMail	msayles@hfcsyr.org
Is CSB Member	No

Member	
Name	Sara Wall-Bollinger
Represents	SWB Consulting
eMail	sarawbollinger@gmail.com
Is CSB Member	Yes

Member	
Name	Tania Anderson
Represents	Arise Inc.
eMail	tania.anderson@ariseinc.org
Is CSB Member	No

Member	
Name	Patricia Reyna
Represents	Community
eMail	preyna027@gmail.com
Is CSB Member	Yes

Member	
Name	Wanda Fremont
Represents	Upstate Medical University
eMail	fremontw@upstate.edu
Is CSB Member	No

Member	
Name	Allison Brooks
Represents	Salvation Army
eMail	allison.brooks@use.salvationarmy.org
Is CSB Member	No

Member	
Name	Brian Cappon
Represents	Circare
eMail	bcappon@cir.care
Is CSB Member	No

Member	
Name	Beth Hurny
Represents	Prevention Network
eMail	bhurny@preventionnetworkcny.org
Is CSB Member	Yes

Member	
Name	Jeri Bond Arcuri
Represents	Community / Catholic Charities
eMail	jarcuri@ccoc.us
Is CSB Member	No

Developmental Disabilities Subcommittee Roster
Onondaga Co Dept of Adult & LTC (70200)
Certified: Gigi Love (5/25/17)

Consult the LSP Guidelines for additional guidance on completing this exercise.

Note: The subcommittee shall have no more than nine members. Three subcommittee members must be members of the board; those members should be identified here. Under item labeled "Represents", enter the name of the member's organization or enter "Consumer", "Family", "Public Representitive", etc. to indicate the perspective the member brings to the subcommittee.

Member	
Name	Cynthia Barnaby
Represents	Community Options
eMail	cynthia.barnaby@comop.or
Is CSB Member	No

Member	
Name	Ellen Gutmaker
Represents	ARC of Onondaga
eMail	egutmaker@arcon.org
Is CSB Member	No

Member	
Name	Sharon Sullivan
Represents	Consumers
eMail	spsull@windstream.net
Is CSB Member	No

Member	
Name	Amanda Matheson
Represents	Cayuga Centers
eMail	amanda.matheson@cayugacenters.org
Is CSB Member	No

Member	
Name	Diane Nappa
Represents	Elmcrest Children's Center
eMail	dnappa@elmcrest.org
Is CSB Member	No

Member	
Name	Paulette Purdy
Represents	Learning Disabilities Association
eMail	ppurdy@ldacny.org
Is CSB Member	No

Member	
Name	Michelle Gillespie
Represents	ARC of Onondaga
eMail	mgillespie@arcon.org
Is CSB Member	No

Member	
Name	Stephen Russell
Represents	Liberty Resources
eMail	srussell@liberty-resources.org
Is CSB Member	No

Member	
Name	James Yonai
Represents	Retired DCS
eMail	jyonai01@gmail.com
Is CSB Member	No

2017 Mental Hygiene Local Planning Assurance
Onondaga Co Dept of Adult & LTC (70200)
Certified: Roshana Daniel (6/1/17)

Consult the LSP Guidelines for additional guidance on completing this exercise.

Pursuant to Article 41 of the Mental Hygiene Law, we assure and certify that:

Representatives of facilities of the offices of the department; directors of district developmental services offices; directors of hospital-based mental health services; directors of community mental health centers, voluntary agencies; persons and families who receive services and advocates; other providers of services have been formally invited to participate in, and provide information for, the local planning process relative to the development of the Local Services Plan;

The Community Services Board and the Subcommittees for Alcoholism and Substance Abuse, Mental Health, and Developmental Disabilities have provided advice to the Director of Community Services and have participated in the development of the Local Services Plan. The full Board and the Subcommittees have had an opportunity to review and comment on the contents of the plan and have received the completed document. Any disputes which may have arisen, as part of the local planning process regarding elements of the plan, have been or will be addressed in accordance with procedures outlined in Mental Hygiene Law Section 41.16(c);

The Community Services Board and the Subcommittees for Alcoholism and Substance Abuse, Mental Health, and Developmental Disabilities meet regularly during the year, and the Board has established bylaws for its operation, has defined the number of officers and members that will comprise a quorum, and has membership which is broadly representative of the age, sex, race, and other ethnic characteristics of the area served. The Board has established procedures to ensure that all meetings are conducted in accordance with the Open Meetings Law, which requires that meetings of public bodies be open to the general public, that advance public notice of meetings be given, and that minutes be taken of all meetings and be available to the public.

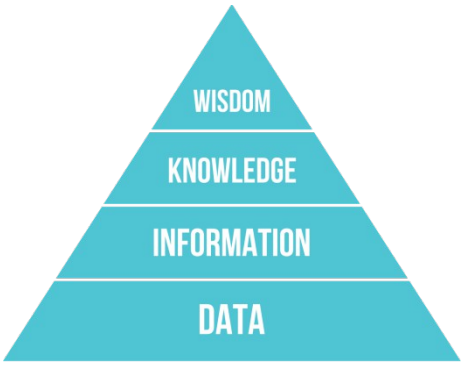
OASAS, OMH and OPWDD accept the certified 2018 Local Services Planning Assurance form in the Online County Planning System as the official LGU assurance that the above conditions have been met for the 2018 Local Services planning process.

2017 Mental Hygiene Executive Summary
Onondaga County Department of Adult and Long Term Care Services

Onondaga County has been working to establish an effective orientation to local/regional planning that recognizes both our limited planning resources, and the changing role of the County Local Government Unit (LGU).

Limited Planning Resources:
Ongoing efforts through the Conference of Local Mental Hygiene Directors (CLMHD) and the state agencies (OASAS, OPWDD, and OMH) have worked to provide access to a range of data sources. Many of these sources are valuable for planning purposes. The challenge arises in considering the ability of Counties to engage with this data in a manner that can drive the planning decisions that are most relevant in the current health care marketplace.

As has been reflected in previous state wide efforts to gather data from local planners, many LGUs prefer a set of canned reports that provide them with a minimum data set of their own data with comparisons from like counties, and trends across time. Rather than access to a wide range of sources that require resources to access, review, prioritize, analyze, etc., a core minimum data set can serve as a foundation to help planners to avoid being lost in data which yields little information. As represented in the (DIKW) pyramid below, the goal is to concentrate our available resources toward a synthesis of core elements that result in the knowledge and wisdom required to drive decisions.



Changing role
As communicated in previous Local Services Plans, Onondaga County LGU continues to work to define and develop our role as a neutral systems broker/ facilitator seeking to enhance access to quality services and supports at the local and regional levels.

Onondaga County continues to seek to utilize resource and partnership opportunities within our county and region to address key needs. Optimal planning efforts involve a primarily data driven orientation that uses data to assess needs, and develops strategies to address those needs. But practical resource limitations dictate that we engage with existing and emerging opportunities in order to effect change. In keeping with this pragmatic approach, Onondaga County seeks to participate in those local and regional activities that provide momentum toward the changes and system enhancements that are aligned with the needs of our community. We seek to take advantage of these opportunities by placing our efforts within these down-stream currents that lead toward progress that aligns with the following values:

Family Focused: Consider all needs within the context of key relationships.
Service Regionalization: Develop and provide services within multi-county care systems.
Integrated care and supports: Support infrastructures and relationships that ensure a holistic orientation to services, including effective coordination of all elements of care.
Recovery: Promote the understanding that individuals can achieve their life goals.
Wellness: Build services that promote well-being, not just the cessation of symptoms/ sickness.
Social Determinants of Health: Address poverty and related factors to support good health.
Disparities/ Disproportionality: Promote interventions that support those groups who are less able to access services, and/or who have poorer outcomes.
Cultural Responsiveness: Ensure that all supports are culturally and linguistically competent, and able to support all populations within the community.
Community Inclusion: Promote the engagement of individuals with the communities in which they live.

An example of this effort to seek down-stream opportunities that align with these core values can be found in our efforts to promote peer services. Currently there are a number of opportunities that Onondaga County is supporting that will help to carry this peer services agenda down-stream. These include the following:

1. BRSSTACS Policy Academy
2. Center of Treatment Innovation (COTI)
3. Regional Crisis Center for Addictions (RCCA)
4. Peer Engagement Service (Local service and regional committee)

These state sponsored projects are promotional of a number of the above values. Onondaga County is engaged in efforts to unite the participants in these projects through our regional Peer Linkage Committee, and will facilitate activities that are designed to ensure that these peer supports are united to achieve a broader scale and deeper impact.

The efforts of Onondaga County LGU to develop this role as a local/ regional broker, within a context of limited resources, has lead us to focus on efforts to develop three core elements to drive our work. Examples of these elements have been attached to this plan for review.

1. County Comparison table
The effort to develop a minimum data set for planning has emerged as an important goal for the Onondaga County LGU. Rather than using our limited planning resources to explore a wide range of sources, we are seeking to consolidate critical data elements into a single spreadsheet that will enable us to do 3 things related to a number of key indicators:

- Regional analysis: We will aggregate our data with that of neighboring counties to develop regional knowledge.
- Like-County comparison: We will compare our data with that of similar sized counties as a first step to deeper analysis. Why are we different? What should/can we change?
- Trends over time: How has our County data changed from year to year? What should/can we do about that?

Our effort to begin to compile this data into a single spread sheet creates a dash board orientation to planning. This single data table, while limited, will serve as an accessible source of data to drive decision making. We are actively seeking to avoid sliding into a pattern of continuous expansion of this table to include an ever increasing volume of data elements. The core question driving the population of this table should be “Is this data critical to creating a compass for planning and decision making, and can we manage/maintain it over time?” and not “Could this data be useful to us?” Almost all data related to the topic under consideration will

have some potential utility. But orienting toward this later question too often results in local planners having access to a fire hose of data which is difficult to manage. Onondaga County's LGU would welcome the opportunity to dialogue with others regarding this effort to optimize a dash board approach to planning data. We seek to avoid a model that involves continuous acquisition of new data sets that tend to grow stale like so many stockpiled foods with a limited shelf life.

As a result of resource challenges, Onondaga County has engaged in modest data analysis over the list 1-2 years. Recent successful efforts to re-establish resources to commit to this task should result in enhanced data analysis going forward. The attached County Comparison Table represents the new approach to data gathering described above, and will be refined over time to create a strong dash board to drive local planning. It will serve to support regional planning, including the work of the Central New York Director's Planning Group (CNYDPG) that includes Cayuga, Cortland, Madison, Oneida, Onondaga, and Oswego counties.

As is often the case this data points us toward some already prioritized concerns, including poverty related challenges to wellness, disparities among ethnic groups, opioid overdoses, and other concerns. Near future efforts will focus on highlighting key data elements that reflect disproportionately high or low numbers compared to like counties and within our region, in order to more effectively target critical needs and coordinate with other counties.

2. 2018 Priority Goals & Priorities Table

Much of the content reflected in the Onondaga County Goals and Objectives Form response is taken from the attached 2018 Priorities List. As reflected above, this list has been generated over time based upon a range of feedback from stake holders, opportunities that have emerged and demanded prioritization, and data from an array of sources.

3. Surveys and focus groups

The unique capacity of an LGU to understand the local culture, market dynamics, and service needs is rooted in relationships with local providers and recipients of services. Onondaga County LGU has developed a plan to survey our CSB and subcommittees on a quarterly basis regarding key issues of concern. Other community stake holders will be incorporated into these survey efforts as appropriate, in order to provide the opportunity for a broader community voice. These surveys will be brief, topical, and timely, so as to address current issues and needs.

In addition to the surveys described above, Onondaga County LGU will also conduct monthly focus groups with a range of community members. These groups will include conversations with all ages (children, youth, adults, seniors) and will be hosted in a range of settings that reflect the values described above. Efforts will be made to avoid a clinical/ pathological orientation to these focus groups. Rather than focusing on whether or not people in a treatment facility have experienced symptom reduction, we will seek to understand the successes and needs of people in the community.

