2017
Local Services Plan
For Mental Hygiene Services

Onondaga Co Dept of Adult & LTC
August 15, 2016

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 Needs Assessment Report
Onondaga County Dept of Mental Health (70200)
Certified: Matthew Roosa (5/31/16)

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

Attachments

- Onondaga County Needs assessment Clinic clients Top 31.xlsx
- Onondaga Co 2017 LSP Summary Document1.docx

PART A: Local Needs Assessment

1. Assessment of Mental Hygiene and Associated Issues - In this section, describe the nature and extent of mental hygiene disabilities and related issues. Use this section to identify any unique conditions or circumstances in the county that impact these issues. You have the option to attach documentation, as appropriate.

see attached

2. Analysis of Service Needs and Gaps - In this section, describe and quantify (where possible) the prevention, treatment and recovery support service needs of each disability population, including other individualized person-centered supports and services. Describe the capacity of existing resources available to meet the identified needs, including those services that are accessed outside of the county and outside the funded and certified service system. Describe the gaps between services needed and services provided. Describe existing barriers to accessing needed services. Identify specific underserved populations or populations that require specialized services. You have the option to attach documentation, as appropriate.

see attached

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

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

x) Workforce Recruitment and Retention	◉	○	○	◉	○	○
y) Coordination/Integration with Other Systems	◉	○	○	○	○	○
z) Other (specify):	○	○	◉	○	○	◉
Developmental Disability Services:						
aa) Crisis Services	◉	○	○	◉	○	○
bb) Clinical Services	○	◉	○	○	◉	○
cc) Children Services	○	◉	○			
dd) Adult Services				○	◉	○
ee) Student/Transition Services	○	◉	○	◉	○	○
ff) Respite Services	○	◉	○	○	◉	○
gg) Family Supports	○	◉	○	○	◉	○
hh) Self-Directed Services	◉	○	○	○	◉	○
ii) Autism Services	○	◉	○	◉	○	○
jj) Person Centered Planning	○	◉	○	○	◉	○
kk) Residential Services	○	◉	○	○	◉	○
ll) Front Door	◉	○	○	◉	○	○
mm) Transportation	○	◉	○	○	◉	○
nn) Service Coordination	○	◉	○	○	◉	○
oo) Employment	○	◉	○	○	◉	○
pp) Workforce Recruitment and Retention.	○	◉	○	○	◉	○
qq) Coordination/Integration with Other Systems.	○	○	◉	○	○	◉
rr) Other (specify):	○	○	◉	○	○	◉

Follow-up Questions to "Prevention Services" (Question 3a)

3a1. Briefly describe the issue and why it is a high need for the populations selected.
Item was chosen as a top priority by community stake holders. See LSP summary for details.

Follow-up Questions to "Opioid Treatment Services" (Question 3d)

3d1. Briefly describe the issue and why it is a high need for the populations selected.
The Opioid crisis continues to have a major impact, with a substantial increase in overdoses, and fatalities.

Follow-up Questions to "Housing" (Question 3g)

3g1. Briefly describe the issue and why it is a high need for the populations selected.
Access to high quality affordable housing with adequate supports remains a primary obstacle to healthy recovery.

Follow-up Questions to "Transportation" (Question 3h)

3h1. Briefly describe the issue and why it is a high need for the populations selected.
Item was chosen as a top priority by community stake holders. See LSP summary for details.

Follow-up Questions to "Recovery Support Services" (Question 3i)

3i1. Briefly describe the issue and why it is a high need for the populations selected.
Item was chosen as a top priority by community stake holders. See LSP summary for details.

Follow-up Questions to "Workforce Recruitment and Retention" (Question 3j)

3j1. Briefly describe the issue and why it is a high need for the populations selected.
Item was chosen as a top priority by community stake holders. See LSP summary for details.

Follow-up Questions to "Coordination/Integration with Other Systems" (Question 3k)

3k1. Briefly describe the issue and why it is a high need for the populations selected.
Item was chosen as a top priority by community stake holders. See LSP summary for details.

Follow-up Questions to "Clinic Treatment Services" (Question 3p)

3p1. Briefly describe the issue and why it is a high need for the populations selected.
Clinic services have become the foundation of the service system, and are being asked to support individuals with higher and higher levels of need. significant access challenges exist, given wait lists and the prescriber shortage.

Follow-up Questions to "HARP HCBS Services (Adult)" (Question 3s)

3s1. Briefly describe the issue and why it is a high need for the populations selected.
Item was chosen as a top priority by community stake holders. See LSP summary for details.

Follow-up Questions to "Housing" (Question 3v)

3v1. Briefly describe the issue and why it is a high need for the populations selected.
Item was chosen as a top priority by community stake holders. See LSP summary for details.

Follow-up Questions to "Transportation" (Question 3w)

3w1. Briefly describe the issue and why it is a high need for the populations selected.
Item was chosen as a top priority by community stake holders. See LSP summary for details.

Follow-up Questions to "Workforce Recruitment and Retention" (Question 3x)

3x1. Briefly describe the issue and why it is a high need for the populations selected.
Item was chosen as a top priority by community stake holders. See LSP summary for details.

Follow-up Questions to "Coordination/Integration with Other Systems" (Question 3y)

3y1. Briefly describe the issue and why it is a high need for the populations selected.
major systems transformations (Medicaid, DSRIP, RPC, prevention agenda, etc) are currently requiring coordination at multiple levels.

Follow-up Questions to "Crisis Services" (Question 3aa)

3aa1. Briefly describe the issue and why it is a high need for the populations selected.
The OMH mental health crisis system remains the de facto crisis support for individuals with DD.

Follow-up Questions to "Student/Transition Services" (Question 3ee)

3ee1. Briefly describe the issue and why it is a high need for the populations selected.
Item was chosen as a top priority by community stake holders. See LSP summary for details.

Follow-up Questions to "Self-Directed Services" (Question 3hh)

3hh1. Briefly describe the issue and why it is a high need for the populations selected.
Item was chosen as a top priority by community stake holders. See LSP summary for details.

Follow-up Questions to "Autism Services" (Question 3ii)

3ii1. Briefly describe the issue and why it is a high need for the populations selected.
Item was chosen as a top priority by community stake holders. See LSP summary for details.

Follow-up Questions to "Front Door" (Question 3ll)

3ll1. Briefly describe the issue and why it is a high need for the populations selected.
Item was chosen as a top priority by community stake holders. See LSP summary for details.

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

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

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

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

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

see attached

5. How have the overall needs of the **substance use disorder** population changed in the past year?
○ a) Overall needs have stayed about the same.
○ b) Overall needs have improved.
◉ c) Overall needs have worsened.
○ d) Overall needs have been a mix of improvement and worsening.
○ e) Not sure.

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

Opiate use.

6. How have the overall needs of the **developmentally disabled** population changed in the past year?
○ a) Overall needs have stayed about the same.
○ b) Overall needs have improved.
○ c) Overall needs have worsened.
◉ d) Overall needs have been a mix of improvement and worsening.
○ e) Not sure.

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

see attached

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

7. In the past year, has your agency been included in collaborative planning activities related to the Prevention Agenda 2013-2018 with your Local Health Department?
◉ a. Yes
○ b. No

7a. Briefly describe those planning activities with your Local Health Department.

The Onondaga County LGU and Health Department have been engaged in in a number of activities that have enhanced collaboration. These have included DSRIP planning, prevention agenda, Opiates, and other issues.

8. In the past year, has your agency participated in collaborative planning activities with other local government agencies and non-government organizations?
◉ a. Yes
○ b. No

8a. Briefly describe those planning activities with other local government agencies and non-government organizations.

Onondaga County maintains an ongoing relationship with the four contiguous counties for planning purposes, and has also been active in planning regionally through DSRIP and RPC activities with the other Counties of the region.

9. In the past year, has your agency participated in collaborative planning activities with other other LGUs in your region?
◉ a. Yes
○ b. No

9a. List each activity and the LGU(s) involved in that collaboration and provide a brief (one or two sentence) description of the activity.

While previous years have seen formal collaborative planning exercises with an LSP focus, current collaborations have been related to the items listed above ((DSRIP, RPC, etc).

9b. Did your collaborative planning activities with other LGUs in your region include identifying common needs that should be addressed at a regional level?
○ a. Yes
◉ b. No

9c. Did the counties in your region reach a consensus on what the regional needs are?
○ a. Yes

◉ b. No

2017 Multiple Disabilities Considerations Form
Onondaga County Dept of Mental Health (70200)
Certified: Matthew Roosa (5/11/16)

Consult the LSP Guidelines for additional guidance on completing this form.
LGU: Onondaga County Dept of Mental Health (70200)

The term "multiple disabilities" means, in this context, persons who have at least two of the following disabling conditions: a developmental disability, a mental illness, or an addiction. In order to effectively meet the needs of these individuals, several aspects should be addressed in a comprehensive plan for services. Accordingly:

1. Is there a component of the local governmental unit which is responsible for identifying persons with multiple disabilities?

