2021 Mental Hygiene Executive Summary
Warren/Washington County Community Services
Certified: Robert York (10/14/20)

The Warren./Washington Community Services Board (CSB) is aware and actively involved in discussions around our local challenges surrounding each of the three disability areas, as well as opportunities that have arisen with the implementation of medicaid redesign and DSRIP funds. We have seen some great successes with the continued collaboration of our local stakeholders along with the support of Adirondack Health Institute, the PPS. The Office of Community Services has developed a fruitful working relationship with AHI that has resulted in many progressive training programs, particularly for law enforcement and the intersection of law enforcement and mental heath. We have seen an increase in expansion of mobile options for mental health, crisis and opioid treatment in our two counties.

We received stakeholder input into the priorities for the county plan from a variety of public and private entities. Our office and community is working dilligently to continue to best utilizie our current resources while collaborating and coordinating to advocate for additional services where we are obviously seeing a gap in need. Warren and Washington Counties continue to be one of many communities that has seen a disproportinate number of opiate related deaths and complications. Additionally, completed suicide rates are also high and continued timely access to transportation as well as outpatient and inpatient behavioral and substance use treatments are critical in nature, particularly now that our largest behavioral health provider, Glens Falls Hospital, is discontinuing outpatient services. We are working with another interested agency on a transition plan for services.

Our Community Services Board and office will continue to do the work necessary to move our communities forward in a dynamic healthcare environment, advancing a population health approach to clinical services as well as further integration of general health and the three disability areas. The state of our communities has changed dramatically, as a reflection of the larger national and world stage, since the onset of the COVID pandemic. We are still in the early stages of determining how this has and will continue to impact the overall physcial, mental and emotional stability of individuals as well as the day to day operations of agenices and service delivery.

.

Office of Addiction Services and Supports

Accessibility   **Contact**

Disclaimer   **Language Access**

Privacy Policy

Chapter One

Adirondacks DSRIP Region

Needs Assessment

NEW YORK STATE | Office of Mental Health

Executive Summary

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

Population Socioeconomic Characteristics

The Adirondacks region includes Clinton, Essex, Franklin, Hamilton, Warren and Washington counties. The region has a population of approximately 300,000 and four of the six counties are designated rural. The socioeconomic characteristics of the region's population are more indicative of need than those in other DSRIP regions. Its median household income of $49,751 is well below the state median of $58,687. Region-wide 14% of the population live below the poverty level, and Franklin County's 20% poverty rate is third highest among all NYS counties. In Clinton and Franklin counties, 15% of the populations are food stamps/SNAP beneficiaries, which is the third highest percentage in any NYS county. Among all DSRIP regions, the Adirondacks has the third highest percentage (13%) of adults without a high school diploma.

More than a third of the region's population are on some type of public health insurance, 22% are Medicaid beneficiaries and 9% have no health insurance coverage. Among all NYS counties, Franklin County has the highest percentage of adults (18%) who reported they did not receive medical care because of cost.

Special populations include 14% that are disabled and 11% that are Veterans, which are the second highest percentages in any DSRIP region. Essex County's population includes 15% disabled, which is the second highest percentage in any NYS county. Four percent of the region's population are foreign born and 6% speak a primary language other than English.

Health Care Resources

Maldistributions and shortages of health care providers in the Adirondacks region are recognized by federal Health Resources and Services Administration (HRSA) health professional shortage area (HPSA) designations. Clinton County has a HPSA whole county primary health care shortage designation and the other five counties have primary health care Medically Underserved Area/Population (MUA/P) designations. The Medicaid eligible population in five counties and the low income population in two counties are designated primary health care MUPs.

Four counties have whole county mental health (MH) professional shortage designations and all counties have MH professional MUA/P designations. Clinton County has a MH professional shortage designation in each HRSA category, including its Medicaid eligible population. The Adirondacks region has 20 licensed MH professionals per 10,000 population, which is the third lowest rate in any DSRIP region. Washington County's 13 licensed MH professionals per 10,000 population is the second lowest rate in any NYS county. There are no psychiatrists in Essex, Hamilton and Washington counties.

The region's total psychiatric bed capacity of 27 beds per 100,000 adults and 17 beds per 100,000 children are the second lowest rates in any DSRIP region. The total inpatient average daily census (ADC) for child beds is 28, which is larger than the total number of child inpatient beds (n=12). The total child inpatient ADC is 39 per 100,000, which is the second highest rate in any DSRIP region.

The Adirondacks region has no substance use disorder crisis programs and only one opioid treatment program. The region has only one physician certified in addiction medicine, which is the smallest

number in any DSRIP region. Hamilton County has no SUD professionals and Washington County has no SUD rehabilitation counselors.

Health Status Challenges
Among all DSRIP regions, the Adirondacks region has the highest:
1) Average percentages of adults with angina, heart attack or stroke, high blood pressure and asthma. Among all NYS counties, Franklin County has the highest percentage of adults with high blood pressure, and Clinton County has the highest percentages of adults with angina, heart attack or stroke and who are overweight or obese.
2) Average hospitalization rate for self-inflicted injury. The rate in Hamilton County is the highest in any NYS county.
3) Rate of alcohol related motor vehicle injuries.

Compared to all other DSRIP regions, the Adirondacks region has the second highest percentages of premature deaths and adults with diabetes and who are overweight or obese.

Behavioral Health Care Utilization Challenges
Compared to all DSRIP regions, the Adirondacks region has the largest percentages of Medicaid inpatient admissions for some other MH diagnosis and Medicaid ER visits for cocaine use disorder.

Unmet Service Needs
Measures of behavioral health medication management suggest unmet need in the region. Approximately two-thirds (68%) of adults with schizophrenia adhere to anti-psychotic medications. Region-wide, 53% of individuals with major depression remain on anti-depressant medication during the entire acute treatment phase and 39% remain on these medications during continuation phase treatment (61% do not). More than half (54%) of children prescribed ADHD medication have one follow-up visit with a practitioner within 30 days after starting the medication. Fifty-five percent of children with a new prescription for ADHD medication remain on the medication for seven months and/or have at least two follow-up visits in the nine month period after the initiation phase.

Region-wide 53% of individuals have follow-up care within 7 days after hospitalization for a mental illness (the second highest percentage in any DSRIP region) and 66% follow-up within 30 days. Engagement in alcohol and other drug dependence (AOD) treatment also suggests unmet need, with only 26% of individuals engaging in AOD treatment within 30 days after initiation (74% do not). With regard to physical health, high rates of potentially avoidable hospital admissions for diabetes short-term complications and asthma chronic conditions in the Adirondacks region suggest a need for further outpatient resources.

Consumer and Provider Input
The Adirondacks region counties' surveys of consumer and provider stakeholders to assess local needs indicate that transportation to health care services and workforce recruitment and retention are issues that need attention for the populations with mental health and/or chemical dependency concerns.

Citizen Advocates, Inc., a clinic in the Adirondacks region surveyed 208 consumers and 39 providers regarding community behavioral health needs in its geographic service area. The needs most frequently reported by both consumers and providers include: transportation to health care services; reduced wait times for an appointment; assistance with paying for services; convenient provider hours (evenings and weekends); ambulatory SUD detoxification; and inpatient mental health.