The most recent planning survey used to support the 2018 LSP included an online questionnaire that was provided to the Community Services Board (CSB) and the developmental disability, mental health, and substance use subcommittees. A total of X individuals reviewed the survey with a response of Y (a Z% response rate) While this was a substantial response, the efforts described above to bolster our survey and focus group efforts will result in a substantially enhanced capacity to understand the voice of the community in coming planning cycles. The attached spreadsheet reflects the details of the responses that are summarized below. As reflected in the attachment, respondents continued a trend found in recent data gathering of viewing issues across the spectrum of disability areas (mental health, developmental disability, and substance use).

Respondents were also asked to define the issues according to age ((adult, child, transition aged youth) and according to four key lenses that have been used as a means of ensuring that efforts are consistently made to address these four priorities:

1. Peer and family
2. Regional collaboration
3. Behavioral and physical health integration
4. Health disparities and social determinants of health

The 2017 survey resulted in some key themes that correspond to a significant number of the Onondaga priorities. While a few highlights are described below, readers are encouraged to review all of the responses in the attached document.

Housing: Respondents continue to indicate a high level of need for safe affordable housing, both transitional and permanent. Particular need was expressed regarding housing for women and the homeless.

Workforce Development: Respondents indicated a range of shortages in the human service work force, and were particularly focused upon the need to develop and engage the peer work force. Low pay and a lack of training were cited as reasons for high rates of turnover in entry level direct care positions.

Law Enforcement: More effective collaboration between law enforcement and human services was viewed as important to enhancing safety for recipients and the community at large.

Mental Health Treatment: The need for improved access to traditional services such as psychiatry was noted, as was the need to integrate mental health supports into nontraditional settings such as schools and drop in centers.

Substance Use Disorder Treatment: The need for expanded and timely access to treatment and detox services to support the rise in opioid addiction was cited by a number of respondents.

Health care/ medical services: Respondents reported regarding the need for enhanced access to primary care for those receiving behavioral health services.

Youth services: Respondents described the need for enhanced access to mental health substance use and developmental disability services for youth. Recommended services would enhance access (school and drop in centers) and focus on preventive, treatment, and crisis needs.

Integration of Services:
Perhaps the most common theme among the responses reflected a need for service integration. Many community stake holders have begun to understand that isolated siloes of support have a modest impact. When efforts across a range of support areas are adequately integrated to include health, housing, income, family, and other concerns, interventions can be exponentially more impactful. This survey intentionally asked for “areas of concern” in order to encourage a response that considered a broader approach to wellness. It seems clear that the broader community of stake holders understands that the social determinants of health related to living in poverty are critical to the well-being of service recipients. .

This focus on integrated and coordinated services points logically toward the care coordination resources that have been established to address this need. Much emphasis has been placed upon the function of care coordinators as standing with recipients at the hub of a complex wheel of services, and supporting this system of providers toward effective collaboration. Given the evidence to date, it appears clear that two elements are lacking in our current approach.

1. **Providers are not adequately engaged**: many feel neither motivated nor impelled to work with care coordinators to improve integration of service delivery.

2. **Care coordinators are not adequately supported**: due to large case loads and/or a lack of experience in leading/ facilitating team processes, care coordinators have a limited capacity to do this very central duty.

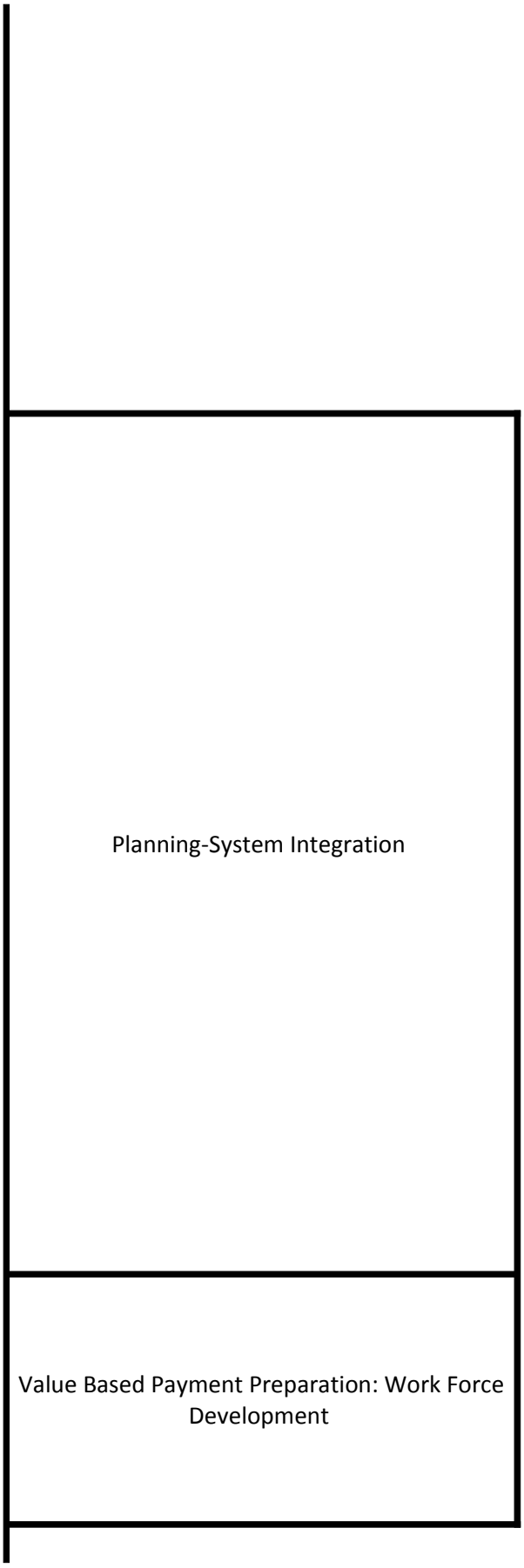
And so our system must ask itself a core question: If we are going to continue to build our work on a foundation of care coordination, when are we going to adequately resource this function? The larger structure is at risk if we fail to shore up this critical corner stone.

Documents attached:
Onondaga County 2018:
- Sheet 1-County Comparison Table
- Sheet 2-Community Planning Survey Results

LGU Goals & Priorities:
- Sheet 1-LGU Table of Goals/Areas of Concerns
- Sheet 2-Onondaga 2018 Priorities Master List

Onondaga County Department of Adult and Lon
Local Government Unit (LGU)

Goals/Area of Concern
Suicide Prevention
Opioid Response
Peer Supports
Access: People to care/Care to people


Planning-System Integration
Value Based Payment Preparation: Work Force Development

Criminal Justice : behavioral health supports

g Term Care Services

Collaboration/community partnerships formed to address concern	Strategies /Action Steps
Onondaga County Suicide Prevention Coalition	Explore how best to serve high utilizers
	Central New York Collaborative Care (CNYCC)-Request for Proposal (RFP)
	Homeless outreach/ engagement (committee work, Rescue mission day ctr, etc)
	Address needs of transition age (16-25)
Drug Task Force and Subcommittee (treatment, prevention, harm reduction)	Increase Medication-Assisted Treatment (MAT)/Opioid Treatment Program (OTP)
Regional Crisis Center for Addition (RCCA)	
Center of Treatment Innovation -Syracuse Behavioral Health (SBH)	
Brining Recovery Support to Scale Technical Assistance Center Strategy (BRSS TACS) Policy Academy	
Drug Task Force and Subcommittee	Expansion and Integration
Center of Treatment Innovation (SBH)	Integrate regional peer resources
BRSS TACS Policy Academy	
Regional Crisis Center for Addition (RCCA)	Maintain 5 day standard for post IP clinic visit
	Optimize length of stay
	Substance abuse services for children and youth
	Transportation
Expand supports for children in foster care experiencing mental health challenges	Monitor compliance of the local Waiver provider agencies with the regulations related to Conflict-free Case Management and Family Choice of service providers.
	Ensure that eligible youth are referred to a Care Management Agency (CMA) that is able to meet their needs.
	Monitor compliance of the local Waiver provider agencies with the regulations related to Conflict-free Case Management and Family Choice of service providers.
School-Based Supports	Prevention services for children & youth
	Increase Crisis services for children & youth: prevent CPEP/ER intervention.
	Expand the current school-based mental health efforts: city to county (multi-tiered system of supports model)

The Senior Health and Resource Partnership Project (SHARP)	Improve service access and sustainment of engagement.
	Workforce training re: social determinants of health/ poverty
RISE Clinic (Refugee & Immigrant Self-Empowerment)	Services in communities of color
Partner with Department of Social Service (DSS)-Economic Security (ES)	Mental Health (MH) First-Aid
Central New York Directors' Planning Group (CNYDPG)	Alignment of LGU planning with the Onondaga County (OC) Health Dept Community Health Improvement Plan (Community Health Assessment (CHA)/Community Health Improvement Plan(CHIP)
Delivery System Reform Incentive Payment (DSRIP) CNYCC	Emergency preparedness: contact list/ mapping (phone, address, leadership) for residential and direct services across 3 areas
Regional Psychiatric Center (RPC)	Refine LGU policy and procedures
Onondaga County Departments (Emergency Preparedness, Health, Children and Family, Social Services)	Enhance utilization of data resources
	Promote emerging role of LGU as neutral systems broker (from statutory authority to unique local/ regional systems broker
	Improve Department of Adult and Long-Term Care (DALTCS) MH web page
	Bolster and engage virtual subcommittees via creation of a quarterly survey agenda
	Develop monthly focus group model: 12 groups per year, including kids, family, adults (range of settings)
	Support the implementation of Health Homes serving children (HHSC): Ensure eligible youth are referred to program and a Case Management Agency (CMA)
RCCA	Integration of Primary care and behavioral health thru the RCCA
DSRIP/ CNYCC participation	Explore how best to serve high utilizers
	Coaching for change seminars
	Workforce training re social determinants of health/ poverty

BRSS TACS Policy Academy	MH/Substance Use (SU) clinic and care management services
	Next steps re: Crisis Intervention Treatment (CIT)
	Vehicles for systems integration
	Prepare and respond to the age for criminal prosecuting to 18. Increase in identified youth with mental health and substance disorders
	Create a more trauma informed service system for youth through ONCare Juvenile
	professionals and families
	Increase awareness and decrease stigma surrounding mental illness
	Equip natural supports with the tools to support youth and their families
	Office of Mental Health (OMH) jail grant

Onondaga County Department of Adult and Long Term Care Services
LGU 2018 priorities

Addressing the **3 disability areas**: MH, SU, DD

Addressing **key lenses**: family, regional, integrated healthcare, recovery, wellness, social determinants, disparities

1 Targeted needs
- suicide prevention
  - CNYCC RFP
  - Onondaga Co. Suicide prevention coalition
- explore how best to serve high utilizers
- homeless outreach/ engagement (committee work, Rescue mission day ctr, etc)
- address needs of transition age (16-25)

2 Opioid response
- RCCA
- drug task force and subcommittee participation (treatment, prevention, harm reduction)
- Increase MAT/ OTP access
- Center of Treatment Innovation (SBH)
- BRSS TACS Policy Academy

3 Peer supports: expansion and integration
- Peer Engagement expansion
- Center of Treatment Innovation (SBH)
- BRSS TACS Policy Academy
- Integrate regional peer resources

4 Access: people to care / care to people
- RCCA
- SHARP
- transportation
- RISE clinic: services for refugee/ immigrant pop.
- services in communities of color
- school based supports
- maintain 5 day standard for post IP clinic visit
- optimize length of stay
- partner with DSS-ES
- MH first Aid