◉ Yes
○ No

If yes, briefly describe the mechanism used to identify such persons:

It is the expectation of our Department that all services have the capacity to identify and serve individuals with co-occurring disorders. The Onondaga County Dual Recovery Coordinator continues to assess the capacity for co-occurring disorder screening in MH and CD provider orgs, and to develop specific interventions to enhance this assessment among those services with a lower level of screening capacity (e.g. residential services)Our Department has also developed the Strategic response Team (SRT) meeting process designed to bring together all of the service providers and natural supports involved with an individual, when the existing community resources do not appear to be adequate to meet the presenting need. Most of the individuals with whom this SRT process is conducted have co-occurring conditions. Typically they have both developmental disabilities and mental health conditions. Given the lack of access to crisis and acute care resources within the OPWDD system, many individuals with significant developmental; disabilities end up stuck in OMH licensed inpatient facilities. A lack of OPWDD residential service options makes it very difficult to discharge these individuals, even though they do not benefit from ongoing mental health inpatient care.

2. Is there a component of the local governmental unit which is responsible for planning of services for persons with multiple disabilities?

◉ Yes
○ No

If yes, briefly describe the mechanism used in the planning process:

Our Dual recovery coordinator is responsible for system wide promotion of effective service deliver to individuals with co-occurring substance use and mental health conditions, and has been instrumental in increasing the capacity for effective COD intervention.

Our Director of Planning and QI has been engaged in recent months in efforts to address the challenges related to serving people with co-occurring DD and MH conditions identified above in #1.

3. Are there mechanisms at the local or county level, either formal or informal in nature, for resolving disputes concerning provider responsibility for serving persons with multiple disabilities?

◉ Yes
○ No

If yes, describe the process(es), either formal or informal, for resolving disputes at the local or county level and/or at other levels of organization for those persons affected by multiple disabilities:

We continue to receive reports from providers regarding challenges accessing OPWDD services for those currently served in OMH settings who have co-occurring developmental disabilities. Increasing challenges to finding residential and service opportunities for these individuals result from a number of factors. There is a pervasive perception on the part of many that OPWDD eligibility criteria continue to be used as a gate keeper to prevent access to needed care, and as a means to shift those with co-occurring conditions toward OMH care.

With the exception of the continued challenge regarding accessing DD supports for individuals with co-occurring DD and MH, we are relatively satisfied with our systems ability to be flexible and person centered in addressing the complex needs of those with multiple conditions.

Mental Hygiene Priority Outcomes Form
Onondaga County Dept of Mental Health (70200)
Plan Year: 2017
Certified: Matthew Roosa (5/31/16)

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

Attachments

- Onondaga County Needs assessment Clinic clients Top 3.xlsx
- Onondaga Co 2017 LSP Summary Document.docx

2017 Priority Outcomes - **Please note that to enter information into the new items under each priority, you must click on the "Edit" link next to the appropriate Priority Outcome number.**

Priority Outcome 1:

Improve access to outpatient mental health treatment as the cornerstone to the system of care.

Progress Report: (optional) *new*

Priority Rank: 1

Applicable State Agency: OMH

Aligned State Initiative: *new*

☑ The Prevention Agenda 2013-2018

Is this priority also a Regional Priority? *new* Not Sure

Strategy 1.1

Sustain current services and expand community and school based clinics.
Applicable State Agency: OMH

Strategy 1.2

Reduce time to first appointment through length of stay analysis, and developing infrastructure for urgent response.
Applicable State Agency: OMH

Strategy 1.3

Improve integration / coordination between primary and mental health care via DSRIP and other related initiatives.
Applicable State Agency: OMH

Strategy 1.4

Address transportation challenges that reduce access to care.
Applicable State Agency: OMH

Strategy 1.5

Develop a mental health clinic service for refugees and immigrants.
Applicable State Agency: OMH

Strategy 1.6

Develop strategies for outreach to seniors to address depression and substance use.
Applicable State Agency: OMH

Strategy 1.7

Engage community stake holders to explore best practices for enhancing the response to pregnant women with substance use and mental health conditions.
Applicable State Agency: OMH

Priority Outcome 2:

Improve crisis mental health services.

Progress Report: (optional) *new

Priority Rank: 3

Applicable State Agencies: OASAS OMH OPWDD

Aligned State Initiative: *new

Is this priority also a Regional Priority? *new Not Sure

Strategy 2.1

Partner with DSRIP in the development and implementation of new crisis stabilization services (mobile crisis, peer respite, etc.).
Applicable State Agencies: OASAS OMH

Strategy 2.2

Enhance suicide prevention efforts through a new County suicide prevention coalition.
Applicable State Agencies: OASAS OMH OPWDD

Priority Outcome 3:

Reduce behavioral health inpatient admissions and ER/CPEP presentations.

Progress Report: (optional) *new

Priority Rank: 2

Applicable State Agencies: OASAS OMH OPWDD

Aligned State Initiative: *new

☑ Adult Medicaid Behavioral Health Managed Care Implementation
☑ Child Medicaid Behavioral Health Managed Care Implementation

Is this priority also a Regional Priority? *new Not Sure

Strategy 3.1

Partner with DSRIP in the development and implementation of new crisis stabilization services (mobile crisis, peer respite, etc.).
Applicable State Agencies: OASAS OMH OPWDD

Strategy 3.2

Implement Peer engagement specialist service to address substance use related ER presentations.
Applicable State Agencies: OASAS OMH

Strategy 3.3

Enhance Outpatient access (see Priority one).
Applicable State Agencies: OASAS OMH OPWDD

Priority Outcome 4:

Assess work force development needs.

Progress Report: (optional) *new

Priority Rank: *Unranked*

Applicable State Agencies: OASAS OMH OPWDD

Aligned State Initiative: *new

Is this priority also a Regional Priority? *new Not Sure

Strategy 4.1

Explore opportunities for training collaboration through surveys and focus group work with Executive Directors and subcommittees.
Applicable State Agencies: OASAS OMH OPWDD

Priority Outcome 5:

Develop the new LGU role in the emerging behavioral health environment.

Progress Report: (optional) *new*

Priority Rank: *Unranked*

Applicable State Agencies: OASAS OMH OPWDD

Aligned State Initiative: *new*

Is this priority also a Regional Priority? *new* Yes

Strategy 5.1

Continued collaboration with DSRIP.
Applicable State Agencies: OASAS OMH OPWDD

Strategy 5.2

Partner with all stake holders for successful RPC implementation.
Applicable State Agencies: OASAS OMH OPWDD

Priority Outcome 6:

Reduce recidivism of people with mental health and substance use conditions who are frequently arrested.

Progress Report: (optional) *new*

Priority Rank: *Unranked*

Applicable State Agencies: OASAS OMH

Aligned State Initiative: *new*

Is this priority also a Regional Priority? *new* Not Sure

Strategy 6.1

Use OMH Corrections pilot grant to develop a system for data sharing and care coordination across forensic, treatment, and other service environments.
Applicable State Agencies: OASAS OMH

Priority Outcome 7:

Develop residential supports for individuals who are poorly served and/or banned from typical residential environments due to their high level of need.

Progress Report: (optional) *new*

Priority Rank: *Unranked*

Applicable State Agencies: OASAS OMH OPWDD

Aligned State Initiative: *new*

Is this priority also a Regional Priority? *new* Not Sure

Strategy 7.1

Work with all stake holders to define a model and financing needed to pilot a program.
Applicable State Agencies: OASAS OMH OPWDD

Priority Outcome 8:

Enhance access to opiate treatment.

Progress Report: (optional) *new*

Priority Rank: 4

Applicable State Agency: OASAS

Aligned State Initiative: *new

☑ Combat Heroin and Prescription Drug Abuse

Is this priority also a Regional Priority? *new Yes

Strategy 8.1

Continue efforts to increase the volume of Medication Assisted Treatment (MAT).
Applicable State Agency: OASAS

Strategy 8.2

Collaborate with community initiatives to enhance public education and treatment access.
Applicable State Agency: OASAS

Priority Outcome 9:

Define the target needs of transition age youth.