I. Description of Communities to Be Served

1. Geographic Service Area

The Adirondacks DSRIP region is the northeastern most part of New York State. It includes six counties: Clinton, Essex, Franklin, Hamilton, Warren and Washington.
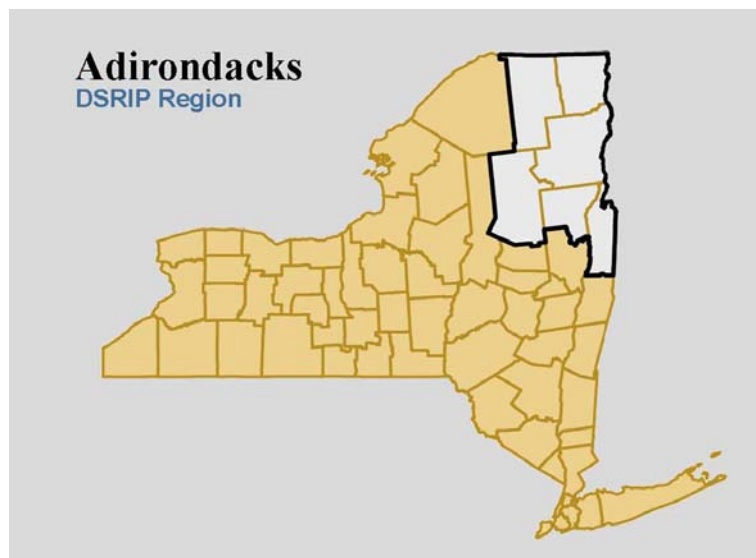
Approximately 300,000 people live in the region (Table 1). Estimated county populations range from a low of 4,864 in Hamilton County (the smallest population in any NYS county) to a high of 82,170 in Clinton County. Four of the region's counties have been designated rural by the U.S. Office of Management and Budget (OMB).[1]

Table 1. Adirondacks Region: Population Size, Density and Urban/Rural County Designations			
County	US Census ACS 2010-2014 Est. Population	Population Density per Square Mile	OMB Urban/Rural Designation[1]
Clinton	82,170	79.2	Rural
Essex	39,318	21.9	Rural
Franklin	51,695	31.7	Rural
Hamilton	4,864	2.8	Rural
Warren	65,686	75.8	Urban
Washington	63,166	76.0	Urban
Totals	306,899	39.0	
Data is from the U.S. Department of Health and Human Services, Health Resources Services Administration Data Warehouse. Retrieved April 14, 2016 from http://datawarehouse.hrsa.gov/ tools/analyzers/geo/Rural.aspx			

Population density per square mile ranges from a low of 2.8 in Hamilton County (the lowest density in any NYS county) to a high of 79.2 in Clinton County. The Adirondacks region is the most rural and has the lowest population density of any DSRIP region.

2. Population Characteristics

A. Gender, Race, Ethnicity and Age
In the Adirondacks region, slightly less than half (48%) of the population are female (Table 2). County percentages of females range from a low of 45% in Franklin to a high of 51% in Warren. The region's percentage of females is the lowest in all DSRIP regions.

Table 2. Adirondacks Region: Gender, Race/Ethnicity and Age									
County	US Census ACS 2010-2014 Est. Population	American Community Survey Data 2010-2014							
		Gender		Race/Ethnicity					Age
		Male	Female	White	African American	Asian	Other*	Hispanic or Latino Ethnicity	19 and Under	65 and Over
Clinton	82,170	51%	49%	92%	4%	1%	3%	3%	23%	13%
Essex	39,318	52%	48%	92%	3%	1%	4%	3%	21%	18%
Franklin	51,695	55%	45%	84%	6%	1%	9%	3%	23%	13%
Hamilton	4,864	51%	49%	97%	1%	0%	2%	1%	19%	23%
Warren	65,686	49%	51%	97%	1%	1%	2%	2%	23%	16%
Washington	63,166	52%	48%	94%	3%	1%	2%	2%	23%	15%
Totals	306,899	52%	48%	92%	3%	1%	4%	2%	23%	15%

*Other includes American Indian and Alaska Native, Native Hawaiian and other Pacific Islander, some other race, and two or more races

The population in the region is primarily White, with percentages varying from a low of 84% in Franklin to a high of 97% each in Hamilton and Warren counties. The Adirondacks rural counties (except for Hamilton) are more racially diverse than its urban counties. For example, 6% of Franklin County's population is African American compared to 1% in urban Warren County. Only 1% of the region's population are Asian and 4% identify as some other race. Two percent of the region's population identify as of Hispanic or Latino ethnicity.

Twenty-three percent of the Adirondacks population are age 19 and under and 15% are age 65 and over. Hamilton County has the smallest percentage of persons age 19 and under (19%) and the largest percentage age 65 and over (23%).

B. Income, Education, Unemployment and Poverty
The median household income in the Adirondacks region is $49,751 (Table 3). Median household incomes range from a low of $44,840 in Franklin County to a high of $54,582 in Warren County. The Adirondacks region's median household income is well below the New York State median household income of $58,687.[2]

Table 3. Adirondacks Region: Income, Education, Unemployment and Poverty								
County	US Census ACS 2010-2014 Est. Population	American Community Survey Data 2010-2014						
		Median Household Income	Educational Attainment[1]		Unemployment and Indicators of Poverty			
			Less than High School	Bachelor's Degree or Higher	Unemployed[2]	Below Poverty Level	On Cash Public Assistance	On Food Stamps/ SNAP Benefits
Clinton	82,170	49,708	16%	22%	6%	15%	5%	15%
Essex	39,318	47,389	12%	24%	6%	11%	2%	9%
Franklin	51,695	44,840	16%	17%	7%	20%	3%	15%
Hamilton	4,864	51,351	11%	25%	6%	9%	1%	4%
Warren	65,686	54,582	10%	28%	6%	12%	2%	10%
Washington	63,166	50,633	13%	17%	5%	13%	2%	12%
Totals	306,899	49,751	13%	22%	6%	14%	3%	12%

[1] Educational attainment are calculated based on population 25 years and older. [2] Unemployment data is the average for 2015 and is from the NYS Department of Labor.

Thirteen percent of the Adirondacks region population age 25 and older does not have a high school diploma and 22% have a bachelor's degree or higher. Adults without a high school diploma range from a low of 10% in Warren County to a high of 16% each in Clinton and Franklin counties. Adults with a bachelor's degree or more range from a low of 17% each in Franklin and Washington counties to a high of 28% in Warren County. Compared to all DSRIP regions, the Adirondacks has the third highest percentage of adults without a high school diploma.

The Adirondacks region has a 6% unemployment rate and 14% of its population live below the poverty level. Rural Franklin County has the largest percentage (20%) of persons living below the poverty level and Hamilton County has the lowest (9%). Three percent of the Adirondacks region population are on cash public assistance and 12% receive food stamps/SNAP benefits. Food stamps/SNAP beneficiaries range from a low of 4% in Hamilton County to a high of 15% each in Clinton and Franklin counties.

C. Health Insurance Status
In the Adirondacks region more than a third of the population are on some type of public health insurance[3] and 9% have no health insurance coverage (Table 4). Percentages of the population on public health insurance range from a low of 34% each in Clinton and Warren counties to a high of 38% in Franklin County. Those with no health insurance range from a low of 8% in Hamilton County to a high of 21% in Clinton County, which is the highest percentage in any NYS county.

Table 4. Adirondacks Region: Health Insurance Status					
County	US Census ACS 2010-2014 Est. Population	American Community Survey Data 2010-2014			
		Public Health Insurance[1] Coverage	No Health Insurance Coverage	Unemployed w/Public Health Insurance	Unemployed w/No Health Insurance
Clinton	82,170	34%	21%	36%	24%
Essex	39,318	37%	10%	33%	29%
Franklin	51,695	38%	12%	35%	39%
Hamilton	4,864	35%	8%	50%	25%
Warren	65,686	34%	10%	29%	40%
Washington	63,166	36%	11%	33%	39%
Totals	306,899	35%	9%	33%	34%

[1] Public coverage includes Medicare, Medicaid and other federal medical assistance programs; VA Health Care; the Children's Health Insurance Program (CHIP); and individual state health plans.

Among the region's unemployed, a third are on public health insurance and more than a third have no health insurance. While the rates of the unemployed on public health insurance are largely comparable to those of the general population, the rates of the unemployed with no health insurance are nearly four times as high as those in the general population (34% compared to 9%). The percentage of unemployed with public health insurance in Hamilton County is the second highest in any NYS county.