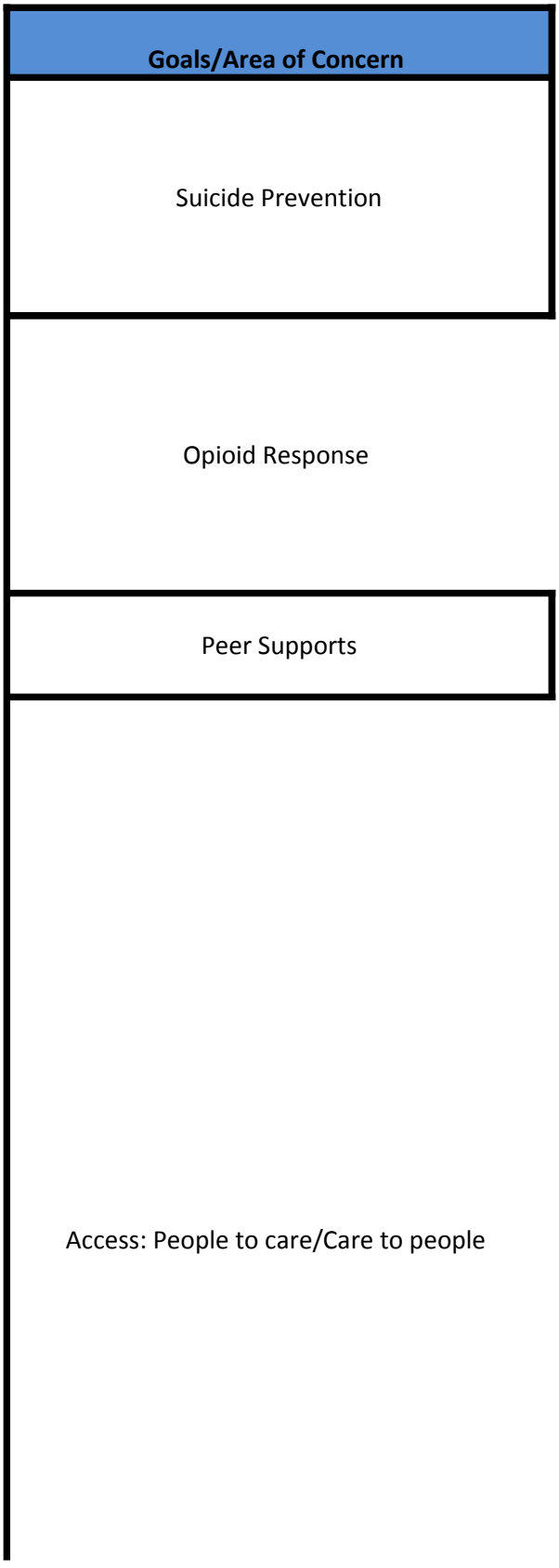
5 Planning
- alignment of LGU planning with the OC Health Dept Community Health Improvement Plan (CHA/CHIP)
- emergency preparedness: contact list/ mapping (phone, address, leadership) for residential and direct services across 3 dis areas
- refine LGU policy and procedures
- enhance utilization of data resources
- promote emerging role of LGU as neutral systems broker (from statutory authority to unique local/ regional systems broker
  - CNYDPG
  - DSRIP CNYCC
  - RPC
- bolster and engage virtual subcommittees
- create quarterly survey agenda
- develop monthly focus group model
- improve DALTC MH web page

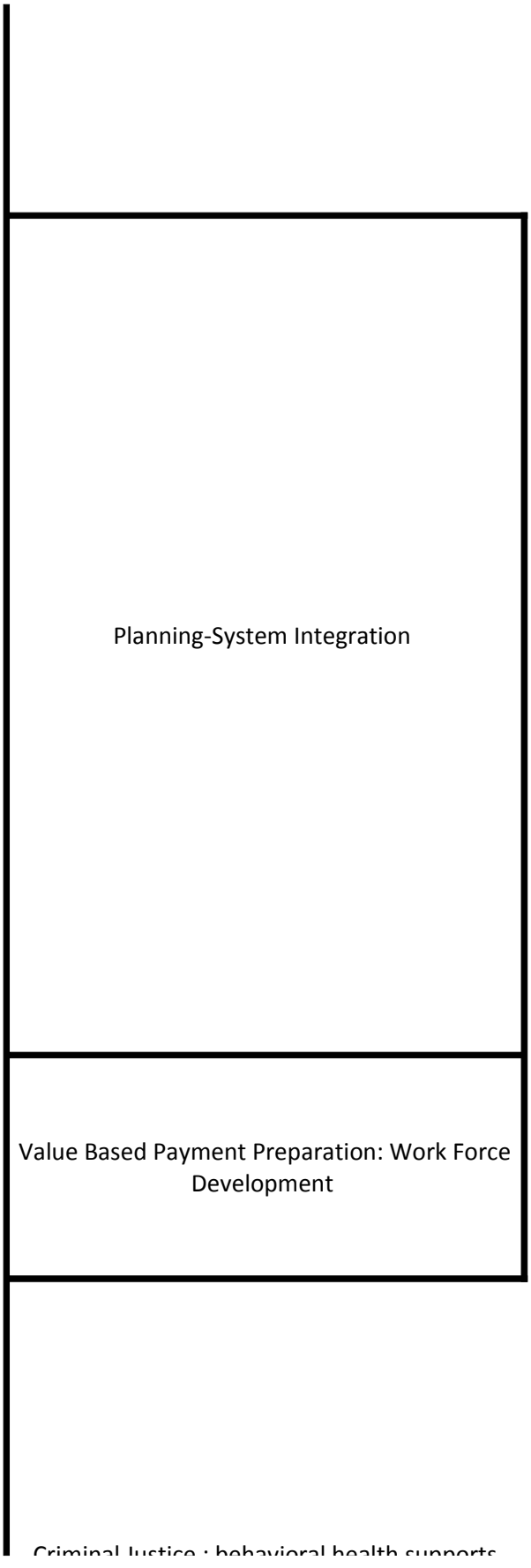
6 Value Based Payment prep: work force development
- Integration of Primary care and behavioral health thru the RCCA
- RCCA
- DSRIP/ CNYCC participation
- explore how best to serve high utilizers
- coaching for change seminars

7 Criminal Justice : behavioral health supports
- BRSS TACS Policy Academy
- OMH jail grant
- improve linkage between probation and MH/SU clinic and care management services
- next steps re CIT

vehicles for systems integration
raise the age

Onondaga County Department of Adult and Lon
Local Government Unit (LGU)

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Criminal Justice : behavioral health supports

g Term Care Services

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	Equip natural supports with the tools to support youth and their families
	Office of Mental Health (OMH) jail grant

County Comparison Table

Key Indicators
Demographics
Major City/Village/Town (highly populated)
Population-Adult
Population-Children
Race and Ethnicity
White alone (Not Hispanic/Latino)
Black/African American
American Indian and Alaskan Native
Asian
White
Two or More Races
Hispanic/Latino
Area (County Size)
Race & Poverty Rate
Poverty Rate (2016)
White
African American
Hispanic/Latin
Female Head of Household
Free Reduced Lunch
Rank

2013 NCHS Urban-Rural Classification scheme for counties
NYS OPWDD Demographics of People We Serve by Age Groups
Date: December 31, 2015
Disability
Dual Diagnosis
Autism
Cerebral Palsy
Seizure Disorder
Intellectual Disability
Enrollment Summary of Services and Supports by Selected Age Groups
Community Residential Enrollments
Individual & Family Support Services
Day Service Enrollments
Self-Direction Service Enrollments
Other Service Enrollments
New York State-County Opioid Quarterly Report, Published April 2017
Opioid overdoses and rates per 100,000 population (date as of March, 2017)
Deaths (2015)
All opioid overdoses
Heroin overdoses
Overdoses involving opioid pain relievers
Outpatient emergency department visits
All opioid overdoses
Heroin overdoses
Opioid overdoses excluding heroin

Hospitalizations
All opioid overdoses
Heroin overdoses
Opioid overdoses excluding heroin
Naloxone administration reports
Naloxone administration report by EMS
Naloxone administration report by law enforcement
Naloxone administrataion report by registered COOP Program
Admissions to OASAS-Certified Chemical Dependence Treatment During 2015* Type of Primary Substance Used By County of Client Residence and Type of Treatment Program**
Crisis
Inpatient Rehabilitation
Residential
Outpatient
Opioid Treatment
Medicaid Mental Health Expenditures (DATE)
Adults (age 18+)

Case Management
Inpatient
Outpatient
Residential
Children (age 0- 17)
Case Management
Inpatient
Outpatient
Residential
Medicaid Mental Health Services Utilization (2015)
Asservice Community Treatment (ACT)-Individuals
Psychiatric Inpatient and Private-Individuals
Continuing Day Treatment (CDT)-Individuals
Comprehensive Psychiatric Emergency Program (CPEP)-Individuals
Intensive Psychiatric Rehabilitation Treatment (IPRT)
Community Residence (CR)
Clinic Treatment (Mental Health Clinic)
Partial Hospitalization (PartHosp)
Personalized Recovery Oriented Service (PROS)
Recovery Services (PMHP-Prepaid Mental Health Plan)
Psychiatric Inpatient OMH (State Psych IP)
Targeted Case Management (ICM, BCM, SCM)
Health Home Outreach
Unduplicated Individuals
New York State-County Opioid Poisoning, Overdose and Prevention 2015 Report to the Governor and NYS Legislature
Deaths Due to Drug Overdose Mean Annual Frequency and Rate by County: NYS Residents, 2009-2013
Mean Annual Frequency
Crude/100,000 Residents
Age-Adjusted Rate/100,000 Residents

Deaths Due to Drug Overdose: Heroin Mean Annual Frequency and Rate by County: NYS Residents, 2009-2013
Mean Annual Frequency
Crude Rate/100,000 Residents
Age-Adjusted Rate/100,000 Residents
Opioid-Related Emergency Department Admissions by County of Residence, 2010-2014 (Number)
2010
2011
2012
2013
2014
2010-2014 Percentage of Change
Opioid-Related Inpatient Hospital Admissions by County of Residence, 2010-2014*
2010
2011
2012
2013
2014
2010-2014 Percentage of Change
Law Enforcement Naloxone Administration Reports, by County through December 31, 2015 (N=1,100)
Number
Percentage
Rate (per 100,000)

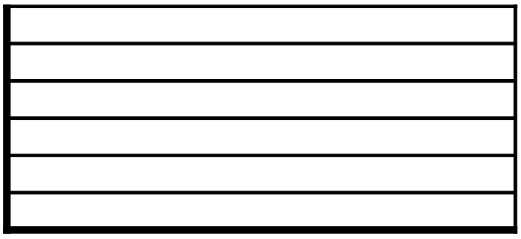
DSRIP Regional Needs Assessment
Adult Mental Health Emergency Programs and Community Support Programs by Provider County
# of Adults Served-Emergency Room
# of Adults Served-Community Support Programs
# of Children Served-Emergency Room
# of Children Served-Community Support Programs
2014 Top Ten Causes of Death-Rates per 100,000 Population by Resident County
Heart Disease
Malignant Neoplasms
Cerebrovascular Disease (Stroke)
AIDS
Pneumonia
Chronic Lover Respiratory Disease
Accidents
Diabetes Mellitus
Homicide or Legal Intervention
Cirrhosis of Liver
Suicide

Total Inpatient Hospital Admissions by Mental Health Diagnosis
Bi-polar Disorder
Depressive Disorders
Schizophrenia
Chronic Stress and Anxiety Diagnosis
Post Tramative Stress Disorder
Other Mental Health Diagnosis
Total Admissions per 10,000
Total Inpatient Hospital Admissions by Substance Use Disorder Diagnosis
Cocaine Use Disorder
Alcohol Use Disorder
Opioid Use Disorder
Drug Use: Cannabis/NOS/NEIC
Other SUID Diagnosis
Total Admissions
Total Patient Emergency Room Visits by Mental Health Diagnosis
Bi-polar Disorder

Depressive Disorders
Schizophrenia
Chronic Stress and Anxiety Diagnosis
Post Tramative Stress Disorder
Other Mental Health Diagnosis
Total Admissions
Total Patient Emergency Room Visits by Substance Use Disorder Diagnosis
Cocaine Use Disorder
Alcohol Use Disorder
Opioid Use Disorder
Drug Use: Cannabis/NOS/NEIC
Other SUID Diagnosis
Total Visits
All Payers Potentially Preventable Emergency Room Visits. ER Discharges 2013: Rate per 100,000All Payers Potentially Preventable Emergency Room Visits. ER Discharges 2013: Rate per 100,000
Observed
Expected
County Health Rankings & Roadmaps: Building a Culture of Health, County by County **A Robert Wood Johnson Foundation Program County Health Rankings & Roadmaps: Building a Culture of Health, County by County A Robert Wood Johnson Foundation Program**