Progress Report: (optional) *new

Priority Rank: *Unranked*

Applicable State Agencies: OASAS OMH OPWDD

Aligned State Initiative: *new

Is this priority also a Regional Priority? *new Not Sure

Strategy 9.1

Engage key stake holders in a renewed effort to define the unique service/ support needs of transition age youth.
Applicable State Agencies: OASAS OMH OPWDD

Priority Outcome 10:

10. Enhance stake holder collaboration across the prevention treatment continuum.

Progress Report: (optional) *new

Priority Rank: 5

Applicable State Agencies: OASAS OMH OPWDD

Aligned State Initiative: *new

☑ The Prevention Agenda 2013-2018
☑ Population Health Improvement Plan (PHIP)

Is this priority also a Regional Priority? *new Not Sure

Strategy 10.1

Develop a plan for integrating substance use treatment and prevention services.
Applicable State Agency: OASAS

Strategy 10.2

Partner with local and State Health Departments to create a plan to integrate efforts, raise community awareness, and develop a primary prevention agenda for behavioral health.
Applicable State Agencies: OASAS OMH

2017 Community Service Board Roster
Onondaga County Dept of Mental Health (70200)
Certified: Gigi Love (3/10/16)

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

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	Rosalee Jenkins
Physician	No
Psychologist	No
Represents	Parent Partners @ Onondaga Case Managment Services
Term Expires	12/31/2019
eMail	rjenkins@ocmsinc.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

Member	
Name	Stephen Russell

Physician	No	**Physician**	No
Psychologist	No	**Psychologist**	No
Represents	Onondaga County DSS: Economic Security	**Represents**	Liberty Resources
Term Expires	12/31/2016	**Term Expires**	12/31/2016
eMail	sarah.merrick@dfa.state.ny.us	**eMail**	srussell@liberty-resources.org

OMH Transformation Plan Survey
Onondaga County Dept of Mental Health (70200)
Certified: Gigi Love (5/11/16)

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

The OMH Transformation Plan aims to rebalance the agency's institutional resources by further developing and enhancing community-based mental health services throughout New York State. By doing so the Plan will strengthen and broaden the public mental health system to enhance the community safety net; allowing more individuals with mental illness to be supported with high quality, cost-effective services within home and community-based settings and avoid costly inpatient psychiatric stays.

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

1. Did your LGU/County receive OMH Transformation Plan Reinvestment Resources (State and Locally funded) over the last year?

- (●) a) Yes
- ( ) b) No
- ( ) c) Don't know

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

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

2017 Mental Hygiene Local Planning Assurance
Onondaga County Dept of Mental Health (70200)
Certified: Matthew Roosa (5/31/16)

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

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

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

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

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

OASAS, OMH and OPWDD accept the certified 2017 Local Services Planning Assurance form in the Online County Planning System as the official LGU assurance that the above conditions have been met for the 2017 Local Services planning process.

May 2016 Needs Assessment Summary: Mental Health (MI

	All Organizations	Arise	Crouse
All Respondents	OP for MH	OP for MH	Job training/Educ Supp
	Peer Supports	Support for family	OP for CD
	Job training/Educ	Crisis & Emerg.	Help getting benefits
Men	OP for MH	Crisis & Emerg.	OP for CD
	Job training/Educ	IP for MH	Peer Supports
	OP for CD	OP for MH	Support for family
		Support for family*	Job training/Educ Supp*
Women	OP for MH	OP for MH	Help getting benefits
	Peer Supports	Support for family	Job training/Educ Supp
	Support for family	Crisis & Emerg.	Housing Support
Under 18 y.o.	OP for MH	OP for MH	
	Job training/Educ	Support for family	
	Peer Support	Crisis & Emerg.	
		IP for MH*	
18-25 y.o.	OP for MH	OP for MH	Peer Supports
	Job training/Educ	OP for CD	Job training/Educ Supp
	Peer Support	Peer Support	OP for CD
26-50 y.o.	OP for MH	OP for MH	Job training/Educ Supp
	Job training/Educ	Support for family	Housing Support
	Housing Support	Crisis & Emerg.	OP for CD
			Support for family*
Over 50 y.o.	OP for MH	OP for MH	OP for CD
	Transportation	Crisis & Emerg	Help getting benefits
	Peer Support	Help getting benefits	services
	Support for family*	Housing Supports*	

*** More than 3 top scores due to tied number of votes.**

H) & Chemical Dependency (CD) clinic clients, Top 3 Responses

HPC Sunrise	liberty	SBH	St Joes
Peer Supports	OP for MH	OP for CD	OP for MH
OP for MH	Peer Supports	OP for MH	Transportation
OP for CD	Support for family	Housing Supports*	Job training/Educ Supp
Transportation*		Job training/Educ Supp*	
OP for CD	OP for MH	OP for CD	Transportation
Peer Supports	Crisis & Emerg	Job training/Educ Supp	OP for MH
OP for MH	Peer Support	Housing Supports	Housing Support
Peer Supports	OP for MH	OP for MH	OP for MH
Transportation	Support for family	OP for CD	Job training/Educ Supp
OP for MH	Peer Support	Housing Supports	Transportation
	services*		
	OP for MH	Help getting benefits	
	Peer Supports	Housing Supports	
	Support for family	Job training/Educ Supp	
	OP for MH	Job training/Educ Supp	Peer Supports
	Crisis & Emerg	OP for CD	OP for MH
	Peer Support	Housing Supports	Support for family
			Help getting benefits*
OP for MH	OP for MH	OP for MH	Job training/Educ Supp
Crisis & Emerg	services	IP for CD	Transportation
Peer Support	Support for family	Housing Supports	OP for MH
OP for MH	OP for MH	IP for CD	OP for MH
Peer Supports	services	OP for MH	Transportation
Transportation	Crisis & Emerg.	OP for CD	Help getting benefits
	Support for family*	Support for family*	Housing Support*

Onondaga County 2017 Local Services Plan Summary

A range of data analysis and key stake holder feedback has resulted in the following issues being designated as current key areas of concern for Onondaga County. This summary represents a portion of the data analysis community outreach, and planning processes that occur throughout the year, and provides rationale for the priority Outcomes found near the end of the document.

Regionalization and systems integration/ the new role for the LGU

At the end of this document in a two page piece that likens the LGU to a family farm, and encourages a focus on moving the LGU toward a new role. This new role recognizes the unique attributes of the LGU as a key contributor to the regionalization and systems integration that is currently underway. A number of key initiatives are moving planning and service provision away from a county centric model and toward a regional orientation that has the potential to provide better care at a reduced cost.

The integration of primary care and behavioral health care, and the integration of public health and LGU functions, are fast becoming the new norm. Zip codes in Syracuse have some of the highest rates of preventable hospital admission in the region, and there is clearly a need for an integrated approach to reduce these rates.

While this new regional and integrated approach offers much potential, there is a risk that the local systems and relationships that support the service systems will be lost in this transition. The LGU role as local broker/ convener/ facilitator will be a critical source for local infrastructure to support regional and state agendas. It will also serve as a bridge across service areas as we develop a more integrated service approach. The LGU can also serve to support providers in their effort to avoid “Initiative Fatigue”, as they are forced to address one new thing after another. These are some of the ways that the LGU will maintain its important role in this time of tremendous change.

Poverty and social determinants of health

Recent months have seen a number of sources point out the painful degree of economic and racial segregation that exists in Syracuse and Onondaga County. Many of our efforts to gather

feedback from recipients of mental health and substance use services continue to indicate that the recovery of many individuals is hindered by poverty. We are also gaining additional understanding regarding the ways that early trauma and environmental challenges impact functioning in later life. We have known for some time that people with serious mental illness die much earlier than the rest of the population. We are now beginning to understand that the same is true for those who are poor. And many with serious mental illness are very poor. Poverty creates vulnerability to mental illness and substance use, and mental illness and substance use create vulnerability to poverty. There is clearly a need to further coordinate behavioral health efforts with social services that address poverty, and to recognize that access to jobs and affordable housing are just as important as access to medications and therapy.

Opioids

In 2011 Opioid admission surpassed alcohol admissions at Crouse Hospital, and just kept climbing from there. During the last 10 years opioid admissions at Crouse have more than tripled, with an 800% increase in heroin admissions in the last fifteen years. The heroin related mortality rate for Onondaga County has seen increases that are substantially higher that the national average and the rest of New York State (excluding NYC). According to Data from Crouse the number of young adults (26-35) and pregnant women being admitted for opioid treatment have both more than doubled in the last five years. Onondaga County rates for Neonatal Abstinence Syndrome (NAS) were the highest in the state in 2012. While no longer the highest in New York, they continue to rise.

Significant efforts are underway to enhance service capacity for opiate treatment in Onondaga County, and these efforts will have a broader regional impact. That is because the lack of treatment capacity in surrounding counties has placed a significant pressure on the local capacity, as individuals from other communities come to Onondaga County for care. Opioid treatment enhancement has significant overlap with other priority concerns, as we work to integrate behavioral and physical care, and work to reduce emergency room presentations through effective utilization of other levels of care.

Disproportionate representation of those with mental health and substance use conditions among those arrested and incarcerated.

A range of data sources indicate that a disproportionately high rate of incarcerated individuals suffer from serious mental illness and substance use conditions. Many have written of the failure of our community based care system to adequately support individuals with serious mental illness after de-institutionalization. The resulting trend has seen the thousands of individuals who might have formally been institutionalized in a psychiatric facility now being institutionalized in prison. America's largest jails now serve as the largest prescribers of

psychiatric medications. Onondaga County has developed a multi-departmental team to develop strategies to coordinate with community providers to try to reduce the arrest rates of this population.