Medicaid Population
More than one fifth (22%) of the estimated population in the Adirondacks region are Medicaid beneficiaries (Table 5). By county, Medicaid beneficiaries range from a low of 15% of the population in Hamilton County to a high of 25% of the population in Franklin County.

Table 5. Adirondacks Region: Medicaid Beneficiaries as Percentage of Total Population			
County	US Census ACS 2010-2014 Est. Population	Total # Medicaid Beneficiaries	% Est. Population Receiving Medicaid
Clinton	82,170	19,355	24%
Essex	39,318	8,194	21%
Franklin	51,695	12,680	25%
Hamilton	4,864	684	14%
Warren	65,686	13,031	20%
Washington	63,166	12,088	19%
Totals	306,899	66,032	22%

Data is from the NYS Department of Health's Medicaid Beneficiaries Inpatient Admissions and Emergency Room Visits data base; 2012 data. Retrieved May 12, 2016 from https://health.data.ny.gov/ Health/Medicaid-Beneficiaries-Inpatient-Admissions-and-Em/m2wt-pje4#About

In the Adirondacks region 68% of Medicaid beneficiaries are adults and 32% are children (Table 6). By county, adult Medicaid beneficiaries range from a low of 64% in Hamilton County to a high of 70% each in Clinton and Essex counties.

County	All Medicaid Beneficiaries	Medicaid Population				Eligibility Type			
		Adults		Children		Medicaid Only		Dual Medicaid and Medicare	
	#	#	%	#	%	#	%	#	%
Clinton	19,355	13,559	70%	5,796	30%	15,247	79%	4,108	21%
Essex	8,194	5,750	70%	2,444	30%	6,277	77%	1,917	23%
Franklin	12,680	8,722	69%	3,958	31%	10,097	80%	2,583	20%
Hamilton	684	455	67%	229	33%	548	80%	136	20%
Warren	13,031	8,791	67%	4,240	33%	10,060	77%	2,971	23%
Washington	12,088	7,772	64%	4,316	36%	9,826	81%	2,262	19%
Totals	66,032	45,049	68%	20,983	32%	52,055	79%	13,977	21%

Table 6. Adirondacks Region: Medicaid Beneficiaries by Population and Eligibility Type

Data is from the NYS Department of Health's Medicaid Beneficiaries Inpatient Admissions and Emergency Room Visits data base; 2012 data. Retrieved May 12, 2016 from https://health.data.ny.gov/ Health/Medicaid-Beneficiaries-Inpatient-Admissions-and-Em/m2wt-pje4#About

Medicaid beneficiaries include individuals that receive Medicaid only and dual-eligible individuals that receive both Medicare and Medicaid benefits by virtue of their age or disability and low incomes.[4] In the Adirondacks region 79% of Medicaid beneficiaries receive Medicaid only (the lowest percentage in any DSRIP region) and 21% are dual-eligible. Medicaid only beneficiaries range from a low of 77% each in Essex and Warren counties to a high of 81% in Washington County.

D. Special Populations, Foreign Born and Primary Language
In the Adirondacks region, 14% of the population are disabled and 11% are Veterans (Table 7), which are the second highest percentages among all DSRIP regions. Percentages of individuals with disabilities range from a low of 13% each in Warren and Washington counties to a high of 15% in Essex County (the second highest percentage in any NYS county). Veterans range from a low of 10% in Franklin County to a high of 15% in Hamilton County (the highest percentage in any NYS county).

There are 339 children 19 years and younger in foster care and 651 individuals in jail in the Adirondacks region. Four percent of the population in the region are foreign born. Clinton, Essex, and Franklin counties have the largest percentages of foreign born (5% each), and are all rural counties.

Table 7. Adirondacks Region: Special Populations and Foreign Born						
County	US Census ACS 2010-2014 Est. Population	American Community Survey Data 2010-2014				Foreign Born
		Special Populations				
		Disabled	Veterans	In Foster Care[1]	In Jail[2]	
Clinton	82,170	14%	11%	109	219	5%
Essex	39,318	15%	12%	20	83	5%
Franklin	51,695	14%	10%	102	109	5%
Hamilton	4,864	14%	15%	–	4	2%
Warren	65,686	13%	11%	67	130	3%
Washington	63,166	13%	12%	41	106	2%
Totals	306,899	14%	11%	339	651	4%

[1] Foster care data includes individuals 19 and under during the 2014 calendar year and is from the NYS Office of Children and Families. [2] Jail data is for 2014 calendar year and is from the NYS Division of Criminal Justice Services.

Table 8 describes the primary languages spoken at home and those who speak English less than "very well" in the population aged five years and older. In the Adirondacks region, 94% of this population speak English as their primary language (the highest percentage in any DSRIP region), 3% speak other Indo-European languages, 2% speak Spanish, 1% each speak Asian and Pacific Islander or some other language and 2% speak English less than "very well" (the lowest percentage in any DSRIP region).

Table 8. Adirondacks Region: Primary Language Spoken at Home							
County	US Census ACS 2010-2014 Est. Population 5 Years and Older	American Community Survey Data 2010-2014					Speak English less than "very well"
		Language Spoken at Home					
		English	Spanish	Other Indo-European	Asian and Pacific Islander	Other	
Clinton	78,056	94%	2%	3%	1%	0%	2%
Essex	37,492	94%	3%	3%	0%	0%	3%
Franklin	48,948	92%	3%	3%	1%	2%	3%
Hamilton	4,671	97%	1%	2%	0%	0%	1%
Warren	62,362	95%	1%	3%	0%	0%	1%
Washington	59,856	96%	2%	1%	0%	0%	1%
Totals	291,385	94%	2%	3%	1%	1%	2%

Percentages of the population aged five and over that speak English as their primary language vary from a low of 92% in Franklin County to a high of 97% in Hamilton County (the highest percentage in any NYS county). Those who speak English less than "very well" range from a low of 1% each in Hamilton, Warren and Washington counties to a high of 3% each in Essex and Franklin counties.

---

[1] Urban areas (metro areas) are geographic entities defined by the U.S. Office of Management and Budget (OMB) for use by Federal statistical agencies in collecting, tabulating, and publishing Federal statistics. An urban area includes one or more counties containing a core urban area of 50,000 or more people, together with any adjacent counties that have a high degree of social and economic integration (as measured by commuting to work) with the urban core. The OMB defines rural as all counties outside metropolitan areas based on 2010 census data. There are currently 24 counties designated rural in New York State. Retrieved April 14, 2016 from http://datawarehouse.hrsa.gov/tools/analyzers/geo/Rural.aspx

[2] Retrieved April 14, 2016 from http://www.census.gov/quickfacts/table/RHI225214/36

[3] Public coverage includes the federal programs Medicare, Medicaid and other medical assistance programs, VA Health Care; the Children's Health Insurance Program (CHIP); and individual state health plans. Retrieved April 14, 2016 from
https://www.census.gov/hhes/www/hlthins/methodology/definitions/acs.html

[4] In this analysis dual status was based upon the last month of enrollment/eligibility during the year. If the Medicaid beneficiary was indicated as being eligible for Part A, B, C or D Medicare services they are classified as dual eligible. The dual-eligible Medicare and Medicaid population is diverse and includes individuals with multiple chronic conditions, physical disabilities, and cognitive impairments such as dementia, developmental disabilities, and mental illness. It also includes some individuals who are relatively healthy. Retrieved May 12, 2016 from http://www.medpac.gov/documents/data-book/january-2015-medpac-and-macpac-data-book-beneficiaries-dually-eligible-for-medicare-and-medicaid.pdf

II. Physical and Behavioral Health Care Resources

This section describes physical and behavioral health care resources in the Adirondacks DSRIP region. Its findings should be considered with those in Sections V and VI of this report, which describe unmet service need by DSRIP region.

Note: Data presented in this section should be interpreted with Hamilton County's small population size (n=4,864, the smallest population in any NYS county) in mind; some data points may be unstable.