Health Outcomes
Length of Life (Years of potential life lost before age 75 pre 100,00 (age adjusted).
Quality of Life
Health Factors
Health Behaviors
Clinical Care

Social & Economic Factors
Physical Environment
Overall Rank (n= 62)



Definition	New York State (NYC not included)
	*15,490,153
	*4,256,074
	56
	18
	1
	9
	70
	2
	19
	15.6%
	11.3%
	23.5%
	25.9%
	38.4%
	58.0%

All poisoning deaths involving opioids, all manners, using all casues of death	1520
	698
Poisoning deaths involving opioid pain relievers, all manners, using all causes of death	999
All outpatient (not being admitted)emergency department visits involving opiod poisonings, all manners, principal diagnosis or first-listed cause of injury	
	4,612
	3,240
Outpatient (not being admitted) emergency department visits involving opioid poisoning except herion, all manners, principal diagnosis or first-listed cause of injury.	1,372

	1873
	619
	22
EMS calls resulting in an evaluation and care provided by an emergency medical technician or paramedic	5567
Each naloxone administration report represents a naloxone administration instance in which a trained law enforcement officier administered one or more doses of naloxone to a person suspected of an opioid overdose.	962
Each naloxone administration report represents a naloxone administration instance in which a trained responder administered one or more doses or naloxone to a person suspected of an ipioid overdose. Naloxone administration instances that are reported to the AIDS Institute by the registered COOP Community Opioid Overdose Prevention programs are excluded from the county report.	488
	80,136
	38,699
	17,587
	127,476
	12,020
	$1,451,150,752

	$84,191,076
	$634,515,924
	$502,720,922
	$229,722,830
	$581,013,338 (100%)
	$18,050,119
	$315,329,927
	$211,848,680
	$35,784,613

This community needs assessment of the New York State Central DSRIP region summarizes specific health care sercice data to identify mental health and substance use disorder treatment needs in the region. The data included are intended to enable planners and others to identify services gaps and disparities and plan for improved service delivery.	

Potentially Avoidable Hospitalizations The Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators (PQIs) are a set of population-based measures that can be used with hospital inpatient discharge data to identify conditions for which good outpatient care can potentially prevent the need for hospitalization, or for which early intervention can prevent complications. PQIs provide a good starting point for assessing quality of health services in the community.Potentially Avoidable Hospitalizations The Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators (PQIs) are a set of population-based measures that can be used with hospital inpatient discharge data to identify conditions for which good outpatient care can potentially prevent the need for hospitalization, or for which early intervention can prevent complications. PQIs provide a good starting point for assessing quality of health services in the community.	
The Observed Rate (per 100,000 people) is the number of PQI discharges divided by the population, multiplied by 100,000.	
The Expected Rate (per 100,000 people) is the number of PQI discharges adjusted by age group, gender and race/ethnicity divided by the population, multiplied by 100,000. Lower ratios of observed to expected rates represent better results.	

contributes to the total number of years of potential life lost. **Premature Death** is the years of potential life lost before age 75 contributes to the total number of years of potential life lost.	
Low birthweight-Percentage of live births with low birthweight(<2500 grams)**Poor or fair health**-Percentage of adults reporting fair or poor health. This helps measure the quality of life in a county. **Poor physical health day**s-Average number of physically unhealthy days reported in the past 30 days. **Poor mental health days**- Average number of mentally unhealthy days reported in past 30 days. **Low birthweight**-Percentage of live births with low birthweight(<2500 grams)	
Adult smoking-Percentage of adults who are current smokers. **Adult obesity**- Percentage of adults that report a BMI of 30 or more. **Food environment index**-Index of factors that contribute to a healthy food environment. **Physical inactivity**-Percentage of adults age 20 and over reporting no leisure-tiem physical activity. **Access to exercise opportunities**-Percentage of population with adequate access to locations for physical activity. **Excessive drinking**-Percentage of adults reporting binge or heavy drinking. **Alcohol-impaired driving deaths**-Percentage of driving deaths with alcohol involvement. **Sexually transmitted infections**-Number of newly diagnosed chlamydia cases per 100,000 population. **Teen births**-Number of births per 1,000 female population ages 15-19	
Uninsured-Percentage of population under age 65 without health insurance. **Primary care physicians**- Ratio to population to primary care physicians. **Dentists-** Ratio of population to dentists. **Mental health providers**-Ratio of population to mental health providers. **Preventable hospital stays**-Number of hospital stays for ambulatory-care sensitivie conditions per 1,000 Medicare enrollees. **Diabetes monitoring**-Percentage of diabetic Medicare enollees ages 65-75 tgat receive HbA1c monitioring. **Mammography screening**-Percentage of female Medicare enrollees ages 67-69 tgat receive mammography screening.	

High school gradutaion-Percentage of ninth-grade cohart that graduates in fours years. **Some college -**Percentage of adults ages25-44 with some post-secendary eduation**.** **Unemployment**-Percentage of population ages 16 and older unemployed but seeking work. **Children in poverty**-Percentage of children under age 18 in poverty. **Income inequality**- Ratio of household income at the 80th percentile to income at te 20th percentile. **Children in single-parent households**-Percentage of children that live in a household headed by single parent. **Social associations**- Number of membership associations per 10,000. **Violent crime**- Number of reported violent crimes offenses oer 100,000 population. **Injury deaths**-Number of deaths due to injury per 100,000 population	
Air population-average daily density of fine particulate matterin micrograms per cubic meter. High levels of population are associated with poor heatlh outcomes such as asthma, broncitis, and poor lung function. **Drinking water violations**-Indicator of the prescence of health-related drinking water violations. These violations measures the quality of drinking water in a county. **Severe housing problems**- Percentage of households with at least 1 of 4 housing problems: overcrowfing, high housings costs, or lack of kitchen or plumbing facilites. This is a measure of housing quality and cost. **Driving alone to work**- Percentage of the workforce that drives alone to work. Indicator of poor public transit infrastructure, sedentary behaviors and low social intercations. **Long commute-driving alone**-Among workers who commute in their care alone the percentage that commutes more than 30 minutes. Indicator of poor community design to encourage active commuting.	
Using above indicators (Health Factors and Outcomes)	

Central New York	Albany	Broome	Cortland	Cayuga
	Albany	Binghamton	Cortland	Auburn
1,552,526	246,300	156,410	38,341	62,824
425,793	61,871	40,939	10,683	15,999
	73	84	94	90
	14	6	2	5
	0	0	0	1
	6	4	1	1
	77	87	95	92
	3	3	2	2
	6	4	3	3
	533 sq miles (1,380 sq km)	716 sq miles (1,854 sq km)	502 sq miles (1,300 sq km)	864 sq miles (2,238 sq km)
	26.7%	17.8%	21.2%	12.4%
	19.4%	14.9%	21.6%	11.6%
	30.9%	45.3%	21.1%	31.7%
	37.0%	43.5%	22.8%	18.4%
	46.9%	44.6%	32.0%	34.0%
	0.0%	56.0%	0.0%	45.0%
	14	16	50	37

	Medium metro	Small metro	Micropolitian	Micropolitan
	707	514	113	211
	647	459	81	182
	345	186	63	101
	544	377	109	154
	1,573	1,276	361	566
	742	427	121	160
	1,715	1,529	437	718
	1,476	881	264	540
	202	132	29	34
	4,955	4,434	996	1,687
	31	29	8	17
	16	13	4	8
	16	13	4	14
	77	154	18	42
	51	128	14	24
	26	26	s	18

	34	38	12	17
	12	18	s	6
	22	20	11	11
	173	317	31	60
	5	17	13	7
	21	32	0	0
	1,032	1,013	144	239
	660	479	132	159
	486	250	73	58
	2,656	1,586	447	738
	196	48	2	9
$127,644,806	$46,940,145	$18,721,634	$2,152,859	$3,618,725 (100%) $3,618,725 (100%) $3,618,725 (100%) $3,618,725 (100%) $3,618,725 (100%) $3,618,725 (100%) $3,618,725 (100%) $3,618,725 (100%)

$5,702,471	$17,243,196	$927,664	$195,862	$332,916
$36,468,158	$9,230,304	$8,471,134	$468,502	$1,031,504
$58,586,643	$10,469,024	$8,007,242	$991,505	$1,373,429
$24,887,534	$9,997,621	$1,315,595	$496,990	$880,876
$88,017,995	$15,243,424	$13,352,007 (100%)	$395,670	$8,837,794
$2,873,930	$2,515,021	$482,751	$124,959	$59,755
$58,291,791	$2,965,297	$9,392,263	$0	$7,845,301
$21,425,670	$8,719,972	$2,758,356	$270,711	$902,640
$5,426,604	$1,043,133	$718,637	$0	$30,098
466	59	72	*	*
2,994	365	449	100	151
69	*	*	34	*
1,783	*	496	*	*
*	*	*	*	*
1,343	661	81	27	63
18,167	1,452	1,302	752	942
15	*	*	*	*
1,572	676	125	*	137
3,089	537	558	*	*
81	30	37	*	*
57	2,455	5	2	*
2,416	237	277	96	102
26,082	*	*	2,584	890
	25	21	2	9
	8	11	4.9**	11
	8	11	4.7**	11

	6	3	*	1
	2	1.6**	*	1.5**
	2	1.8**	*	1.8**
	444	310	53	103
	572	347	59	149
	674	508	100	113
	556	600	105	104
	721	458	83	157
	62%	48%	57%	52%
	1,015	460	52	92
	836	473	69	155
	975	548	88	149
	1,007	604	71	133
	956	602	109	170
	0	0	1	0
	8	23	14	7
	0	0	0	0
	3	12	28	5

	48	58	*	*
	346	444	*	74
	31	35		*
	233	73	25	56
160	166	166	157	170
160	153	154	149	152
35	24	26	37	35
1	1	2	0	1
17	9	13	19	20
42	30	36	41	32
35	20	43	32	32
19	15	20	22	12
2	4	2	0	1
9	11	9	15	6
10	9	13	7	10

3887	1031	778	149	181
19325	5008	3036	918	1103
5609	1367	888	183	286
6204	1628	885	279	373
1805	498	189	80	150
9014	1830	1056	450	612
45844	11362	341	2059	2705
2929	864	323	41	99
5728	2050	1083	311	211
5100	1226	735	124	206
3628	1310	641	76	198
3740	691	403	217	127
21125	6141	3185	769	841
13745	5175	3105	574	837

57797	17223	11159	2477	4430
19122	6089	3980	543	1325
23705	6808	4470	1021	1871
7303	2428	1154	401	593
33416	9632	6036	1624	2606
155088	47355	29904	6640	11662
14681	6413	3147	500	629
8093	3101	1280	61	226
14188	4652	2758	369	649
11472	4917	2484	150	631
12106	3393	1777	352	572
60540	22476	11446	1432	2707
	22	24	36	23
	22	19	18	19

	27	55	34	19
	25	53	35	22
	30	53	27	17
	8	45	29	36
	14	4	35	33
	7	55	25	39

	8	45	30	29
	32	4	5	43
	25	53	35	22

Erie	Madison	Monroe	Oneida	Onondaga
Buffalo	Oneida	Rochester	Utica	Syracuse
730,524	56,665	586,275	182,807	363,568
192,311	15,704	163,582	50,064	104,628
76	93	71	83	77
14	2	16	7	12
1	1	0	0	1
3	1	4	4	4
80	95	77	87	80.4
2	1	3	2	3
5	2	8	6	5
1227 sq miles (3178 sq km)	661 sq miles (1,700 sq km)	1366 sq miles (3538 sq km)	1258 sq miles (3,258 sq miles)	806 sq miles (2,088 sq km)
14.7%	11.2%	15.4%	16.5%	15.2%
9.3%	10.6%	9.9%	13.3%	10.2%
36.1%	38.2%	36.4%	40.9%	39.6%
38.6%	23.2%	35.3%	44.5%	38.2%
42.0%	35.6%	44.5%	42.2%	41.2%
53.0%	41.0%	55.0%	59.0%	52.0%
5	45	6	15	10