The critical role of outpatient clinic services

A long standing priority has been placed on efforts to insure that individuals receive care in the least restrictive environment (the lowest level of care) to insure community integration and opportunities for a healthy recovery. This value has recently been joined by a cost containment agenda which seeks to prevent very expensive inpatient care whenever possible, and to integrate care for both behavioral and primary care health needs in clinic environments. The union of these priorities has placed a significant amount of pressure on the outpatient clinic system, as it is asked to serve larger and larger volumes of individuals who suffer from more acute symptoms. A resulting access challenge has resulted, with waiting lists that push people back toward emergency care. Onondaga County is currently engaged in several strategies designed in increase clinic access through the development of new resources, and through the efficient utilization of existing resources. This includes efforts to serve a diverse population, including immigrants, refugees, and seniors.

Cost Containment

Many of the transformational changes impacting our health care service system currently are designed to contain ever rising Medicaid costs. Shifts toward managed care and pay for performance models are designed to move care away from fee-for-service models that do not create incentives for quality outcomes. The Onondaga County LGU seeks to align with a range of initiatives that are supporting the implementation of these new models, and is dedicated to supporting providers as they transition their systems. Performance incentives that reward the achievement of outcomes create an important “win-win” in which providers prosper when they support recipients in ways that achieve real results.

Peer Support

Significant progress has been made in Onondaga County to bolster a range of peer services for mental health and substance use services, and additional peer services are currently under development. These include peer engagement specialists who will support individuals with substance use related ER presentations through a grant from OASAS, and the development of peer respite services through DSRIP. There has been a significant transition in the community of providers, as more become aware of the unique value that peer services have to offer. Current efforts are underway to engage in regional efforts to further the development of quality peer supports.

Residential supports for the people we do not serve well.
Individuals with a history of violence, aggression, sexual behaviors, property destruction, poor self-care skills, serious mobility limitation and health conditions etc. are often difficult to place in residential supports. In past years a periodic planning meeting (Strategic Response Team or SRT meeting) would be required in order for the Onondaga County LGU to support a group of organizations in trying to find service solutions for individuals with complex needs. Rather than viewing these people as challenging, we have chosen to view our service system as inadequate to the task of supporting the presenting needs, and have sought to find creative means to address these inadequacies to meet unique needs. .

Recent months have seen an increase in calls for such planning meetings. An increasing volume of community resources is being utilized to resolve the challenges associated with these individuals being housed in inappropriately high and expensive levels of care. Our system has also struggled to meet unique needs in lower and inadequate levels of care through the additional of staffing resources. A combination of multiple factors similar to those driving the higher levels of acuity in outpatient care have increased this need, including reduced access to long term inpatient care, and a push toward community based treatment. There is currently a significant cohort of individuals who are prohibited from receiving residential services, based upon state regulations, provider policy, and insurance liabilities, due to a history of challenging behaviors and symptoms. These individuals are not capable of living independently, and are in need of 24 hr. supports. Onondaga's LGU is currently beginning a process designed to explore ways to create a unique residential environment that can provide the needed supports to insure the wellbeing of these individuals.

Community Services Board development and survey: engaging key stake holders.
The maintenance of subcommittees for the Onondaga County CSB has been a long standing challenge. While the CSB has maintained a diverse and strong participation, it has been difficult to recruit and maintain membership for the 3 subcommittee groups. This challenge has increase in recent years, given the volume of major initiatives and changes that have impacted the behavioral health community. These major changes have placed additional demands on the time of key stake holders who might otherwise participate in the subcommittees.

Given this challenge, the Onondaga County CSB, in conjunction with LGU staff, developed a plan for the development of "virtual" subcommittees. These new subcommittees would communicate primarily via emails and surveys, and would serve as a principal resource for gathering community feedback, without requiring meeting attendance on a regular basis.

A strong pool of individuals was recruited to participate. Membership volume in the CSB and subcommittees is reflected below.

Community Services Board	14
Chemical Dependency Subcommittee	21
Developmental Disabilities Subcommittee	31
Mental health Subcommittee	38

An initial survey of the group was designed to support the completion of Local Services Plan requirement for submission of ranked service priority areas. The table below reflects the results of that survey. These subcommittee responses, along with the responses from a service recipient survey (see below) were both used to support the development of priority outcomes and strategies.

Service Area	**#1 priority service area**	**#2 priority service area**	**#3 priority service area**
Dev. Dis. Youth	Front Door	Self-directed services	Service coordination
Dev. Dis. Adult	Front Door	Autism services	Student Transition services
Mental Health Youth	Transportation	Workforce	Housing
Mental Health Adult	HARP, HCBS	Workforce	Transportation
Substance Use Youth	Coordination/ integration	Workforce	Transportation
Substance Use Adult	Transportation	Recovery supports	prevention

Cross cutting themes from the Subcommittee survey:
<u>The OPWDD "Front Door" initiative</u> is designed to provide people with information that options that insure a higher level of self-determination and community integration. It is clear from the responses that this initiative is a primary focal point for stake holders involved with the DD system.

<u>Transportation</u> remains a major concern, and received more votes than any other item across the six service area categories. The lack of public transportation, in conjunction with a

Medicaid transportation system that is often described as difficult to access and of poor quality, leave many individuals isolated and struggling to access services.

Work force recruitment and retention received the second highest number of votes across the six categories. It is clear that the stake holders who participated are well aware of the challenges of staffing behavioral health services. Budgetary constraints force organizations to offer low salaries for many entry level positions, and to struggle to hire and retain high quality staff as a result. Staff shortages in key professional categories also result in work force challenges. Many respondents commented on the challenges related to accessing medications, which have been primarily driven by a shortage of prescribers.

Coordination/ integration: while not a top 3 item in most of the response categories, this category consistently received a high number of votes, and received the third largest vote total across the six service areas. This is particularly noteworthy, as specific and more concrete issues (e.g. transportation, housing) tend to attract more votes. The fact that this category received so many votes indicates that community stake holders are well aware of the critical need to integrate and coordinate diverse services in order to move the service systems toward better outcomes, more efficiency, and more person centered supports. Many respondents made comments expressed the need for more services for those with co-occurring conditions.

Based upon the above feedback and a broader analysis of planning resources, the following prioritization grid has been developed for submission as part of the Onondaga County Local services Plan. The Grid indicates high, medium, and low priority levels, with high priority for those items rated as high by the subcommittees, or through other planning activities. The last lines of the table reflect low priority scores for coordination/ integration between developmental disability services and other systems. While this item is often described as a priority for many recipients and service providers, recent challenges in efforts to engage OPWDD have resulted in a general state of hopelessness among all stake holders regarding the likelihood of any substantive response or plan to support such efforts, resulting in the low priority scores. As such, these scores reflect a belief that little can currently be done in this area, rather than a reduced desire to see action.

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

w) Transportation

x) Workforce Recruitment and Retention

y) Coordination/Integration with Other Systems

Developmental Disability Services:

aa) Crisis Services

bb) Clinical Services

cc) Children Services

dd) Adult Services

ee) Student/Transition Services

ff) Respite Services

gg) Family Supports

hh) Self-Directed Services

ii) Autism Services

jj) Person Centered Planning

kk) Residential Services

ll) Front Door

mm) Transportation

nn) Service Coordination

oo) Employment

pp) Workforce Recruitment and Retention.

qq) Coordination/Integration with Other Systems.

Recipient survey: Which Services Should We Grow and Improve?

In order to insure a strong consumer voice in our effort to define service priorities, Onondaga County developed a simple paper survey to administer to recipients of services in a number of agency settings. Like the above CSB subcommittee survey, this data gathering was also focused on defining unmet need in priority service areas. As sex and age data were collected, we were able to sort the data to gain a better understanding of the needs of some subpopulations.

Respondents were asked to choose 3 priorities from the list below that they judged to be *"most important for helping you to meet your needs and achieve your goals.".*

1. Crisis and emergency services (CPEP, emergency rooms, mobile outreach)
2. Outpatient clinic services for mental health
3. Outpatient clinic services for drug and alcohol use
4. Inpatient services for mental health
5. Inpatient services for drug and alcohol use
6. Peer support (support provided by people with your same experiences)
7. Support for family members
8. Help getting benefits (Medicaid, welfare, food stamps, etc.)
9. Housing support
10. Transportation
11. Job training/ education supports
12. Supports to help me get services, and organize my services.
13. Other supports_____

Responses were gathered during a week in May 2016 from six clinic services (four mental health and two substance use clinics). A total of 561 responses were gathered. The table below reflects the rank order of responses according to the number of votes received by each item.

Recipient Survey: which services should we grow & improve?		
1	OP for Mental Health	281
2	Peer Supports	148
3	Job training / Education	147
4	Housing Supports	137
5	OP for Chemical Dependency	135
6	Support for family	134
7	Transportation	122
8	Supports to help get services	122
9	Help getting benefits	112
10	Crisis & Emergency Services	87
11	IP for Mental Health	58
12	IP for Chemical Dependency	49

Attached as a separate file and addendum to this document is a summary of the top responses from each of the participating clinics based upon a number of demographic categories. This table sorts the top responses by clinic, by sex, and by age groups. This sorting reveals some interesting findings.