Physical Health Care Resources

1. Inpatient Physical Health Care Facilities
The Adirondacks DSRIP region has four acute care hospitals and 17 nursing homes that provide inpatient health care (Table 1).

Table 1. Adirondacks Region: Inpatient Physical Health Care by Certified Beds								
County	**Acute Care Hospitals**					**Nursing Homes**		
	# Hospitals	**# Certified Beds**				**# Nursing Homes**	**# Certified Beds**	
		Total # All Bed Types	**Chemical Dependence Rehab**	**Chemical Dependence Detox**	**Psychiatric**		**Total Beds**	**BH Intervention Beds**
Clinton	1	300	0	0	34	4	423	0
Essex	0	0	0	0	0	3	340	0
Franklin	2	171	0	0	12	2	195	0
Hamilton	0	0	0	0	0	0	0	–
Warren	1	410	0	0	32	4	282	0
Washington	0	0	0	0	0	4	406	0
Totals	**4**	**881**	**0**	**0**	**78**	**17**	**1,646**	**0**
Acute care hospital data is from the NYS Open Data Health Facility General Information dataset. Retrieved April 12, 2016 from https://health.data.ny.gov/Health/Health-Facility-General-Information/vn5v-hh5r . Nursing home data is from the NYS Open Data Nursing Home Profile dataset. Retrieved April 12, 2016 from https://health.data.ny.gov/Health/Nursing-Home-Profile/dypu-nabu								

In the Adirondacks region, the four acute care hospitals are located in Clinton, Franklin (n=2) and Warren counties and collectively have 881 beds where physical health care is the primary type of care provided. Among these beds are 78 psychiatric beds, but no chemical dependence beds. The region's 17 nursing homes have a total of 1,646 beds, but no behavioral health intervention beds.[1] All counties, except Hamilton, have nursing homes.

2. Outpatient Physical Health Care Facilities

In the Adirondacks region, all counties have certified home health care facilities and four counties have long-term home health care facilities (Table 2). Ambulatory surgical centers are located in Clinton and Warren counties.

Table 2. Adirondacks Region: Outpatient Physical Health Care						
County	Home Health Care		Ambulatory Surgical Centers	Primary Health Care		
	Certified Home Health	Long-term Home Health		School-based Health Centers	Diagnostic and Treatment Centers	Federally Qualified Health Centers
	# Facilities					
Clinton	1	1	1	0	4	1
Essex	1	0	0	0	2	4
Franklin	1	1	0	1	2	2
Hamilton	1	0	0	0	1	1
Warren	1	1	1	2	4	9
Washington	2	1	0	0	1	1
Totals	7	4	2	3	14	18
Ambulatory surgical center data is from the NYS HCRA Provider List dataset. Retrieved April 12, 2016 from https://www.health.ny.gov/regulations/hcra/provider/provamb.htm. Federally qualified HC data is from the HRSA Data Warehouse. Retrieved April 21, 2016 from http://datawarehouse.hrsa.gov/tools/hdwreports/Filters.aspx?id=60#. All other data is from the NYS Open Data Health Facility General Information dataset. Retrieved April 12, 2016 from https://health.data.ny.gov/Health/ Health-Facility-General-Information/vn5v-hh5r .						

There are three types of institutional providers that provide primary care: school-based health centers, diagnostic and treatment centers,[2] and federally qualified health centers.[3] Franklin and Warren counties are the only counties in the region that have school-based health centers. All counties have at least one diagnostic and treatment center and one federally qualified health center.

3. Physical Health Care Practitioners

Physical health care providers include primary care providers, medical specialists, dentists, and physical rehabilitation specialists. Health practitioners in primary care and medical specialties include physicians, physician assistants, and nurse practitioners.

Primary Care Providers

In the Adirondacks region family medicine providers include 262 physicians and a total of 251 nurse practitioners and physician assistants (Table 3). The number of family medicine providers of all types is lowest in Hamilton County (n=18) and highest in Warren County (n=201).

Internal medicine providers include 221 physicians and a total of 181 nurse practitioners and physician assistants. The number of internal medicine physicians is highest in Warren County (n=89) and lowest in Hamilton County (n=5). Internal medicine nurse practitioners and physician assistants are found in the greatest numbers in Franklin County (n=50) and the fewest are in Hamilton County (n=9).

Table 3. Adirondacks Region: Primary Care Providers									
County	US Census ACS 2010-2014 Est. Population	Family Medicine		Internal Medicine		Pediatrics		Total	Total per 10,000 population
		MD/DO	NP/PA	MD/DO	NP/PA	MD/DO	NP/PA		
Clinton	82,170	27	31	39	27	14	6	144	18
Essex	39,318	60	48	16	38	17	2	181	46
Franklin	51,695	18	48	46	50	26	5	193	37
Hamilton	4,864	10	8	5	9	5	1	38	78
Warren	65,686	109	92	89	45	51	10	396	60
Washington	63,166	38	24	26	12	8	2	110	17
Totals	306,899	262	251	221	181	121	26	1,062	35

MD=medical doctor; DO=doctor of osterpathy; NP=nurse practitioner; PA=physician assistant. Data is from the DSRIP Managed Care Provider Network Database. Retrieved April 21, 2016 from https://www.health.ny.gov/health_care/medicaid/redesign/providernetwork/

Pediatric health care providers are the smallest group of primary care providers in the region. Throughout the Adirondacks region there are 121 physicians and only 26 pediatric nurse practitioners and physician assistants providing pediatric care. The number of pediatric health providers is highest in Warren County (n=61) and lowest in Hamilton County (n=6).

The maldistribution of primary care providers in the Adirondacks region is made clearer by looking at the number of providers per 10,000 population in the region's counties. Washington County has 17 primary care providers per 10,000 population, while Warren and Hamilton have 60 and 78 respectively.

This maldistribution is also recognized by designations of county health professional shortage areas (HPSAs) made by the federal Health Resources and Services Administration (HRSA).[4] In addition to county wide shortage area designations, HRSA also makes county census tract, special population, and health care facility shortage designations. Table 3a describes all of the HRSA primary care professional shortage designations for the counties in the Adirondacks region.

Clinton County has a whole county primary care shortage designation. The five remaining counties have a census tract, population or facility designated as a primary care Medically Underserved Area/Population (MUA/P). In all counties, except Hamilton, the Medicaid eligible populations have been designated primary care MUPs. In Essex and Hamilton counties the low income populations are designated primary care MUPs.

Table 3a. Adirondacks Region: HRSA Federal Primary Care Professional Shortage Designations				
County	Whole County	Census tract, populations or facilities	Medicaid Eligible population	Low Income Population
Clinton	Yes		Yes	
Essex		Yes	Yes	Yes
Franklin		Yes	Yes	
Hamilton		Yes		Yes
Warren		Yes	Yes	
Washington		Yes	Yes	
HRSA federal shortage designations retrieved March 17, 2016 from http://datawarehouse.hrsa.gov/tools/analyzers/hpsafind.aspx				

Physical Health Medical Specialists

The Adirondacks region has a total of 274 physical medical health specialists or nine providers per 10,000 population, which is the second lowest ratio of any DSRIP region (Table 4).