Large central metro	Medium metro	Large central metro	Medium metro	Medium metro
2,203	216	1,996	853	823
1,564	177	1,526	618	1,055
1,236	92	881	405	485
1,717	155	1,259	656	762
5,498	509	4,789	1,847	2,490
2,336	190	1,841	918	717
4,463	856	5,356	2,098	3,937
5,117	324	4,031	0	1,645
266	200	442	263	1,027
15,664	1,443	14,505	4,315	8,079
238	7	81	36	70
67	2	45	16	40
212	7	49	23	45
921	33	253	96	307
723	24	167	64	233
198	9	86	32	74

203	8	133	41	94
57	s	34	22	34
146	0	99	19	60
188	32	500	256	548
221	4	8	11	33
210	0	28	2	4
3,631	144	2,068	955	1,964
1,735	145	1,884	670	1,434
808	39	946	207	489
9,091	481	9,263	2,070	4,877
402	4	92	18	195
$66,845,263 (100%)	$1,709,183	$44,105,178	$22,019,183	$34,454,790

$2,602,728	$199,808	$4,176,953	$1,303,239	$639,540
$24,215,664	$0	$14,816,652	$4,100,669	$10,490,436
$27,207,608	$1,051,491	$16,413,991	$10,794,468	$17,818,867
$12,819,264	$457,884	$8,697,582	$5,820,807	$5,505,948
$41,149,946	$324,253	$22,610,297	$18,571,049	$20,042,365
$532,908	$85,085	$945,901	$211,219	$428,577
$28,698,114	$0	$11,783,693	$16,615,495	$11,663,132
$10,908,175	$239,168	$9,210,933	$1,714,611	$7,122,766
$1,010,748	$0	$669,770	$29,724	$827,890
242	*	103	204	82
1,126	*	871	660	708
366	*	*	35	*
603	*	909	*	1,287
29	*	*	*	*
585	31	386	222	189
7,844	360	9,704	2,769	3,441
90	*	461	*	15
803	117	1,480	*	601
874	*	139	767	1,010
53	*	28	*	22
7	*	13	8	8
993	63	1,268	643	324
1,094	6,125	*	*	1,476
94	7	66	17	47
10	9	9	7	12
11	10	9	8	12

15	*	15	4	10
2	*	2	1.5**	2
2	*	2	1.6**	2
1,585	70	796	456	729
1,847	83	784	365	867
2,252	94	995	419	1,188
2,406	115	1,194	444	1,264
2,328	156	1,513	570	1,263
47%	123%	90%	25%	73%
1,579	54	876	468	741
3,232	112	172	619	1,206
3,027	110	1,432	712	1,391
2,932	111	1,637	667	1,538
3,163	148	1,804	613	1,570
0	1	0	0	0
231	7	10	12	36
0	0	0	0	0
25	10	1	5	8

217	*	249	14	130
1087	37	812	605	758
21		107	7.0	40
385	24	65	37	124
171	144	143	191	141
177	152	162	151	175
36	34	33	31	35
2	0	1	1	2
12	11	18	13	17
36	53	28	37	36
31	33	30	36	33
2	26	13	22	16
8	3	5	4	5
8	11	7	7	8
11	9	7	10	9

2899	115	2489	1092	1942
14272	769	13780	5556	8734
4270	214	3606	1530	2708
4513	227	3698	1817	2565
1502	29	862	522	833
6149	235	5059	2668	3839
33605	1589	29494	13185	20621
3350	49	3860	864	1793
5394	150	5387	1546	2950
4453	158	3821	1356	2596
4749	168	2642	1130	1710
3447	86	2090	1266	1624
21393	611	17800	6162	10673
10882	837	10310	3652	6652

45796	4430	50929	15009	26093
15258	1325	15525	4997	9529
18992	1871	15079	6797	9368
6855	593	4466	2124	3209
26312	2606	22721	8791	14329
124095	11662	119030	41370	
15,822	756	15093	3456	7974
10,127	206	10739	1807	5463
12,732	833	12258	3529	7145
13,902	792	7918	3302	5496
11,476	616	8174	3116	5928
64059	3203	54182	15210	32006
24	25	24	26	21
21	18	22	19	22

50	12	32	52	38
59	14	21	49	31
43	8	47	56	37
31	23	26	49	25
27	31	17	28	7
10	12	32	52	38

35	23	26	49	25
58	31	17	28	7
50	59	21	52	38

Oswego
Oswego
94.1
1.1
0.5
0.8
96.2
1.4
2.5
1312 sq miles (3,398 sq km)
18.5%
18.1%
28.5%
47.5%
50.1%
52.0%
20

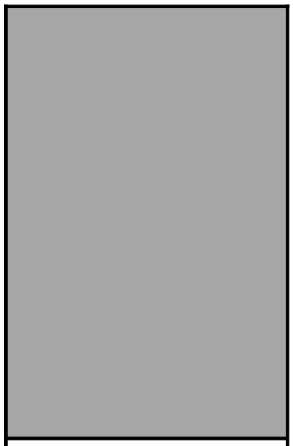
Medium metro
172
217
120
176
559
142
936
15,667
113
1,685
15
9
8
54
46
8

18
s
15
99
5
0
446
307
86
1,236
24
$4,636,780

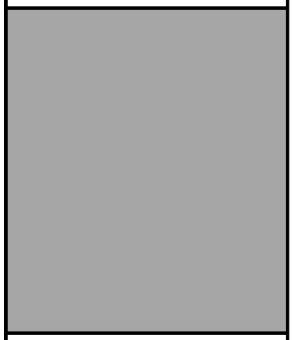
$245,088
$1,378,912
$1,278,371
$1,734,408
$874,156
$196,809
$0
$665,412
$11,935
53
185
*
*
*
258
953
*
*
*
*
5
267
4,568
16
13
13

1
1.2**
1.2**
115
134
203
223
245
113%
135
251
316
331
380
1
6
1
5

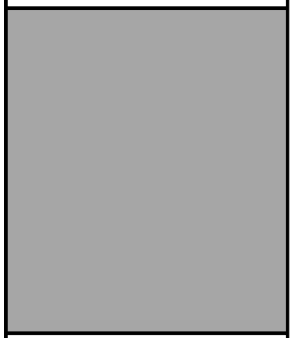
*
61
40
156
179
37
0
21
52
47
18
1
8
15



408
2245
688
943
191
1210
5685

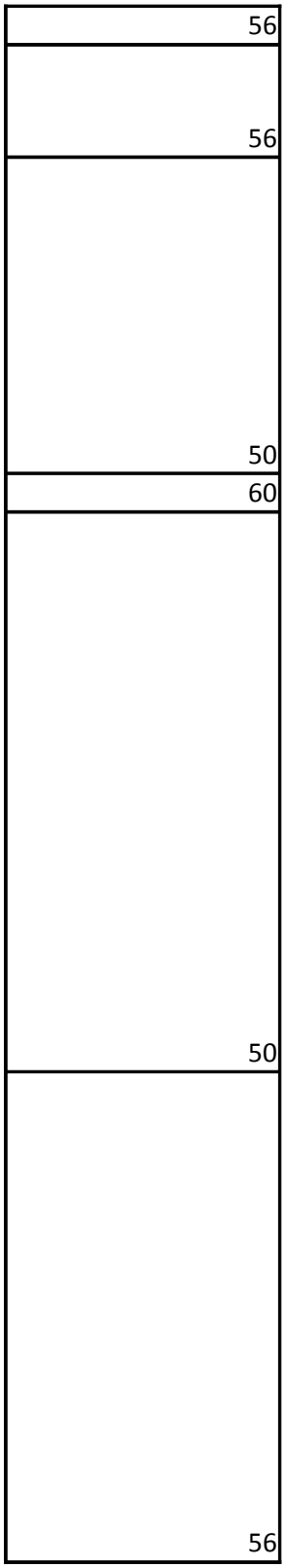


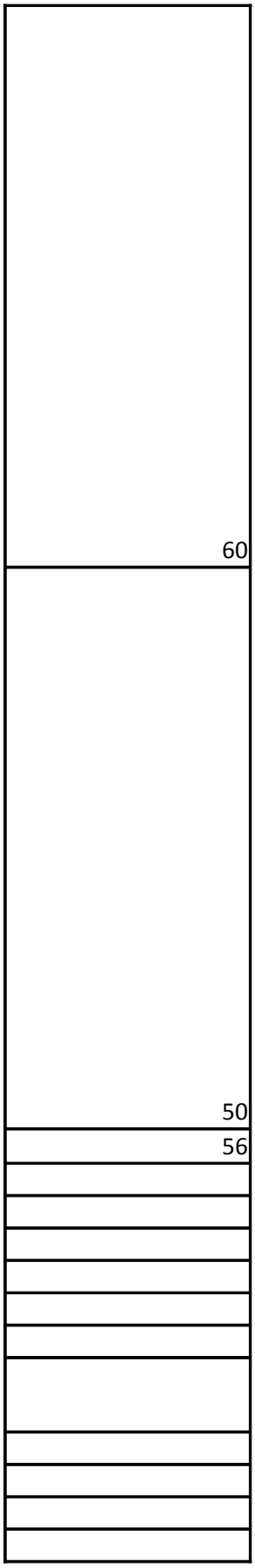
83
560
660
346
420
2069

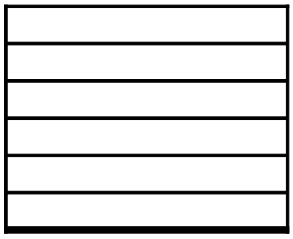


1319

5983
1723
3048
703
4281
17057
1366
330
1663
1101
1522
5982
18
18


56
56
50
60
50
56


60
50
56



Sources

County Website

2014 Census

2015 Census

2015 Census (https://www.census.gov/quickfacts/)

County Website

This data from the US Census Bureau's American Communities Survey (ACS) report S1701 - Poverty Status in the Past 12 Months, 2010 - 2014 five year estimates. (factfinder2.census.gov). Prepared by New York State Community Action Association (NYSCAA)

NYSCAA

NYSCAA

NYSCAA

NYSCAA

NYSCAA

CDC-2013 NCHS Urban-Rural Classification Scheme for Counties

https://cps.oasas.ny.gov/cps/secured/countydata/index.cfm?selection=58

https://cps.oasas.ny.gov/cps/secured/countydata/index.cfm?filename=opwdd%2Dcounty%2Dprofile%2DAlbany%2D2014

https://www.health.ny.gov/statistics/opioid/data/pdf/nys_apr17.pdf

New York State-County Opioid Quaterly Report Published April, 2017

Indicators are not mutally exclusive. Decedents and patients may have multiple substances in their system. Thus, overdoses involving heroin and overdoses involving pressciption opioid pain relievers will not add up to the overdoses onvolving all opioids.

Vital Statistics

This indicator included pharmaceutically and illicity produced opioids such as fentanyl.