- Growth and improvement in outpatient mental health services was the #1 priority for all demographic groups, and was the #2 priority for one chemical dependency clinic.
- Transportation was a priority for respondents over 50 y.o. and was a top 3 priority for three organizations. It was less of a priority for younger respondents.
- Job training/ education was a top priority for four organizations.
- Several demographic groups chose peer support as a top 3 priority, including women, and all age groups other than the 26-50 y.o. group.
- Younger respondents (under 18y.o. and 18-25 y.o.) were far more likely to prioritize peer supports.
- More women than men chose family support, as a top 3 priority.

An open box was included at the end of the survey, asking, "*What else do you need to help you to meet your needs and achieve your goals?"* 88 respondents included comments in this box. Responses reflected the level of poverty among many recipients, and challenges related to financial management and employment. Other primary themes included the need for transportation and housing supports, and the desire for a wide range of peer and professional counseling and related services.

Provider survey: clinic challenges

Given the emerging role of clinics in our service system, we utilized a single question web based survey to gather feedback from clinic leaders using the following question.

Clinics are being asked to provide an expanding array of services, and are a corner stone of the systemic efforts to reduce hospitalization and costs. The result is a rising demand and acuity level among clients served. The shortage of prescribers and other providers make it difficult to respond to this demand. How can our clinics respond to this need with timely and effective services, given these and other challenges?

Nine clinics responded to this question. The items below were drawn from the narrative responses and were sorted into categories. There are a number of suggestions that reflect a creative orientation to this service dilemma, and they consider a range of strategies to increase the efficiency of our service system. A number of suggestions point toward the need to consider new approaches to serving current case loads to insure that capacity is maintained for new admissions. A number of suggestions also point toward creative means to address the prescriber shortage.

Prescribers

- Expand tele-psychiatry. Especially for hard to reach rural areas.

- create a stronger network with primary care physicians and nurse practitioners
- Increase consultation to primary care providers around psychopharmacology.
- Support legislation that would give prescription privileges to licensed psychologists.
- Remove the current suboxone cap (raise the number of clients from 100 to 200 per prescriber in OASAS clinics, and allow 100 clients per prescriber in non OASAS clinicians.)
- The lack of psychiatry
- Hire more nurse practitioners and PAs to work in clinic settings.

Other staff issues

- Increase staffing / Increase number of providers,
- Avoid over use/ inappropriate use of interns.
- Use more "peer support" (e.g., recovery counselors, peer counselors, etc.) to help extend clinical practice.

Program models and improvements

- Develop partial hospitalization services
- Combine clinic with primary care practices.
- Offer flexible hours
- Provide translation services
- Mobile crisis teams.
- Resurrect "traditional case management" (i.e., ICM, SCM) to help provide hands on support for impaired clients.
- Provide different service offerings for cohorts of recipients with more long term or maintenance needs
- increased use of group therapy
- Increasing mental health availability on outpatient /community clinics.
- Reimbursement to meet the additional staffing needs
- Increased collaboration between clinics;
- 2) Increase in off-site services;
- Increase volume of Mental Health Services
- Clinics need to talk to parents and get feedback from the community.
- Clinics need to allow families to receive medication management only.
- We need to expand funding for school based clinics to meet the needs of the community.

2017 priority outcomes.

Onondaga County has defined the items below as the priority outcomes for the 2017 Local Services Plan. This list is the result of a review of a number of data sources, local meetings, focus groups and surveys, including some of the data gathering described above. This list is also an effort to seek alignment with some of the key initiatives underway that will be transforming the service system in the coming years.

These priorities reflect several core themes:
Service Access: While relatively service rich in comparison with more rural counties, the demand on Onondaga County services remains high, with challenging waiting lists throughout the service system. A number of priorities seek to expand services, and to use existing services more efficiently in order to improve access to care.

Crisis Prevention: In keeping with the broader systems changes designed to reduce the cost of care through early preventive interventions, our local priorities have an emphasis on partnering with systems stake holders to develop and expand services that will enable individuals to remain healthy and avoid more intensive levels of care.

Recovery: Onondaga County maintains a strong commitment to recovery, as reflected in priorities that support individuals who have been struggling to achieve their goals and move forward toward recovery.

The Onondaga County CSB has defined the following four themes as important areas of focus, and as the key "Lenses" through which we should consider services issues and community need. The 2017 Priority outcomes above are well aligned with these Lenses.

Onondaga County CSB 4 Lenses:
Lens #1: Health Disparities and Social Determinants of Health: Recognize the importance of poverty and other social determinants of health as a means of insuring that services are accessible and utilized by underserved populations. Partner with the broader health system to foster primary prevention.

Lens #2: Regional Collaboration: Support a range of vehicles for enhancing access and service quality through the economies of scale and enhanced knowledge achieved through regional collaboration.

Lens #3: Behavioral and Physical Health Integration: assist in the implementation of a range of state and national initiatives that are focused on efforts to integrate care in order to reduce

stigma, enhance access, and insure quality for those with behavioral health conditions through an integration with primary care.

Lens #4: Peer and family Supports: Support the expansion of peer and family supports, and work to promote the value of these supports to assist in the achievement of recovery goals.

2017 Onondaga County LGU Priorities

1. **Improve access to outpatient mental health treatment as the cornerstone to the system of care.**

   Strategy 1: Sustain current services and expand community and school based clinics.
   Strategy 2: Reduce time to first appointment through length of stay analysis, and developing infrastructure for urgent response.
   Strategy 3: Improve integration / coordination between primary and mental health care via DSRIP and other related initiatives.
   Strategy 4: Address transportation challenges that reduce access to care.
   Strategy 5: Develop a mental health clinic service for refugees and immigrants.
   Strategy 6: Develop strategies for outreach to seniors to address depression and substance use.

   Strategy 7: Engage community stake holders to explore best practices for enhancing the response to pregnant women with substance use and mental health conditions.

2. **Improve crisis mental health services.**

   Strategy 1: Partner with DSRIP in the development and implementation of new crisis stabilization services (mobile crisis, peer respite, etc.).
   Strategy 2: Enhance suicide prevention efforts through a new County suicide prevention coalition.

3. **Reduce behavioral health inpatient admissions and ER/CPEP presentations.**

   Strategy 1: Partner with DSRIP in the development and implementation of new crisis stabilization services (mobile crisis, peer respite, etc.).

Strategy 2: Implement Peer engagement specialist service to address substance use related ER presentations.
Strategy 3: Enhance Outpatient access (see Priority one).

4. **Assess work force development needs.**

   Strategy 1: Explore opportunities for training collaboration through surveys and focus group work with Executive Directors and subcommittees.

5. **Develop the new LGU role in the emerging behavioral health environment.**

   Strategy 1: Continued collaboration with DSRIP.
   Strategy 2: Partner with all stake holders for successful RPC implementation.

6. **Reduce recidivism of people with mental health and substance use conditions who are frequently arrested.**

   Strategy 1: Use OMH Corrections pilot grant to develop a system for data sharing and care coordination across forensic, treatment, and other service environments.

7. **Develop residential supports for individuals who are poorly served and/or banned from typical residential environments due to their high level of need.**

   Strategy 1: Work with all stake holders to define a model and financing needed to pilot a program.

8. **Enhance access to opiate treatment.**

   Strategy 1: Continue efforts to increase the volume of Medication Assisted Treatment (MAT).
   Strategy 2: Collaborate with community initiatives to enhance public education and treatment access.

9. **Define the target needs of transition age youth.**

   Strategy 1: Engage key stake holders in a renewed effort to define the unique service/ support needs of transition age youth.

10. **Enhance stake holder collaboration across the prevention treatment continuum.**

    Strategy 1: Develop a plan for integrating substance use treatment and prevention services.

    Strategy 2: Partner with local and State Health Departments to create a plan to integrate efforts, raise community awareness, and develop a primary prevention agenda for behavioral health.

Local Government Units are like Family Farms
Economies of Scale for Planning

The age of the family farm is over. While they toiled mightily, technological advances and economic shifts left them unable to compete on production volume and speed. Small scale means higher costs.

Some family farms have survived. They have become agri-tourism destinations, or makers of artisanal goat cheeses. They have learned that they can survive by avoiding the head to head competition with big scale agriculture. They have learned to thrive by doing what only they can do, and doing it well.

Local Government Unit (LGU) planning is a lot like family farming. There are powerful systemic changes occurring that require economies of scale for systems planning. LGUs toiling in isolation are not going to be able to compete with the big systems that can rapidly deliver large volumes of planning information. The big management and data systems of state and federal government sources and managed care organizations can deliver timely planning and outcomes data for covered lives. LGUs cannot.