Table 4. Adirondacks Region: Physical Medical Specialists													
County	US Census ACS 2010-2014 Est. Population	Allergy and Immunology		Cardiology and Other Cardiology Specialties		Endocrinology and Other Endocrinology Related Specialties		Obstetrics and Gynecology		General Surgery		Total	Total per 10,000 population
		MD/DO	NP/PA	MD/DO	NP/PA	MD/DO	NP/PA	MD/DO	NP/PA	MD/DO	NP/PA		
Clinton	82,170	1	0	18	3	1	0	10	13	17	1	64	8
Essex	39,318	0	0	5	1	0	0	9	5	4	2	26	7
Franklin	51,695	1	0	13	1	2	0	15	8	12	6	58	11
Hamilton	4,864	0	0	0	0	0	0	0	1	3	0	4	8
Warren	65,686	2	5	18	5	0	0	20	15	29	8	102	16
Washington	63,166	0	0	8	0	1	0	4	7	0	0	20	3
Total	306,899	4	5	62	10	4	0	58	49	65	17	274	9
MD=medical doctor; DO=doctor of osterpathy; NP=nurse practitioner; PA=physician assistant. Data is from the DSRIP Managed Care Provider Network Database. Retrieved April 21, 2016 from https://www.health.ny.gov/health_care/medicaid/redesign/providernetwork/													

Endocrinology providers (n=4) and allergy and immunology providers (n=9) are in shortest supply, while obstetrics and gynecology providers are most prevalent (n=107), followed by general surgery (n=82), and cardiology (n=72). The number of medical specialists is highest in Warren County (n=102) and lowest in Hamilton County (n=4). Washington County has the second lowest ratio of physical health medical specialists (3 per 10,000) among all NYS counties.

Dentists
In the Adirondacks region, a total of 88 dentists serve the population of more than 300,000 residents (Table 5). The number of dentists ranges from a low of zero in Hamilton County (the only county in the state with no dentists) to a high of 42 in Warren County. Region-wide there are three dentists per 10,000 population, which is the second lowest rate among all DSRIP regions.

Table 5. Adirondacks Region: Dentists					
County	US Census ACS 2010-2014 Est. Population	Number of Dentists			Per 10,000 Population
		General Dentist	Specialist Dentist	Total	
Clinton	82,170	11	5	16	2
Essex	39,318	4	2	6	2
Franklin	51,695	8	0	8	2
Hamilton	4,864	0	0	0	0
Warren	65,686	17	25	42	6
Washington	63,166	15	1	16	3
Totals	306,899	55	33	88	3
Data is from the DSRIP Managed Care Provider Network Database. Retrieved April 21, 2016 from https://www.health.ny.gov/health_care/medicaid/redesign/providernetwork/					

Physical Rehabilitation Specialists
In the Adirondacks region a total of 201 physical rehabilitation specialists serve the population of more than 300,000 residents (Table 6).

Table 6. Adirondacks Region: Physical Rehabilitation Specialists						
County	US Census ACS 2010-2014 Est. Population	Occupational Therapy	Physical Therapy	Speech Therapy	Total	Total per 10,000 population
Clinton	82,170	10	42	15	67	8
Essex	39,318	3	14	0	17	4
Franklin	51,695	0	4	2	6	1
Hamilton	4,864	0	0	0	0	0
Warren	65,686	15	59	16	90	14
Washington	63,166	0	16	5	21	3
Totals	306,899	28	135	38	201	7
Data is from the DSRIP Managed Care Provider Network Database. Retrieved April 21, 2016 from https://www.health.ny.gov/health_care/medicaid/redesign/providernetwork/						

In the region, occupational therapists (n=28) are in shortest supply, while physical therapists are most prevalent (n=135), followed by speech therapists (n=38). The number of physical rehabilitation specialists ranges from a low of zero in Hamilton County (one of two state counties with no such specialists) to a high of 90 in Warren

County. Region-wide there are seven physical rehabilitation specialists per 10,000 population, the third lowest rate among all DSRIP regions.

Behavioral Health Care Resources

4. Inpatient Behavioral Health Care Facilities and Programs

The data presented in this section is by county of provider location, with the exception of psychiatric inpatient average daily census, which is by patient county of residence. Individuals may access services in a county other than the county in which they reside.

Mental Health Inpatient Facilities

The Adirondacks DSRIP region has a total of 64 adult psychiatric beds and 12 psychiatric beds for children (Table 7).[5] The adult psychiatric beds are located in Clinton, Franklin and Warren counties. The psychiatric beds for children are located in Clinton County. Warren County has the largest number of adult beds (n=30) and Franklin has the fewest (n=12).

Table 7. Adirondacks Region: Total Psychiatric Inpatient Bed Capacity by Provider County and Average Daily Census by Patient County of Residence								
County	**- Adults -**				**- Children -**			
	Total Inpatient Beds[1]	Total Bed Capacity per 100,000	Total Inpatient ADC[2,3]	Total ADC per 100,000[4]	Total Inpatient Beds[1]	Total Bed Capacity per 100,000	Total Inpatient ADC	Total ADC per 100,000[4]
Clinton	22	35	23	36	12	63	6	30
Essex	0	0	6	19	0	1	3	35
Franklin	12	31	11	27	0	0	2	14
Hamilton	0	0	0.2	5	0	0	0.1	12
Warren	30	60	14	28	0	0	12	78
Washington	0	0	12	24	0	0	5	37
Totals	**64**	**27**	**65**	**28**	**12**	**17**	**28**	**39**

Notes: 1. Includes General Hospital, Private Psychiatric Hospital and State Psychiatric Centers' budgeted capacity for the county of the providers. Children's capacity includes residential treatment facility (RTF) beds for the county of the providers. 2. Average Daily Census (ADC) covers General, Private Psychiatric, State Psychiatric hospital and RTF (children only). 3. ADC is shown for patient county of residence. 4. The ADC per 100,000 population of adults or children as indicated. Data Sources: Capacity -- General Hospital and Private Psychiatric Hospital current capacity: NYSOMH CONCERTS database, 10/2015. Current capacity includes all beds licensed for operation as of that date. State Psychiatric Center budgeted capacity: NYSOMH MHARS EHR, 10/2015. RTF capacity: NYSOMH CAIRS database, 10/2015. US Census 2014 Est. Populations. Average Daily Census -- General Hospital (Art. 28): SPARCS, CY 2014. Private Psychiatric Hospital (Art. 31): Medicaid, CY 2014. Institutional Cost Report (ICR), CY 2014: county distribution using the 2013 Patient Characteristics Survey (PCS). State Psychiatric Centers: MHARS, CY 2014. RTF: CAIRS, CY 2014. US Census 2014 estimates.

Total psychiatric bed capacity in the region is 27 per 100,000 adults and 17 per 100,000 children. These psychiatric bed capacity rates are the second lowest in all DSRIP regions. The total inpatient average daily census (ADC) for adult beds is 65, while the ADC for child beds is 28, which is larger than the total number of child beds (n=12). Clinton County has the highest total ADC for adults (n=23) and Hamilton County has the lowest among all NYS counties (n=0.2). In comparison, Warren County has the highest total ADC for children (n=12) and Hamilton County has the lowest among all NYS counties (n=0.1).

In the Adirondacks region, the total ADC per 100,000 adults is 28 (the second lowest rate in any DSRIP region), while the total ADC per 100,000 children is 39 (the second highest rate in any DSRIP region). For adults, the total ADC per 100,000 adults is highest for residents of Clinton County (n=36) and lowest for residents of Hamilton County (n=5, the lowest adult rate in any NYS county). In comparison, the total ADC per 100,000 children is highest for residents of Warren County (n=78, the highest of any NYS county) and lowest for residents of Hamilton (n=12).

Substance Use Disorder Inpatient Programs
In New York State, substance use disorder (SUD) inpatient programs include crisis, inpatient rehabilitation, and residential programs.[6] In the Adirondacks region (Table 8) there are no SUD crisis programs. The region's two inpatient rehabilitation programs are located in Franklin County and its five residential programs are located in Clinton, Franklin, Warren (n=2), and Washington counties.

| County | US Census ACS 2010-2014 Est. Population | Inpatient Programs | | | | | | Total Capacity | Total Capacity per 10,000 |
| | | Crisis | | Inpatient Rehabilitation* | | Residential | | | |
		# Programs	Capacity	# Programs	Capacity	# Programs	Capacity		
Clinton	82,170	–	–	–	–	1	20	20	2
Essex	39,318	–	–	–	–	–	–	–	–
Franklin	51,695	–	–	2	83	1	25	108	21
Hamilton	4,864	–	–	–	–	–	–	–	–
Warren	65,686	–	–	–	–	2	33	33	5
Washington	63,166	–	–	–	–	1	15	15	2
Totals	**306,899**	**–**	**–**	**2**	**83**	**5**	**93**	**176**	**6**

Table 8. Adirondacks Region: Substance Use Disorders Inpatient Program Capacity

Notes and Data Sources: *Includes State Addiction Treatment Centers. Data is from the NYS Office of Alcoholism and Substance Abuse Services (OASAS) Provider Directory System. Includes programs that were operational as of April 2, 2016. More information about OASAS inpatient programs is available at http://www.oasas.ny.gov/hps/state/CD_descriptions.cfm

The region's inpatient rehabilitation capacity is 83 and its residential capacity is 93. The regional capacity per 10,000 for all SUD inpatient programs is six.