SPARCS

Indicators related to hospitalizations and emergency department data used ICD-9-CM codes prior to Oct 1, 2015. ICD-10-CM codes are used from Oct 1, 2015 and thereafter. Changes should be interpreted with caution due to the chande in codes used for the definition. s=Data for indicators related to hospitalizations and emergency departments are suppressed for confidentiality purposes if there are less than 6 discharges.
Numbers displayed in the table represent only naloxone administration events reported electroniclally, therefore actual numbers of events mya be higher. He numbers for NYS excl. NYC do not include Suffolk County.
NYS e-PCR data and other regional EMS Office data collection methods
NYS Law Enforcement Naloxone Administration Database
NYS Community Opioid Overdose Prevention Naloxone Administration Database
"NOTES * Based on 10/30/16 data extract from OASAS Client Data System (CDS). - Primary client admissions only (i.e., excludes significant others). - Admissions do not necessarily represent unique persons. An individual admitted to more than one service type during the year would be counted more than once. **Primary Substance Used represents substance reported at admission as a primary substance type. - Examples of drugs in the ""Other Substance"" category include: PCP, Methamphetamine, Benzodiazepine, Ketamine, and Ecstasy."
OMH. County Profiles. http://bi.omh.ny.gov/cmhp/dashboard?utm_source=CLMHD+Dashboard+%26+Portal+Dialogu

OMH County Profiles--http://bi.omh.ny.gov/cmhp/mh-services#central-ny

* No information to report

NYS Opioid Poisoning, Overdose and Prevention 2015 Report to the Governor and NYS Legislature Table B-2:
https://www.health.ny.gov/diseases/aids/general/opioid_overdose_prevention/docs/annual_report2015.pdf

NYS Opioid Poisoning, Overdose and Prevention 2015 Report to the Governor and NYS Legislature Table B-3:
https://www.health.ny.gov/diseases/aids/general/opioid_overdose_prevention/docs/annual_report2015.pdf

*-No information reported

NYS Opioid Poisoning, Overdose and Prevention 2015 Report to the Governor and NYS Legislature Appendix C-Emergency Department Admissions-
https://www.health.ny.gov/diseases/aids/general/opioid_overdose_prevention/docs/annual_report2015.pdf

Table D-1a: https://www.health.ny.gov/diseases/aids/general/opioid_overdose_prevention/docs/annual_report2015.pdf

Data Sources: Includes adults receiving emergency services and support services (e.g., vocational, self-help, care coordination) as reported by the New York State Office of Mental Health 2013 Patient Characteristics Survey (PCS). US Census ACS 2010-2014 Est. Population. Service use is reported because there are no licensed capacities for nearly all of these programs. https://www.omh.ny.gov/omhweb/special-projects/dsrip/docs/chapter-3-central.pdfData Sources: Includes adults receiving emergency services and support services (e.g., vocational, self-help, care coordination) as reported by the New York State Office of Mental Health 2013 Patient Characteristics Survey (PCS). US Census ACS 2010-2014 Est. Population. Service use is reported because there are no licensed capacities for nearly all of these programs. https://www.omh.ny.gov/omhweb/special-projects/dsrip/docs/chapter-3-central.pdfData Sources: Includes adults receiving emergency services and support services (e.g., vocational, self-help, care coordination) as reported by the New York State Office of Mental Health 2013 Patient Characteristics Survey (PCS). US Census ACS 2010-2014 Est. Population. Service use is reported because there are no licensed capacities for nearly all of these programs. https://www.omh.ny.gov/omhweb/special-projects/dsrip/docs/chapter-3-central.pdfData Sources: Includes adults receiving emergency services and support services (e.g., vocational, self-help, care coordination) as reported by the New York State Office of Mental Health 2013 Patient Characteristics Survey (PCS). US Census ACS 2010-2014 Est. Population. Service use is reported because there are no licensed capacities for nearly all of these programs. https://www.omh.ny.gov/omhweb/special-projects/dsrip/docs/chapter-3-central.pdf
Data is from the NYS department of Health, Retrieved April 26, 2016 from https://www.heatlh. Ny.gov/statistics/vital_statistics/2014/table40.htm * Age-Sex adjusted rates are directly standardized using the age-sex distribution for the United States 2000 Census

Data is from the NYS Department of Health Medicaid Chronic Conditions and Inpatient Admissions data base, 2012 data. Retrieved May 4, 2016 from https://health.data.ny.gov/Health/Medicaid-Chronic-Conditions-Inpatient-Admissions-a/2yck-xisk#ExportData is from the NYS Department of Health Medicaid Chronic Conditions and Inpatient Admissions data base, 2012 data. Retrieved May 4, 2016 from https://health.data.ny.gov/Health/Medicaid-Chronic-Conditions-Inpatient-Admissions-a/2yck-xisk#ExportData is from the NYS Department of Health Medicaid Chronic Conditions and Inpatient Admissions data base, 2012 data. Retrieved May 4, 2016 from https://health.data.ny.gov/Health/Medicaid-Chronic-Conditions-Inpatient-Admissions-a/2yck-xisk#Export

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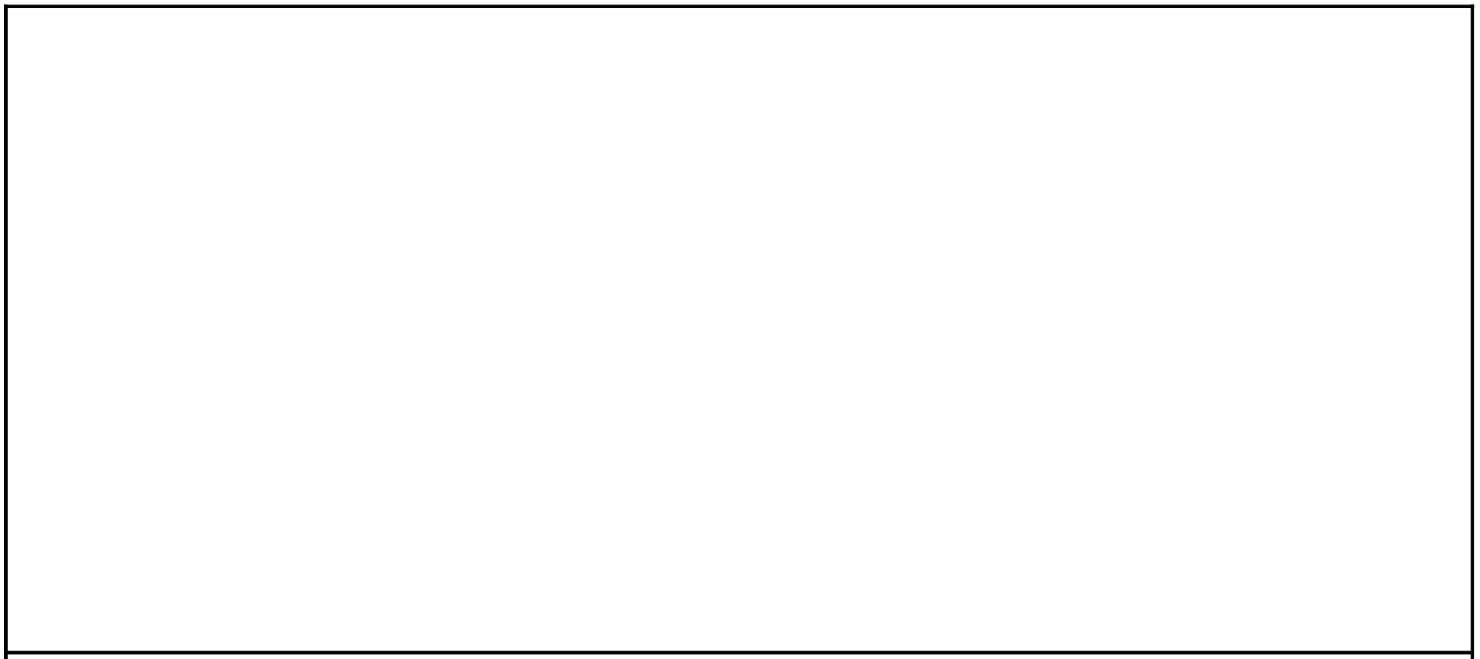
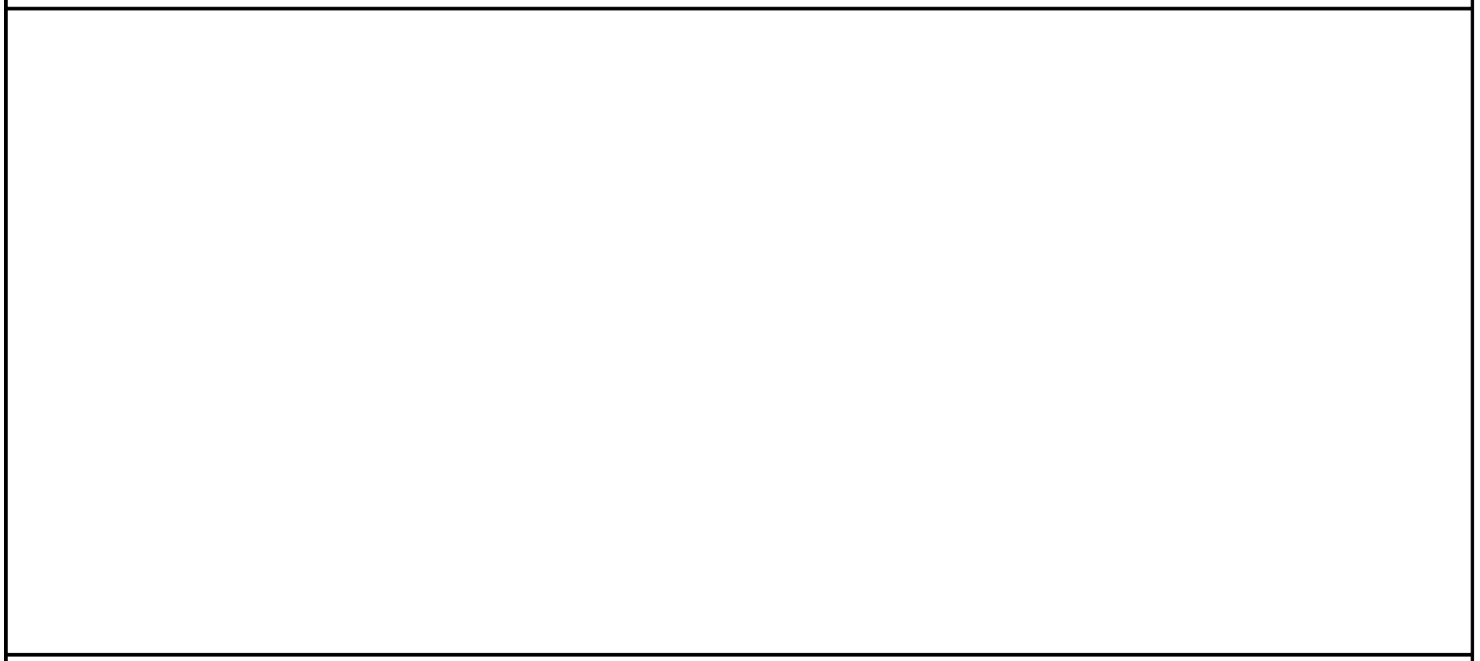
Notes and Data Sources: Data is from the NYS Department of Health All Payer Potentially Preventable Emergency Visit (PPV) database. Rates by patient county, SPARCS data 2013. Retrieved May 6, 2016 from https://health.data.ny.gov/Health/All-Payer-Potentially-Preventable- Emergency-Visit-/f8ue-xzy3#About

http://www.countyhealthrankings.org/app/new-york/2017/overview





Notes

The ten New York State counties with the greatest number of people living in poverty, from highest to lowest, are: Kings, Bronx, Queens, New York, Erie, Monroe, Suffolk, Westchester, Nassau, and Onondaga. The ten counties with the highest percentage of the population living in poverty, from highest to lowest, are: Bronx, Kings, Franklin, Montgomery, St. Lawrence, Tompkins, Chautauqua, Cattaraugus, Oswego and New York.