So what about the "goat cheese"? What are the unique contributions that the LGU brings to the table that cannot be achieved by these large systems? The Cheese that the LGUs can make comes in two key flavors:

1. Qualitative data: Surveys, focus groups, engagement of recipients and key stake holders, etc.: This work is only possible at the local level, by local stake holders, and LGUs are best able to do it.
2. Local Quantitative data collection and analysis: Granular, boots-on-the-ground data collection and analysis regarding local needs and populations using sources that are not available to the big data systems

Some family farms seek to toil on, doing the same work that they have done for generations, without turning to cheese or tourism, and without seeking a buy out from big agriculture. Similarly, some LGUs report that they are able to continue to do the planning required for their communities. But how long will they be able to continue? Will they be able to meet the rising demands for data sophistication, volume and speed? Will they remain relevant as the larger systems become the primary sources for this information that is used to drive planning? Are their resources being utilized in a manner that best preserves the local voice in future decision making? Some traditional family farms may survive, but will they benefit anyone but the farmer?

As such, it seems that our communities are best served if LGUs do the following:

1. Partner with the big systems that will drive the data future. (DSRIP, DOH, Managed care, RPC, etc.)
2. Develop a core set of canned local data sets/ reports that are recommended for all LGU level systems monitoring
3. Do what LGUs do best: (qualitative analysis and planning based on some selective local quantitative data sources.
4. Discontinue isolated and labor intensive planning processes that can be more efficiently completed by larger systems and shared with all stake holders.
5. Develop a customer service orientation in working with the larger systems, including a shift in emphasis from reliance on statutory authority toward an emphasis on the demonstration of value.

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	Job training/Educ	Crisis & Emerg.	Help getting benefits
Men	OP for MH	Crisis & Emerg.	OP for CD
	Job training/Educ	IP for MH	Peer Supports
	OP for CD	OP for MH	Support for family
		Support for family*	Job training/Educ Supp*
Women	OP for MH	OP for MH	Help getting benefits
	Peer Supports	Support for family	Job training/Educ Supp
	Support for family	Crisis & Emerg.	Housing Support
Under 18 y.o.	OP for MH	OP for MH	
	Job training/Educ	Support for family	
	Peer Support	Crisis & Emerg.	
		IP for MH*	
18-25 y.o.	OP for MH	OP for MH	Peer Supports
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	Peer Support	Peer Support	OP for CD
26-50 y.o.	OP for MH	OP for MH	Job training/Educ Supp
	Job training/Educ	Support for family	Housing Support
	Housing Support	Crisis & Emerg.	OP for CD
			Support for family*
Over 50 y.o.	OP for MH	OP for MH	OP for CD
	Transportation	Crisis & Emerg	Help getting benefits
	Peer Support	Help getting benefits	services
	Support for family*	Housing Supports*	

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HPC Sunrise	liberty	SBH	St Joes
Peer Supports	OP for MH	OP for CD	OP for MH
OP for MH	Peer Supports	OP for MH	Transportation
OP for CD	Support for family	Housing Supports*	Job training/Educ Supp
Transportation*		Job training/Educ Supp*	
OP for CD	OP for MH	OP for CD	Transportation
Peer Supports	Crisis & Emerg	Job training/Educ Supp	OP for MH
OP for MH	Peer Support	Housing Supports	Housing Support
Peer Supports	OP for MH	OP for MH	OP for MH
Transportation	Support for family	OP for CD	Job training/Educ Supp
OP for MH	Peer Support	Housing Supports	Transportation
	services*		
	OP for MH	Help getting benefits	
	Peer Supports	Housing Supports	
	Support for family	Job training/Educ Supp	
	OP for MH	Job training/Educ Supp	Peer Supports
	Crisis & Emerg	OP for CD	OP for MH
	Peer Support	Housing Supports	Support for family
			Help getting benefits*
OP for MH	OP for MH	OP for MH	Job training/Educ Supp
Crisis & Emerg	services	IP for CD	Transportation
Peer Support	Support for family	Housing Supports	OP for MH
OP for MH	OP for MH	IP for CD	OP for MH
Peer Supports	services	OP for MH	Transportation
Transportation	Crisis & Emerg.	OP for CD	Help getting benefits
	Support for family*	Support for family*	Housing Support*

Onondaga County 2017 Local Services Plan Summary

A range of data analysis and key stake holder feedback has resulted in the following issues being designated as current key areas of concern for Onondaga County. This summary represents a portion of the data analysis community outreach, and planning processes that occur throughout the year, and provides rationale for the priority Outcomes found near the end of the document.

Regionalization and systems integration/ the new role for the LGU

At the end of this document in a two page piece that likens the LGU to a family farm, and encourages a focus on moving the LGU toward a new role. This new role recognizes the unique attributes of the LGU as a key contributor to the regionalization and systems integration that is currently underway. A number of key initiatives are moving planning and service provision away from a county centric model and toward a regional orientation that has the potential to provide better care at a reduced cost.

The integration of primary care and behavioral health care, and the integration of public health and LGU functions, are fast becoming the new norm. Zip codes in Syracuse have some of the highest rates of preventable hospital admission in the region, and there is clearly a need for an integrated approach to reduce these rates.

While this new regional and integrated approach offers much potential, there is a risk that the local systems and relationships that support the service systems will be lost in this transition. The LGU role as local broker/ convener/ facilitator will be a critical source for local infrastructure to support regional and state agendas. It will also serve as a bridge across service areas as we develop a more integrated service approach. The LGU can also serve to support providers in their effort to avoid “Initiative Fatigue”, as they are forced to address one new thing after another. These are some of the ways that the LGU will maintain its important role in this time of tremendous change.

Poverty and social determinants of health

Recent months have seen a number of sources point out the painful degree of economic and racial segregation that exists in Syracuse and Onondaga County. Many of our efforts to gather

feedback from recipients of mental health and substance use services continue to indicate that the recovery of many individuals is hindered by poverty. We are also gaining additional understanding regarding the ways that early trauma and environmental challenges impact functioning in later life. We have known for some time that people with serious mental illness die much earlier than the rest of the population. We are now beginning to understand that the same is true for those who are poor. And many with serious mental illness are very poor. Poverty creates vulnerability to mental illness and substance use, and mental illness and substance use create vulnerability to poverty. There is clearly a need to further coordinate behavioral health efforts with social services that address poverty, and to recognize that access to jobs and affordable housing are just as important as access to medications and therapy.

Opioids

In 2011 Opioid admission surpassed alcohol admissions at Crouse Hospital, and just kept climbing from there. During the last 10 years opioid admissions at Crouse have more than tripled, with an 800% increase in heroin admissions in the last fifteen years. The heroin related mortality rate for Onondaga County has seen increases that are substantially higher that the national average and the rest of New York State (excluding NYC). According to Data from Crouse the number of young adults (26-35) and pregnant women being admitted for opioid treatment have both more than doubled in the last five years. Onondaga County rates for Neonatal Abstinence Syndrome (NAS) were the highest in the state in 2012. While no longer the highest in New York, they continue to rise.

Significant efforts are underway to enhance service capacity for opiate treatment in Onondaga County, and these efforts will have a broader regional impact. That is because the lack of treatment capacity in surrounding counties has placed a significant pressure on the local capacity, as individuals from other communities come to Onondaga County for care. Opioid treatment enhancement has significant overlap with other priority concerns, as we work to integrate behavioral and physical care, and work to reduce emergency room presentations through effective utilization of other levels of care.

Disproportionate representation of those with mental health and substance use conditions among those arrested and incarcerated.

A range of data sources indicate that a disproportionately high rate of incarcerated individuals suffer from serious mental illness and substance use conditions. Many have written of the failure of our community based care system to adequately support individuals with serious mental illness after de-institutionalization. The resulting trend has seen the thousands of individuals who might have formally been institutionalized in a psychiatric facility now being institutionalized in prison. America's largest jails now serve as the largest prescribers of

psychiatric medications. Onondaga County has developed a multi-departmental team to develop strategies to coordinate with community providers to try to reduce the arrest rates of this population.

The critical role of outpatient clinic services

A long standing priority has been placed on efforts to insure that individuals receive care in the least restrictive environment (the lowest level of care) to insure community integration and opportunities for a healthy recovery. This value has recently been joined by a cost containment agenda which seeks to prevent very expensive inpatient care whenever possible, and to integrate care for both behavioral and primary care health needs in clinic environments. The union of these priorities has placed a significant amount of pressure on the outpatient clinic system, as it is asked to serve larger and larger volumes of individuals who suffer from more acute symptoms. A resulting access challenge has resulted, with waiting lists that push people back toward emergency care. Onondaga County is currently engaged in several strategies designed in increase clinic access through the development of new resources, and through the efficient utilization of existing resources. This includes efforts to serve a diverse population, including immigrants, refugees, and seniors.

Cost Containment

Many of the transformational changes impacting our health care service system currently are designed to contain ever rising Medicaid costs. Shifts toward managed care and pay for performance models are designed to move care away from fee-for-service models that do not create incentives for quality outcomes. The Onondaga County LGU seeks to align with a range of initiatives that are supporting the implementation of these new models, and is dedicated to supporting providers as they transition their systems. Performance incentives that reward the achievement of outcomes create an important “win-win” in which providers prosper when they support recipients in ways that achieve real results.