Table 9 describes the average daily enrollment (ADE) in these programs. The ADE in the region is 80 for inpatient rehabilitation and 82 for residential. The regional ADE per 10,000 for these programs is five.

County	US Census ACS 2010-2014 Est. Population	Inpatient Programs						Total Avg. Daily Enrollment	Total Avg. Daily Enrollment per 10,000
		Crisis		Inpatient Rehabilitation*		Residential			
		# Programs	Avg. Daily Enrollment	# Programs	Avg. Daily Enrollment	# Programs	Avg. Daily Enrollment		
Clinton	82,170	–	–	–	–	1	19	19	2
Essex	39,318	–	–	–	–	–	–	–	–
Franklin	51,695	–	–	2	80	1	17	97	19
Hamilton	4,864	–	–	–	–	–	–	–	–
Warren	65,686	–	–	–	–	2	32	32	5
Washington	63,166	–	–	–	–	1	14	14	2
Totals	306,899	–	–	2	80	5	82	162	5

Table 9. Adirondacks Region: Substance Use Disorders Inpatient Program Average Daily Enrollment

*Includes State Addiction Treatment Centers. Data is from the NYS Office of Alcoholism and Substance Abuse Services (OASAS) Provider Directory System. Includes programs that were operational as of April 2, 2016.

5. Outpatient Behavioral Health Care Services
The data presented here is by county of provider location. Individuals may access services in a county other than the county in which they reside.

Mental Health Outpatient and Clinic Programs

Adults
Adult mental health outpatient programs include: assertive community treatment (ACT), clinic, continuing day treatment (CDT), intensive psychiatric rehabilitative treatment (IPRT), partial hospitalization (PH), and personalized recovery-oriented services (PROS). The Adirondacks region's capacity and service use in these programs are presented in Table 10.

Outpatient programs (other than clinic) are located in Clinton (n=106 slots) and Warren (n=27 slots) counties. There is a total of 133 non-clinic outpatient program slots in the region or 57 slots per 100,000 adults, the third lowest rate in any DSRIP region.

Clinics may be locally- or state-operated. While the Adirondacks region has no state-operated clinics, all counties, except Hamilton, have locally-operated clinics. These clinics served a total of 4,429 adult Medicaid recipients and 1,344 adult non-Medicaid recipients. In the region 2,467 adults received clinic treatment per 100,000 adults. Franklin County's rate of 5,154 adults per 100,000 adults is the second highest rate in any NYS county. Washington County's service rate of 1,223 adults per 100,000 adults is the lowest in the region.

Table 10. Adirondacks Region: Adult Mental Health Outpatient Capacity and Service Use by Provider County

County	Outpatient Programs (PH, IPRT, CDT, PROS, ACT)		Clinics: Total Number of Adults			
			Locally Operated Clinics		Recipients in State-operated Clinics[4]	Clinic Treatment per 100,000 Adults[5]
	Capacity[1] (Slots)	Slots per 100,000 Adults[5]	Medicaid Recipients[2]	Non-Medicaid Recipients (Estimated #)[3]		
Clinton	106	170	1,093	316	–	2,262
Essex	–	–	356	96	–	1,476
Franklin	–	–	1,635	392	–	5,154
Hamilton	–	–	–	–	–	–
Warren	27	54	992	308	–	2,597
Washington	–	–	353	232	–	1,223
Totals	133	57	4,429	1,344	–	2,467

Notes and Data Sources: Clinics are not licensed for specific slot capacities, therefore size is measured by estimated total number of persons served annually. 1. Includes the total capacity for Partial Hospitalization (PH), Intensive Psychiatric Rehabilitative Treatment (IPRT), Continuing Day Treatment (CDT), Personalized Recovery-Oriented Services (PROS) and Assertive Community Treatment (ACT) (Data Source: New York State Office of Mental Health (NYSOMH) CONCERTS database, 10/2015). 2. Includes adults and children enrolled in Medicaid and served annually in non-State clinic programs (Data Source: Medicaid, CY 2014). 3. Includes annual estimate of adults not receiving Medicaid and served in non-State clinics during the NYSOMH 2013 Patient Characteristics Survey (PCS). 4. Includes adults served annually in State-run clinics (Data Source: NYSOMH MHARS database, CY 2014). 5. US Census ACS 2010-2014 Est. Population.

Children

Mental health outpatient programs that serve children include: assertive community treatment (ACT), clinic, day treatment (DT), and partial hospitalization (PH). The Adirondacks region's capacity and service use in these programs are presented in Table 11.

Table 11. Adirondacks Region: Child Mental Health Outpatient Capacity and Service Use by Provider County

County	Outpatient Programs (PH, DT, ACT)		Clinics: Total Number of Children			
			Locally Operated Clinics		Recipients in State-operated Clinics[4]	Clinic Treatment per 100,000 Children[5]
	Capacity[1] (Slots)	Slots per 100,000 Children[5]	Medicaid Recipients[2]	Non-Medicaid Recipients (Estimated #)[3]		
Clinton	–	–	538	292	–	4,310
Essex	–	–	77	36	–	1,364
Franklin	–	–	225	156	–	3,171
Hamilton	–	–	–	–	–	-
Warren	–	–	388	136	66	3,930
Washington	–	–	174	88	60	2,180
Totals	–	–	1,402	708	126	3,183

Notes and Data Sources: Clinics are not licensed for specific slot capacities, therefore size is measured by estimated total number of children served annually. 1. Includes the total capacity for Partial Hospitalizations (PH), Day Treatment (DT) and Children's Assertive Community Treatment (ACT) (Data Source: New York State Office of Mental Health (NYSOMH) CONCERTS database, 10/2015). 2. Includes children enrolled in Medicaid and served annually in locally-operated (non-State) clinic programs (Data Source: Medicaid, CY 2014). 3. Includes annual estimate of children not receiving Medicaid and served in locally-operated (non-State) clinics during the week of the NYSOMH 2013 Patient Characteristics Survey (PCS). 4. Includes children served annually in State-run clinics (Data Source: NYSOMH MHARS database, CY 2014). 5. US Census ACS 2010-2014 Est. Population.

There are no child outpatient programs other than clinic in the Adirondacks region. There are locally-operated clinics in all counties, except Hamilton, and state-operated clinics in Warren and Washington counties. The locally-operated clinics served a total of 1,402 Medicaid child recipients and 708 non-Medicaid child recipients, while the state-operated clinics served a total of 126 child recipients.

In the Adirondacks region, 3,183 children received clinic treatment per 100,000 children, which is the second highest rate in any DSRIP region. Clinton County's rate of 4,310 children per 100,000 children is the highest in the region, while Essex County's rate of 1,364 children per 100,000 children is the lowest.

Mental Health Emergency and Community Support Programs

Adults
Table 12 describes the Adirondacks region's service use in adult mental health emergency and community support programs. A total of 32 adults were served in emergency programs located in Clinton and Warren counties. In the region 14 adults received emergency services per 100,000 adults.