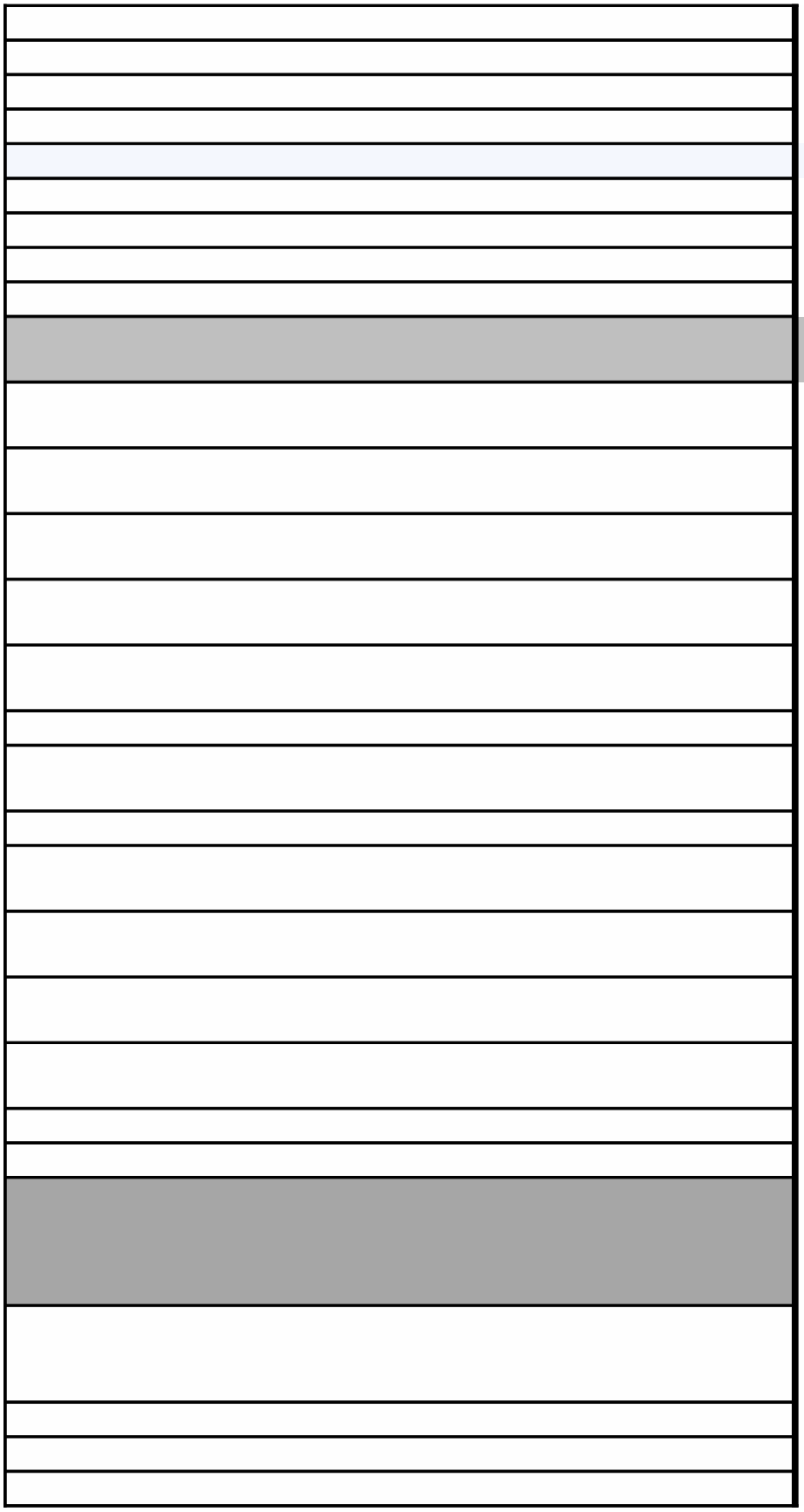
Office of Management and Budget definitions: **Small metro**-Counties in MSAs of populations less than 250,000 **Medium** **metro** - Counties in MSAs of populations of 250,000-999,999 **Large** **central metro**-Counties in MSAs of 1 million or more population **Micropolitan**- Counties with populations at less 10,000 but less than 50, 000
Totals from Birth-65+
NYS Opioid Poisoning, Overdose and Prevention 2015 Report to the Governor and NYS Legislature

and prescription opioid misuse https://ww

Numbers reported by law enforcement and registered COOP programs to the NYSDOH AIDS Institute. The actual numbers of naloxone administration events may be higher.

Totals across all drugs: Heroin, other opioids, alcohol, crack/cocaine, marijuana, other substance

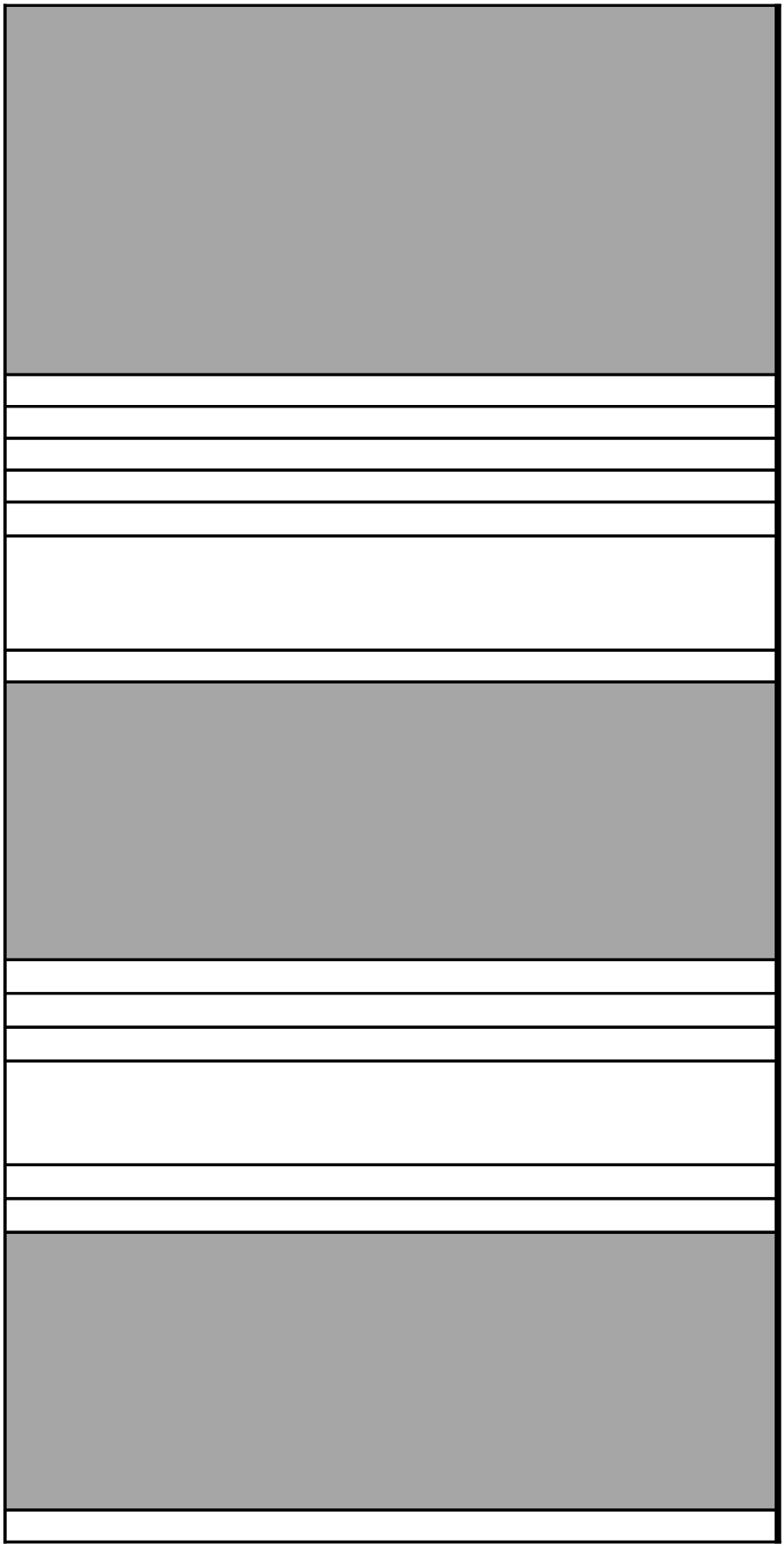
This report displays summary information about the selected county and NY State annual Medicaid expenditures for mental health services provided to adults and children who were Medicaid eligible on the date of service within 2014 and prior Local Fiscal Years (Calendar Year for all counties except New York City; July 1, 2013 - June 30 2014 for NYC counties).



All rates are calculated based on the US Census Bureau's 2010 decennial census estimates, based on 100,000 population Source: SPARCS, July 2015. Prepared by NYSDOH, AIDS Institute ** Caution: Rates calculated using frequencies of less than 20 (five-year total) are unstable. Source:NYSDOH, Bureau of Occupational Health and Injury Prevention Vital Statistics Death File, June 2015, www.health.nygov/prevention/injury_preventation

All rates are calculated based on the U.S. Census Bureau's 2010 decennial census estimates, based on 100,000 population. Source: SPARC July 2015. Prepared by NYSDOH, AIDS Institute

Data Sources: Includes children receiving emergency services and support services (e.g., vocational, home-based family treatment, residential treatment facility transition) as reported by the New York State Office of Mental Health 2013 Patient Characteristics Survey (PCS). US Census ACS 2010-2014 Est. Population. Service use is reported because there are no licensed capacities for nearly all of these programs.Data Sources: Includes children receiving emergency services and support services (e.g., vocational, home-based family treatment, residential treatment facility transition) as reported by the New York State Office of Mental Health 2013 Patient Characteristics Survey (PCS). US Census ACS 2010-2014 Est. Population. Service use is reported because there are no licensed capacities for nearly all of these programs.Data Sources: Includes children receiving emergency services and support services (e.g., vocational, home-based family treatment, residential treatment facility transition) as reported by the New York State Office of Mental Health 2013 Patient Characteristics Survey (PCS). US Census ACS 2010-2014 Est. Population. Service use is reported because there are no licensed capacities for nearly all of these programs.Data Sources: Includes children receiving emergency services and support services (e.g., vocational, home-based family treatment, residential treatment facility transition) as reported by the New York State Office of Mental Health 2013 Patient Characteristics Survey (PCS). US Census ACS 2010-2014 Est. Population. Service use is reported because there are no licensed capacities for nearly all of these programs.



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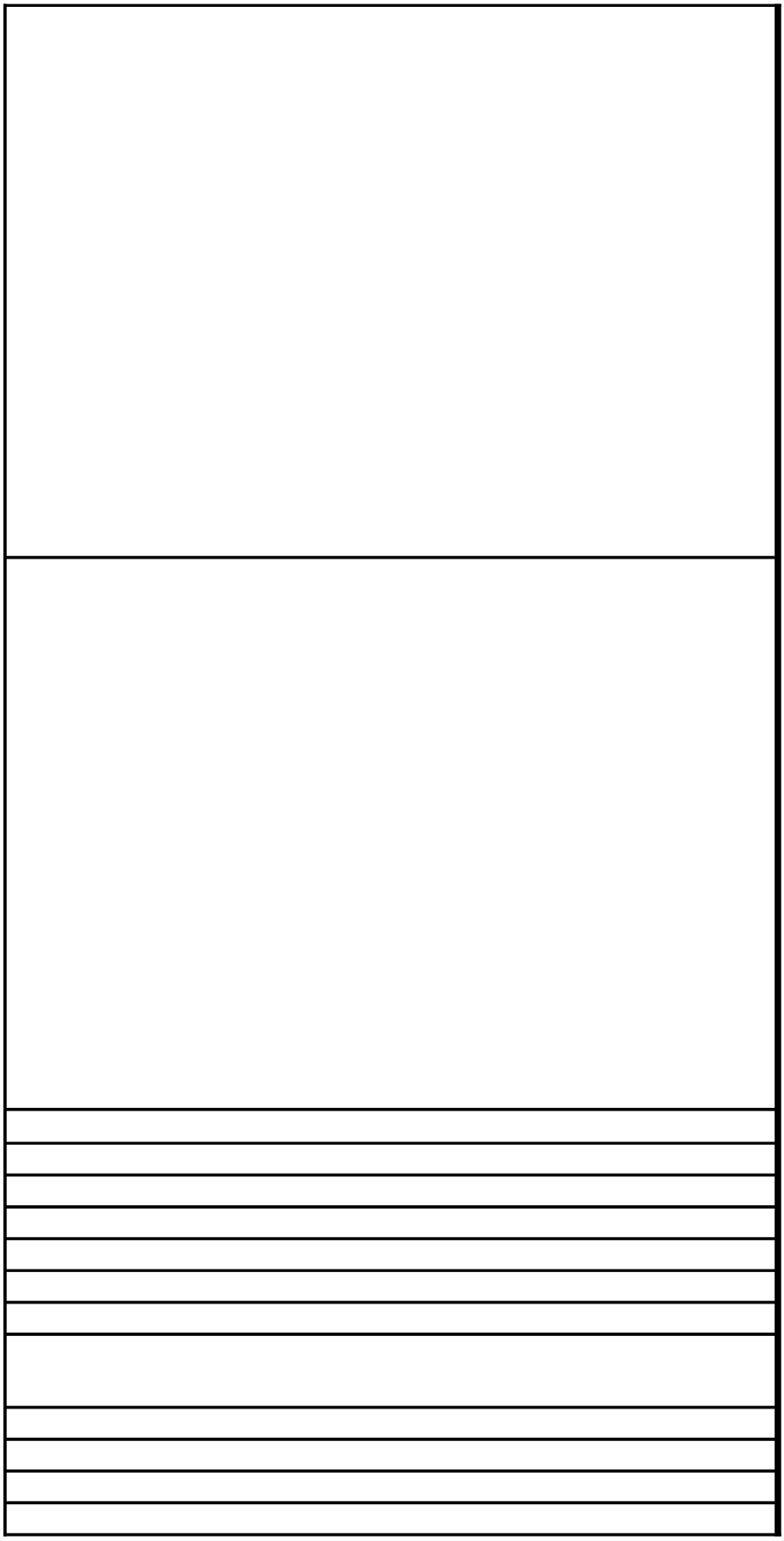