Peer Support

Significant progress has been made in Onondaga County to bolster a range of peer services for mental health and substance use services, and additional peer services are currently under development. These include peer engagement specialists who will support individuals with substance use related ER presentations through a grant from OASAS, and the development of peer respite services through DSRIP. There has been a significant transition in the community of providers, as more become aware of the unique value that peer services have to offer. Current efforts are underway to engage in regional efforts to further the development of quality peer supports.

Residential supports for the people we do not serve well.
Individuals with a history of violence, aggression, sexual behaviors, property destruction, poor self-care skills, serious mobility limitation and health conditions etc. are often difficult to place in residential supports. In past years a periodic planning meeting (Strategic Response Team or SRT meeting) would be required in order for the Onondaga County LGU to support a group of organizations in trying to find service solutions for individuals with complex needs. Rather than viewing these people as challenging, we have chosen to view our service system as inadequate to the task of supporting the presenting needs, and have sought to find creative means to address these inadequacies to meet unique needs. .

Recent months have seen an increase in calls for such planning meetings. An increasing volume of community resources is being utilized to resolve the challenges associated with these individuals being housed in inappropriately high and expensive levels of care. Our system has also struggled to meet unique needs in lower and inadequate levels of care through the additional of staffing resources. A combination of multiple factors similar to those driving the higher levels of acuity in outpatient care have increased this need, including reduced access to long term inpatient care, and a push toward community based treatment. There is currently a significant cohort of individuals who are prohibited from receiving residential services, based upon state regulations, provider policy, and insurance liabilities, due to a history of challenging behaviors and symptoms. These individuals are not capable of living independently, and are in need of 24 hr. supports. Onondaga's LGU is currently beginning a process designed to explore ways to create a unique residential environment that can provide the needed supports to insure the wellbeing of these individuals.

Community Services Board development and survey: engaging key stake holders.
The maintenance of subcommittees for the Onondaga County CSB has been a long standing challenge. While the CSB has maintained a diverse and strong participation, it has been difficult to recruit and maintain membership for the 3 subcommittee groups. This challenge has increase in recent years, given the volume of major initiatives and changes that have impacted the behavioral health community. These major changes have placed additional demands on the time of key stake holders who might otherwise participate in the subcommittees.

Given this challenge, the Onondaga County CSB, in conjunction with LGU staff, developed a plan for the development of "virtual" subcommittees. These new subcommittees would communicate primarily via emails and surveys, and would serve as a principal resource for gathering community feedback, without requiring meeting attendance on a regular basis.

A strong pool of individuals was recruited to participate. Membership volume in the CSB and subcommittees is reflected below.

Community Services Board	14
Chemical Dependency Subcommittee	21
Developmental Disabilities Subcommittee	31
Mental health Subcommittee	38

An initial survey of the group was designed to support the completion of Local Services Plan requirement for submission of ranked service priority areas. The table below reflects the results of that survey. These subcommittee responses, along with the responses from a service recipient survey (see below) were both used to support the development of priority outcomes and strategies.

Service Area	**#1 priority service area**	**#2 priority service area**	**#3 priority service area**
Dev. Dis. Youth	Front Door	Self-directed services	Service coordination
Dev. Dis. Adult	Front Door	Autism services	Student Transition services
Mental Health Youth	Transportation	Workforce	Housing
Mental Health Adult	HARP, HCBS	Workforce	Transportation
Substance Use Youth	Coordination/ integration	Workforce	Transportation
Substance Use Adult	Transportation	Recovery supports	prevention

Cross cutting themes from the Subcommittee survey:
<u>The OPWDD "Front Door" initiative</u> is designed to provide people with information that options that insure a higher level of self-determination and community integration. It is clear from the responses that this initiative is a primary focal point for stake holders involved with the DD system.

<u>Transportation</u> remains a major concern, and received more votes than any other item across the six service area categories. The lack of public transportation, in conjunction with a

Medicaid transportation system that is often described as difficult to access and of poor quality, leave many individuals isolated and struggling to access services.

Work force recruitment and retention received the second highest number of votes across the six categories. It is clear that the stake holders who participated are well aware of the challenges of staffing behavioral health services. Budgetary constraints force organizations to offer low salaries for many entry level positions, and to struggle to hire and retain high quality staff as a result. Staff shortages in key professional categories also result in work force challenges. Many respondents commented on the challenges related to accessing medications, which have been primarily driven by a shortage of prescribers.

Coordination/ integration: while not a top 3 item in most of the response categories, this category consistently received a high number of votes, and received the third largest vote total across the six service areas. This is particularly noteworthy, as specific and more concrete issues (e.g. transportation, housing) tend to attract more votes. The fact that this category received so many votes indicates that community stake holders are well aware of the critical need to integrate and coordinate diverse services in order to move the service systems toward better outcomes, more efficiency, and more person centered supports. Many respondents made comments expressed the need for more services for those with co-occurring conditions.

Based upon the above feedback and a broader analysis of planning resources, the following prioritization grid has been developed for submission as part of the Onondaga County Local services Plan. The Grid indicates high, medium, and low priority levels, with high priority for those items rated as high by the subcommittees, or through other planning activities. The last lines of the table reflect low priority scores for coordination/ integration between developmental disability services and other systems. While this item is often described as a priority for many recipients and service providers, recent challenges in efforts to engage OPWDD have resulted in a general state of hopelessness among all stake holders regarding the likelihood of any substantive response or plan to support such efforts, resulting in the low priority scores. As such, these scores reflect a belief that little can currently be done in this area, rather than a reduced desire to see action.

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

w) Transportation

x) Workforce Recruitment and Retention

y) Coordination/Integration with Other Systems

Developmental Disability Services:

aa) Crisis Services

bb) Clinical Services

cc) Children Services

dd) Adult Services

ee) Student/Transition Services

ff) Respite Services

gg) Family Supports

hh) Self-Directed Services

ii) Autism Services

jj) Person Centered Planning

kk) Residential Services

ll) Front Door

mm) Transportation

nn) Service Coordination

oo) Employment

pp) Workforce Recruitment and Retention.

qq) Coordination/Integration with Other Systems.

Recipient survey: Which Services Should We Grow and Improve?

In order to insure a strong consumer voice in our effort to define service priorities, Onondaga County developed a simple paper survey to administer to recipients of services in a number of agency settings. Like the above CSB subcommittee survey, this data gathering was also focused on defining unmet need in priority service areas. As sex and age data were collected, we were able to sort the data to gain a better understanding of the needs of some subpopulations.

Respondents were asked to choose 3 priorities from the list below that they judged to be *"most important for helping you to meet your needs and achieve your goals.".*

1. Crisis and emergency services (CPEP, emergency rooms, mobile outreach)
2. Outpatient clinic services for mental health
3. Outpatient clinic services for drug and alcohol use
4. Inpatient services for mental health
5. Inpatient services for drug and alcohol use
6. Peer support (support provided by people with your same experiences)
7. Support for family members
8. Help getting benefits (Medicaid, welfare, food stamps, etc.)
9. Housing support
10. Transportation
11. Job training/ education supports
12. Supports to help me get services, and organize my services.
13. Other supports_____

Responses were gathered during a week in May 2016 from six clinic services (four mental health and two substance use clinics). A total of 561 responses were gathered. The table below reflects the rank order of responses according to the number of votes received by each item.

Recipient Survey: which services should we grow & improve?		
1	OP for Mental Health	281
2	Peer Supports	148
3	Job training / Education	147
4	Housing Supports	137
5	OP for Chemical Dependency	135
6	Support for family	134
7	Transportation	122
8	Supports to help get services	122
9	Help getting benefits	112
10	Crisis & Emergency Services	87
11	IP for Mental Health	58
12	IP for Chemical Dependency	49

Attached as a separate file and addendum to this document is a summary of the top responses from each of the participating clinics based upon a number of demographic categories. This table sorts the top responses by clinic, by sex, and by age groups. This sorting reveals some interesting findings.

- Growth and improvement in outpatient mental health services was the #1 priority for all demographic groups, and was the #2 priority for one chemical dependency clinic.
- Transportation was a priority for respondents over 50 y.o. and was a top 3 priority for three organizations. It was less of a priority for younger respondents.
- Job training/ education was a top priority for four organizations.
- Several demographic groups chose peer support as a top 3 priority, including women, and all age groups other than the 26-50 y.o. group.
- Younger respondents (under 18y.o. and 18-25 y.o.) were far more likely to prioritize peer supports.
- More women than men chose family support, as a top 3 priority.

An open box was included at the end of the survey, asking, "*What else do you need to help you to meet your needs and achieve your goals?"* 88 respondents included comments in this box. Responses reflected the level of poverty among many recipients, and challenges related to financial management and employment. Other primary themes included the need for transportation and housing supports, and the desire for a wide range of peer and professional counseling and related services.

Provider survey: clinic challenges

Given the emerging role of clinics in our service system, we utilized a single question web based survey to gather feedback from clinic leaders using the following question.

Clinics are being asked to provide an expanding array of services, and are a corner stone of the systemic efforts to reduce hospitalization and costs. The result is a rising demand and acuity level among clients served. The shortage of prescribers and other providers make it difficult to respond to this demand. How can our clinics respond to this need with timely and effective services, given these and other challenges?