Table 12. Adirondacks Region: Adult Mental Health Emergency Programs and Community Support Programs by Provider County				
County	**Emergency Programs**		**Community Support Programs**	
	# Adults Served	**# Served per 100,000 Adults**	**# Adults Served**	**# Served per 100,000 Adults**
Clinton	4	6	107	162
Essex	–	–	79	246
Franklin	–	–	112	274
Hamilton	–	–	19	474
Warren	28	53	177	335
Washington	–	–	35	70
Totals	**32**	**14**	**529**	**226**
Data Sources: Includes adults receiving emergency services and support services (e.g., vocational, self-help, care coordination) as reported by the New York State Office of Mental Health 2013 Patient Characteristics Survey (PCS). US Census ACS 2010-2014 Est. Population. Service use is reported because there are no licensed capacities for nearly all of these programs.				

In comparison, there are adult community support programs (e.g., vocational, self-help and care coordination) in each county in the Adirondacks region, which collectively served 529 adults. In the region, 226 adults per 100,000 adults received services from community support programs, which is the third highest rate in all DSRIP regions. In the counties, service rates per 100,000 adults ranged from a low of 70 in Washington County to a high of 474 in Hamilton County.

<u>Children</u>
The Adirondacks region's service use in child mental health emergency and community support programs is presented in Table 13. Seven children received emergency services from programs in Warren County. In the region, 10 children received emergency services per 100,000 children.

County	Emergency Programs		Community Support Programs	
	# Children Served	# Served per 100,000 Children	# Children Served	# Served per 100,000 Children
Clinton	—	—	28	178
Essex	—	—	28	422
Franklin	—	—	29	280
Hamilton	—	—	26	3,688
Warren	7	58	68	559
Washington	—	—	9	73
Totals	7	10	188	268

Table 13. Adirondacks Region: Child Mental Health Emergency Programs and Community Support Programs by Provider County

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

Community support programs for children (e.g., vocational, home-based family treatment, and residential treatment facility transition) are located in all counties in the Adirondacks region and together served 188 children. These programs served 268 children per 100,000 children, which is the second highest rate in all DSRIP regions. In the counties, service rates per 100,000 children ranged from a low of 73 in Washington County to a high of 3,688 in Hamilton County.

Behavioral Health Housing Programs

<u>Adults</u>
In New York State adult behavioral health housing services are provided in licensed beds in family care, congregate treatment and apartment treatment programs, and in unlicensed beds in housing support and supported housing programs. More information about these programs is available on the NYS Office of Mental Health web page at http://bi.omh.ny.gov/adult_housing/index.

These adult housing services in the Adirondacks region are described in Table 14. The region has no beds in the family care or housing support programs. In the region licensed congregate treatment beds (n=65) are available in all counties except Essex and Hamilton, and apartment treatment beds (n=60) are available in Clinton, Franklin and Washington counties. Unlicensed supported housing beds (n=220) are available in

all counties. The housing capacity per 100,000 adults in the region is 147. In the counties housing capacity per 100,000 adults ranged from a low of 98 in Essex County to a high of 197 in Clinton County.

Table 14. Adirondacks Region: Adult Behavioral Health Community-Based Housing Capacity by Provider County						
	Licensed Beds			Unlicensed Beds		Housing Capacity per 100,000 Adults
County	Family Care	Congregate Treatment	Apartment Treatment	Housing Support Programs	Supported Housing	
Clinton	—	20	18	—	85	197
Essex	—	—	—	—	30	98
Franklin	—	20	9	—	47	193
Hamilton	—	—	—	—	4	103
Warren	—	12	—	—	49	122
Washington	—	13	33	—	5	107
Totals	—	65	60	—	220	147
Data Sources: Licensed and unlicensed beds: New York State Office of Mental Health CONCERTS database; data as of 10/2015. US Census ACS 2010-2014 Est. Population.						

Children

In New York State, child behavioral health housing services are provided in licensed beds in teaching family homes and child and youth community residences, and in home and community-based services (HCBS). These child housing services in the Adirondacks region are described in Table 15.

The region has no teaching family home beds. Licensed child and youth community residence beds (n=8) are located in Franklin County. The Adirondacks region has a capacity of 11 child and youth community residence beds per 100,000 children.

Table 15. Adirondacks Region: Child Behavioral Health Community-Based Housing Capacity and Home & Community-Based Services (HCBS) Slots by Provider County					
	Number of Licensed Housing Beds			HCBS Slots	
County	Teaching Family Home	Child & Youth Community Residence	Capacity per 100,000 Children	Number of Slots	Slots per 100,000 Children
Clinton	—	—	—	12	62
Essex	—	—	—	18	217
Franklin	—	8	67	12	100
Hamilton	—	—	—	6	662
Warren	—	—	—	12	80
Washington	—	—	—	12	81
Totals	—	8	11	72	102
Data Sources: New York State Office of Mental Health databases. Licensed housing capacity: CONCERTS, 10/2015. Home & Community-based Services (HCBS): CAIRS, CY 2014. US Census ACS 2010-2014 Est. Population.					

All counties in the region have HCBS slots (n=72) ranging from a high of 18 in Essex County to a low of six in Hamilton County. The region's HCBS slots served 102 children per 100,000 children. In the counties HCBS slots per 100,000 children ranged from a low of 62 in Clinton County to a high of 662 in Hamilton County.

Substance Use Disorder Outpatient Programs
New York State has a variety of substance use disorder (SUD) outpatient programs including clinic and rehabilitation. In the Adirondacks region, all counties except Hamilton have SUD outpatient programs. The average daily enrollment (ADE) in these programs (n=1,457) is described in Table 16. In the region, Franklin County has the highest ADE (n=465), while Hamilton has zero.

Region-wide these SUD programs have an ADE of 47 per 10,000. This is the highest ADE in SUD programs in any DSRIP region. In the counties, ADE per 10,000 ranged from a low of zero in Hamilton County to a high of 90 in Franklin County, which is the highest ADE in any NYS county.

County	US Census ACS 2010-2014 Est. Population	Outpatient Avg. Daily Enrollment	
		Total	Per 10,000
Clinton	82,170	377	46
Essex	39,318	95	24
Franklin	51,695	465	90
Hamilton	4,864	0	0
Warren	65,686	338	51
Washington	63,166	183	29
Totals	306,899	1,457	47

Table 16. Adirondacks Region: Substance Use Disorders Outpatient Program Average Daily Enrollment

Notes and Data Sources: Outpatient programs (OP) include Medically Supervised Outpatient, Outpatient Rehabilitation, Specialized OP – Traumatic Brain Injury, Outpatient Chemical Dependency for Youth, Specialized OP – Mobile, and Specialized Services OP Rehabilitation. Data is from the NYS Office of Alcoholism and Substance Abuse Services (OASAS) Provider Directory System. Includes programs that were operational as of April 2, 2016.

New York State also has outpatient opioid treatment programs (Table 17). The Adirondacks region has one opioid treatment program located in Clinton County, which has a capacity of 100 and an ADE of 62. Region-wide the program has a capacity of three per 10,000 and an ADE of two per 10,000, which are the lowest such rates in any DSRIP region.

Table 17. Adirondacks Region: Substance Use Disorders Outpatient Opioid Treatment Program Capacity and Average Daily Enrollment						
County	US Census ACS 2010-2014 Est. Population	Number of Programs	Opioid Treatment (Methadone)			
			Capacity		Avg. Daily Enrollment	
			Total	Per 10,000	Total	Per 10,000
Clinton	82,170	1	100	12	62	8
Essex	39,318	–	–	–	–	–
Franklin	51,695	–	–	–	–	–
Hamilton	4,864	–	–	–	–	–
Warren	65,686	–	–	–	–	–
Washington	63,166	–	–	–	–	–
Totals	306,899	1	100	3	62	2
Data is from the NYS Office of Alcoholism and Substance Abuse Services (OASAS) Provider Directory System. Includes programs that were operational as of April 2, 2016.						