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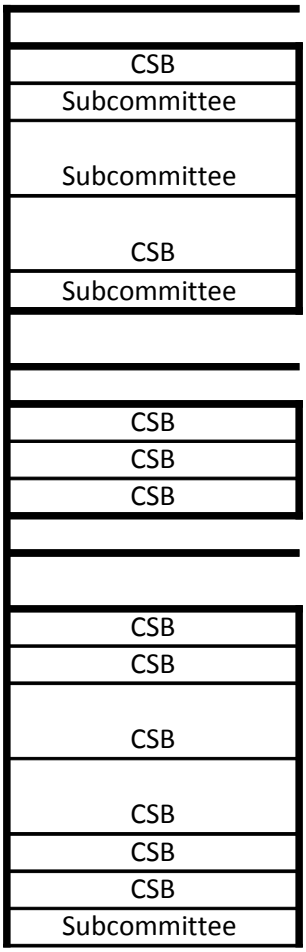
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2018 Community Planni

Areas of Concern
What improvements, innovations, services and supports are most in need to enhance the wellness of Onondaga County residents related to Developmental Disabilities, Mental Health, Substance Use conditions or other concerns?

New models of affordable housing - affordable with supports, but less expensive than current models http://www.wesoldieron.org/projects/New models of affordable housing - affordable with supports, but less expensive than current models http://www.wesoldieron.org/projects/
Housing
Not enough housing for persons w/MH & MH/Forensic pop workforce (comm based supports)
Safe and affordable housing, better code enforcement and tracking of Landlords and related LLC companies to avoid re selling via land bank.
housing- affordable
Housing for emergency, transition, permanentHousing for emergency, transition, permanent
residential options for folks with Developmental Disabilities who require 24/7 staffing
HOUSING IS A BIG PROBLEM IN THIS COUNTY
Appropriate kinds and levels of housing pose ongoing problems for our citizens in need - emergency, transition, permanent, 24 hr care for those in need.
Single women supportive (transitional/permanent)housing
Homeless Women (coming out of jail; impatient treatment facilities; Domestic violence situations)
Women's with children supportive(transitional/permanent) housing
Increased community policing at and around the Rescue Mission and Syr. Housing Authority projects.
Housing
Sustained supports for homeless population enabling them to set out of shelter and not return (Approx. 4000 per yr.)
Strengthern economic/job/housing opportunities for those with SA and or MH issues
New models of shared housing. Single apartments are too expensive and isolating. Need co-ops etc.

Higher level work opportunities/volunteers for individuals with disabilities
Incentives for moving from DSS assistance to employment by offering actual jobs through Jobs Plus in exchange for an increased benefit, possibly cleaning up the city trash and overgrowth.
More State/County funding for peer service community work
Strengthern economic/job/housing opportunities for those with SA and or MH issues
Find funding for DD providers to stop alarming turnovers

Employment

ɔment/Training

Workforce development, pay
Training and ongoing supervision/support for "peer services"
More qualified Behavior Intervention Specialists (qualification per regulations promulgated 2012/2013). The qualifications are difficult to find and behaviors supports cannot be provided without it.
Provide workforce training in social determinants of health (particularly poverty) and their impact on those we serve with regard to access to and sustainability of services/supports.
Training of Professional Doctors on Special Needs people
Direct care workforce-salaries & training
Education-continued for providers
Mandatory administrative training in hospitals and treatment centers on peer support
Increased primary prevention education-need increase staff
Workforce shortage - especially direct support, teaching assistants, personal care aides. We need both higher salaries and better training.

Teaching Sign Language to professional individuals
Education programming for individuals who dropped out of HS

Increased community policing at and around the Rescue Mission and Syr. Housing Authority projects.
Blue light warning system to alert for difficulties/ decompensation in community
Employment opportunites/living wage for support providers
Increased collaboration with law enforcement and SUD/Behavior health peers working as such
Significant shift in police attitudes and training, and possibly laws. Much more de-escalation; crisis teams with police & MH counselor. Too many people in Justice Center!!
Changes in law inforcement of alcoholism and addictions. Stop locking up sick people and treating them like criminals
ALL OF THESE AREAS NEED TO BEEN ADDRESSED IN A BETTER MANNER IN ORDER TO MAKE SYRACUSE A MUCH BETTER PLACE TO LIVE AND PEOPLE CAN FEEL SAFE YES THAT IS THE ONE THING I DO NOT SEE ON HERE IS SAFTEY

Strengthen 'ombudsperson' and 'consumer protection' role so that once private, for-profit, managed care companies rule the world there will somewhere for people to turn
A new policy for maintenance of sidewalks that actually results in repairs and enforcement, and way more public trash cans throughout entire city.
Prepare and respond to the "Raise the Age" legislation in anticipation of the increase in identified youth with mental health and substance abuse issues

ɑtment

It is not easy to find qualified counseling services for families of children with severe behavioral needs. Funding for family supports is also an issue.
More free or low-cost psychiatric services for children and adolescents
Increased/ improved psychiatric services
Mental health services are lacking in this county
Psychiatry
Need more mentoring/skillbuilding services (MH)
Integrated emergency services available to all mental health areas
Adult respite/drop-in center-low-key social-not yet in MH crisis but needing "home supports"
Available "stash" of supplies for (drop in place; for 6 at cup of coffee, etc) "street" mental health folks-basic needs leading to trust relationships
School options w/psychiatry new day treatment options

r Treatment

There is an epidemic of opioid abuse/addiction that needs to be addressed by better preventive care, treatment, and family intervention.
More slots for in-patient and out-patient substance abuse treatment
Not enough detox facilities ready to accept people when they're ready. Waiting for a detox bed isn't an option for people ready to go into treatment.
building, what unacceptable behavior is, why to be non judgements.
detection while lessening laws on Cannibus use.
Detox
Addiction services expansion
Buddy or peer system to support those waiting for rehab-check-in, follow through system
Opiod epidemic

Peer Services need to expand
Resources-Peers are important
Peer run respite

al Services

There needs to be better coordination of behavioral healthcare with physical healthcare.
Quality dental care 7 days a week in multiple locations. Dental care is an unmet need because most families and individuals resources is spent on meeting basic needs e.g. food, shelter clothing etc.
Health Outreach to vulnerable populations
Primary care access: need non-traditional hours

Transportation
Transportation
Transportation
Transportation outside the city. How do we not concentrate poverty when we can only place people without transportation in the city?
Need for improved transportation services in order for commuity residents to have easy access to all support services
Better transportation system

Prevention/Wellnes
Community Wellness calendar=Listing all opportunities each month
Increase access to prevention live services system wide increase crisis response
Access to a single stream P.O.S. for wellness

Youth Services
Services for Transition Age Youth
Care Coordination for Non-Medicaid eligible children
If new service array comes into play (SPA & HCBS) we need to ensure some array for Non-Medicaid eligible kids
If new service array does not, we need those services to ensure kids successful in home, school, & community.
Increased MH & HH supports for students through school in Onon Co. Onondaga PZ
More prevention/awareness child & adolecent MH issues
More free or low-cost psychiatric services for children and adolescents

Alateen for teenage kids that have a parent with addiction. The need of learning acceptance, self esteem building, what unacceptable behavior is, why to be non judgements.
Expansion of childrens services for developmental disabilities
Expansion of mental health options for children
Engage students at middle-school ages
Increase in Crisis Respite resources and/or the creation of a "Crisis Center" for children/youth that enables parents to address issues/concerns before they reach the level of CPEP/ER intervention.
Expand school based servicesExpand school based services
More prevention/awareness child & adolecent MH issues
Childcare often not available to allow individuals to seek treatment
Establish a more effective community response to child/youth presentations that spark the debate of it being "behavioral vs. psychiatric" and often results in "cracks" in the system and youth not getting the help they need

Other Services
More intensive services
Support groups for different demographics now/currently severely lacking
Sorting out funding & reimbursement models for DD and family populations
Increased community awareness & understanding of the signicant role secondary & tertiary prevention plays in wellness
Communicating with the provider/community}Raise awareness by 211 (hot line), social media, app
Aging caregivers
Selfcare for caregivers (not just respite)i.e. parent to parent fellowship workshops, day trips
How to help agency with possible changed in the ACA
Reduce poverty
Improve access to care- Front Door
Worksite wellness programs to enhance mental as well as physical heatlh
Managed care/payment charges, value based payment (medicaid & non-medicaid)
Access -what -where -how
Access to solution based services=crisis/short & long term
More options/level of care options to avoid crisis intervention need for

Intergration of Service
A holistic approach to treating addiction and mental illness
Regulatory reform: Health, DD, MH and SA still have different rules that force providers into silos
Better integration of developmental disabilities with mental health/substance abuse, etc.
Services need to be structured to meet the needs of the family as a unit. When one member is struggling, ill or in crisis it effects everyone in the household.
A holistic approach in providing treatment that is centrally located and interconnected. Lessen the burden of repeatedly supplying same information to multiple providers
A holistic approach in providing treatment that is centrally located and interconnected. Lessen the burden
Increased collaboration with law enforcement and SUD/Behavior health peers working as such
Establish a more effective community response to child/youth presentations that spark the debate of it being "behavioral vs. psychiatric" and often results in "cracks" in the system and youth not getting the help they need

Expand the current school-based efforts in the city (e.g. school-based health & mental health clinics, placement of child welfare liaisons, etc.) to a county-wide scope.
Rehabilitation Center for Special need services
Access to Psychiatric services for individuals with dual diagnosis of IDD/MH with a primary diagnosis of IDD.
Mobile Crisis teams to support certified IRA's (OPWDD residential services) for individuals with dual diagnosis of IDD/MH (instead of CPEP).
School options w/psychiatry new day treatment options
Wrap around services for mothers and children living in poverty
Access to services for individuals that don't qualify for in home services due to living in a certified IRA. Example: specialized nursing care, nutritional counseling, in home OT/PT services, etc
How best to approach individuals sub. abuse & mental health related issues in a coordinated manner. How best to approach individuals sub. abuse & mental health related issues in a coordinated manner.
Not enough or adeq.svcs for persons (aging parents) w/DD & MH
Strengthern economic/job/housing opportunities for those with SA and or MH issues
Improved linkage of Temporary Assistance "Exempt" population with appropriate community resources-enabling them to work and/or improved wellness. Exempt -conditions preventing them to work (Approx. 2000 adults)
Heatlh Home roll out/waiver connect to HH increased M-HS Seven Challenges-adolescent SU specific MH foster care population
Increase regional partership & collaboration
Business community needs to be considered "providers"& important professionals in wellness roles! Businesses interface with MH, SU & DD communities very often.

ng Survey

Area			Child/Adult			Lens			
Mental Health **(MH)** Developmental Disabilities **(DD)** Substance Use **(SU)Mental Health (MH)** Developmental Disabilities **(DD)** Substance Use **(SU)**			Adult **(A)** Child **(C)** Transitional Age (16-25 years old) **(TC) Adult (A)** Child **(C)** Transitional Age (16-25 years old) **(TC)**			**1.)** Peer and Family **2.)** Regional Collaboration **3.)** Behavioral and Physical Health Integration **4.)** Health Disparities and Social Determinants of Health **1.)** Peer and Family **2.)**			
MH	**DD**	**SU**	**A**	**C**	**TC**	**1**	**2**	**3**	**4**
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