Nine clinics responded to this question. The items below were drawn from the narrative responses and were sorted into categories. There are a number of suggestions that reflect a creative orientation to this service dilemma, and they consider a range of strategies to increase the efficiency of our service system. A number of suggestions point toward the need to consider new approaches to serving current case loads to insure that capacity is maintained for new admissions. A number of suggestions also point toward creative means to address the prescriber shortage.

Prescribers

- Expand tele-psychiatry. Especially for hard to reach rural areas.

- create a stronger network with primary care physicians and nurse practitioners
- Increase consultation to primary care providers around psychopharmacology.
- Support legislation that would give prescription privileges to licensed psychologists.
- Remove the current suboxone cap (raise the number of clients from 100 to 200 per prescriber in OASAS clinics, and allow 100 clients per prescriber in non OASAS clinicians.)
- The lack of psychiatry
- Hire more nurse practitioners and PAs to work in clinic settings.

Other staff issues

- Increase staffing / Increase number of providers,
- Avoid over use/ inappropriate use of interns.
- Use more "peer support" (e.g., recovery counselors, peer counselors, etc.) to help extend clinical practice.

Program models and improvements

- Develop partial hospitalization services
- Combine clinic with primary care practices.
- Offer flexible hours
- Provide translation services
- Mobile crisis teams.
- Resurrect "traditional case management" (i.e., ICM, SCM) to help provide hands on support for impaired clients.
- Provide different service offerings for cohorts of recipients with more long term or maintenance needs
- increased use of group therapy
- Increasing mental health availability on outpatient /community clinics.
- Reimbursement to meet the additional staffing needs
- Increased collaboration between clinics;
- 2) Increase in off-site services;
- Increase volume of Mental Health Services
- Clinics need to talk to parents and get feedback from the community.
- Clinics need to allow families to receive medication management only.
- We need to expand funding for school based clinics to meet the needs of the community.

2017 priority outcomes.

Onondaga County has defined the items below as the priority outcomes for the 2017 Local Services Plan. This list is the result of a review of a number of data sources, local meetings, focus groups and surveys, including some of the data gathering described above. This list is also an effort to seek alignment with some of the key initiatives underway that will be transforming the service system in the coming years.

These priorities reflect several core themes:
Service Access: While relatively service rich in comparison with more rural counties, the demand on Onondaga County services remains high, with challenging waiting lists throughout the service system. A number of priorities seek to expand services, and to use existing services more efficiently in order to improve access to care.

Crisis Prevention: In keeping with the broader systems changes designed to reduce the cost of care through early preventive interventions, our local priorities have an emphasis on partnering with systems stake holders to develop and expand services that will enable individuals to remain healthy and avoid more intensive levels of care.

Recovery: Onondaga County maintains a strong commitment to recovery, as reflected in priorities that support individuals who have been struggling to achieve their goals and move forward toward recovery.

The Onondaga County CSB has defined the following four themes as important areas of focus, and as the key "Lenses" through which we should consider services issues and community need. The 2017 Priority outcomes above are well aligned with these Lenses.

Onondaga County CSB 4 Lenses:
Lens #1: Health Disparities and Social Determinants of Health: Recognize the importance of poverty and other social determinants of health as a means of insuring that services are accessible and utilized by underserved populations. Partner with the broader health system to foster primary prevention.

Lens #2: Regional Collaboration: Support a range of vehicles for enhancing access and service quality through the economies of scale and enhanced knowledge achieved through regional collaboration.

Lens #3: Behavioral and Physical Health Integration: assist in the implementation of a range of state and national initiatives that are focused on efforts to integrate care in order to reduce

stigma, enhance access, and insure quality for those with behavioral health conditions through an integration with primary care.

Lens #4: Peer and family Supports: Support the expansion of peer and family supports, and work to promote the value of these supports to assist in the achievement of recovery goals.

2017 Onondaga County LGU Priorities

1. **Improve access to outpatient mental health treatment as the cornerstone to the system of care.**

   Strategy 1: Sustain current services and expand community and school based clinics.
   Strategy 2: Reduce time to first appointment through length of stay analysis, and developing infrastructure for urgent response.
   Strategy 3: Improve integration / coordination between primary and mental health care via DSRIP and other related initiatives.
   Strategy 4: Address transportation challenges that reduce access to care.
   Strategy 5: Develop a mental health clinic service for refugees and immigrants.
   Strategy 6: Develop strategies for outreach to seniors to address depression and substance use.

   Strategy 7: Engage community stake holders to explore best practices for enhancing the response to pregnant women with substance use and mental health conditions.

2. **Improve crisis mental health services.**

   Strategy 1: Partner with DSRIP in the development and implementation of new crisis stabilization services (mobile crisis, peer respite, etc.).
   Strategy 2: Enhance suicide prevention efforts through a new County suicide prevention coalition.

3. **Reduce behavioral health inpatient admissions and ER/CPEP presentations.**

   Strategy 1: Partner with DSRIP in the development and implementation of new crisis stabilization services (mobile crisis, peer respite, etc.).

Strategy 2: Implement Peer engagement specialist service to address substance use related ER presentations.
Strategy 3: Enhance Outpatient access (see Priority one).

4. **Assess work force development needs.**

   Strategy 1: Explore opportunities for training collaboration through surveys and focus group work with Executive Directors and subcommittees.

5. **Develop the new LGU role in the emerging behavioral health environment.**

   Strategy 1: Continued collaboration with DSRIP.
   Strategy 2: Partner with all stake holders for successful RPC implementation.

6. **Reduce recidivism of people with mental health and substance use conditions who are frequently arrested.**

   Strategy 1: Use OMH Corrections pilot grant to develop a system for data sharing and care coordination across forensic, treatment, and other service environments.

7. **Develop residential supports for individuals who are poorly served and/or banned from typical residential environments due to their high level of need.**

   Strategy 1: Work with all stake holders to define a model and financing needed to pilot a program.

8. **Enhance access to opiate treatment.**

   Strategy 1: Continue efforts to increase the volume of Medication Assisted Treatment (MAT).
   Strategy 2: Collaborate with community initiatives to enhance public education and treatment access.

9. **Define the target needs of transition age youth.**

   Strategy 1: Engage key stake holders in a renewed effort to define the unique service/ support needs of transition age youth.

10. **Enhance stake holder collaboration across the prevention treatment continuum.**

    Strategy 1: Develop a plan for integrating substance use treatment and prevention services.

    Strategy 2: Partner with local and State Health Departments to create a plan to integrate efforts, raise community awareness, and develop a primary prevention agenda for behavioral health.

Local Government Units are like Family Farms
Economies of Scale for Planning

The age of the family farm is over. While they toiled mightily, technological advances and economic shifts left them unable to compete on production volume and speed. Small scale means higher costs.

Some family farms have survived. They have become agri-tourism destinations, or makers of artisanal goat cheeses. They have learned that they can survive by avoiding the head to head competition with big scale agriculture. They have learned to thrive by doing what only they can do, and doing it well.

Local Government Unit (LGU) planning is a lot like family farming. There are powerful systemic changes occurring that require economies of scale for systems planning. LGUs toiling in isolation are not going to be able to compete with the big systems that can rapidly deliver large volumes of planning information. The big management and data systems of state and federal government sources and managed care organizations can deliver timely planning and outcomes data for covered lives. LGUs cannot.

So what about the "goat cheese"? What are the unique contributions that the LGU brings to the table that cannot be achieved by these large systems? The Cheese that the LGUs can make comes in two key flavors:

1. Qualitative data: Surveys, focus groups, engagement of recipients and key stake holders, etc.: This work is only possible at the local level, by local stake holders, and LGUs are best able to do it.
2. Local Quantitative data collection and analysis: Granular, boots-on-the-ground data collection and analysis regarding local needs and populations using sources that are not available to the big data systems

Some family farms seek to toil on, doing the same work that they have done for generations, without turning to cheese or tourism, and without seeking a buy out from big agriculture. Similarly, some LGUs report that they are able to continue to do the planning required for their communities. But how long will they be able to continue? Will they be able to meet the rising demands for data sophistication, volume and speed? Will they remain relevant as the larger systems become the primary sources for this information that is used to drive planning? Are their resources being utilized in a manner that best preserves the local voice in future decision making? Some traditional family farms may survive, but will they benefit anyone but the farmer?

As such, it seems that our communities are best served if LGUs do the following:

1. Partner with the big systems that will drive the data future. (DSRIP, DOH, Managed care, RPC, etc.)
2. Develop a core set of canned local data sets/ reports that are recommended for all LGU level systems monitoring
3. Do what LGUs do best: (qualitative analysis and planning based on some selective local quantitative data sources.
4. Discontinue isolated and labor intensive planning processes that can be more efficiently completed by larger systems and shared with all stake holders.
5. Develop a customer service orientation in working with the larger systems, including a shift in emphasis from reliance on statutory authority toward an emphasis on the demonstration of value.