6. Care Coordination

New York State's Medicaid health home initiative is designed to expand and improve care management for beneficiaries with intensive, high-cost service needs. The health home model provides the basis for unified systems of care to coordinate and integrate physical and behavioral health care, and social services provided to health home members. In the Adirondacks region one Health Home provider serves all six counties (Table 18).

Table 18. Adirondacks Region: Health Homes Serving Medicaid Enrollees by County		
County	Total # Health Homes Serving Region	# Health Homes Serving County
Clinton		1
Essex		1
Franklin	1	1
Hamilton		1
Warren		1
Washington		1
Data is from the NYS Department of Health Designated Health Homes Web page. Retrieved May 4, 2016 from https://www.health.ny.gov/health_care/ medicaid/program/medicaid_health_homes/contact_information/list_by_county.htm #clinton		

7. Behavioral Health Care Practitioners

Licensed Mental Health Professionals
In New York State, the licensed mental health (MH) workforce includes psychiatrists, psychologists, clinical or master level social workers, nurse practitioners–psychiatry, marriage and family therapists, mental health counselors, psychoanalysts, and creative arts therapists.[7] The number and distribution of these practitioners in the Adirondacks region is presented in Table 19.

County	US Census ACS 2010-2014 Est. Population	Psychiatrists	Psychologists	LCSWs	LMSWs	Mental Health Counseling	Nurse Practitioner - Psychiatry	*Other	Total	Per 10,000
Clinton	82,170	13	8	43	32	51	6	4	157	19
Essex	39,318	0	11	29	20	20	2	1	83	21
Franklin	51,695	3	11	28	21	22	2	2	89	17
Hamilton	4,864	0	2	4	4	2	1	0	13	27
Warren	65,686	13	31	68	47	21	9	7	196	30
Washington	63,166	0	6	34	29	9	1	0	79	13
Totals	**306,899**	**29**	**69**	**206**	**153**	**125**	**21**	**14**	**617**	**20**

Table 19. Adirondacks Region: Licensed Mental Health Professionals

Data for psychiatrists is from the American Board of Psychiatry and Neurology, Inc. and was retrieved from https://application.abpn.com/verifycert/verifycert.asp on July 15, 2014. Data for all other professions is as of June 2, 2014 and was provided by the Office of the Professions at the New York State Education Department. *Other category includes marriage and family therapists, psychoanalysts, and creative arts therapists.

The Adirondacks region has a total of 617 licensed MH professionals or 20 per 10,000 population, which is the third lowest rate in any DSRIP region. There are maldistributions of MH professionals across the region's counties. Washington County has the lowest county distribution of MH professionals — 13 per 10,000 (the second lowest rate among all NYS counties) compared to Warren County which has the highest — 30 per 10,000. In addition, there are no psychiatrists in Essex, Hamilton and Washington counties.

MH Professional Shortage Designations
The maldistribution of licensed MH professionals in the Adirondacks region is recognized by federally designated health professional shortage areas (HPSAs). HPSAs are designated on the county level by the federal Health Resources and Services Administration (HRSA). HPSAs are designated using several criteria, including population-to-clinician ratios. This

Table 19a. Adirondacks Region: HRSA Federal Mental Health Professional Shortage Designations

County	Whole County	Census tract, populations or facilities	Medicaid Eligible population
Clinton	Yes	Yes	Yes
Essex	Yes	Yes	
Franklin	Yes	Yes	
Hamilton	Yes	Yes	
Warren		Yes	
Washington		Yes	

HRSA federal shortage designations retrieved March 17, 2016 from http://datawarehouse.hrsa.gov/tools/analyzers/hpsafind.aspx

ratio is usually 6,000 to 1 for mental health care.

In the Adirondacks region, Clinton, Essex, Franklin and Hamilton counties each has a whole county MH professional shortage designation (Table 19a). All of the counties in the region have a census tract, population or facility designated as a MH Medically Underserved Area/Population (MUA/P). Clinton County's Medicaid eligible population has also been designated a MH professional MUP.

Certified and Credentialed Substance Use Disorder Professionals
In New York State, the certified and credentialed substance use disorder (SUD) workforce includes physicians and counselors. The number and distribution of these practitioners in the Adirondacks region is presented in Table 20. Hamilton County is the only county in NYS with no SUD professionals.

Table 20. Adirondacks Region: Certified and Credentialed Substance Use Disorder Professionals							
County	US Census ACS 2010-2014 Est. Population	Physicians		Counselors		Total	Per 10,000 Population
		Board Certified Addiction Medicine	Authorized for Buprenorphine Prescription	Credentialed Alcoholism and Substance Abuse	Certified Rehabilitation		
Clinton	82,170	0	12	23	3	38	5
Essex	39,318	0	2	23	1	26	7
Franklin	51,695	1	7	30	1	38	7
Hamilton	4,864	0	0	0	0	0	0
Warren	65,686	0	13	19	2	34	5
Washington	63,166	0	2	20	0	22	3
Totals	306,899	1	36	115	7	158	5

Data is from the NYS Office of Alcoholism and Substance Abuse Services (OASAS) Human Resources Office and is as of May 13, 2016.

SUD physicians include those board certified in addiction medicine and those authorized to prescribe buprenorphine to treat opioid addiction. In the Adirondacks region there is one physician certified in addiction medicine, the lowest number in any DSRIP region. All counties except Hamilton have physicians authorized to prescribe buprenorphine.

SUD counselors include those credentialed in alcoholism and substance abuse and those certified in rehabilitation. All counties except Hamilton have alcoholism and substance abuse counselors and all counties except Hamilton and Washington have rehabilitation counselors.

Overall, the Adirondacks region has a total of 158 certified and credentialed SUD professionals or five per 10,000 population. Hamilton County has the lowest county distribution of SUD professionals — zero compared to the highest in Essex and Franklin counties — seven per 10,000.

While there are no HPSA shortage designations for SUD professionals, an area will be considered to have unusually high needs for mental health services if: 1) there is a high prevalence of alcoholism in the population, as indicated by prevalence data showing the area's alcoholism rates to be in the worst quartile of the nation, region, or State; or 2) there is a high degree of substance abuse in the area, as indicated by prevalence data showing the area's substance abuse to be in the worst quartile of the nation, region, or State.[8]

---

[1] NYS Nursing Home Behavioral Intervention Services: This program must include a discrete unit with a planned combination of services with staffing, equipment and physical facilities designed to serve individuals whose severe behavior cannot be managed in a less restrictive setting. The program's services are directed at attaining or maintaining the individual at the highest practicable level of physical, affective, behavioral and cognitive functioning. Retrieved April 21, 2016 from https://www.health.ny.gov/facilities/nursing/all_services.htm .

[2] Diagnostic and Treatment Centers provide a comprehensive range of primary health care services to a population that includes uninsured individuals.

[3] Federally qualified health centers (FQHCs) include all organizations receiving grants under Section 330 of the Public Health Service Act (PHS). FQHCs qualify for enhanced reimbursement from Medicare and Medicaid, as well as other benefits. FQHCs must serve an underserved area or population, offer a sliding fee scale, and provide comprehensive services.

[4] A primary care HPSA is a collection of census tracts that has been designated as having a shortage of primary care health professionals. HRSA uses two methodologies to determine whether there are adequate health care resources for specific geographical areas. Aggregate ZIP codes or census tracts can be designated as a Medically Underserved Area/Population (MUA/P) based on an analysis of four criteria: the ratio of primary care medical care physicians per 1,000 population, infant mortality rate, percentage of the population with incomes below the poverty level, and percentage of the population age 65 or over. A medically underserved population faces economic barriers (e.g. low-income or Medicaid-eligible populations), or cultural and/or linguistic access barriers to primary medical care services, and population specific information is assessed according to the above criteria to achieve MUP designation.

[5] In this report adults are individuals aged 20 and older and children are individuals aged 19 and younger.

[6] More information about OASAS inpatient programs is available at http://www.oasas.ny.gov/hps /state/CD_descriptions.cfm

[7] Licensed Mental Health Workforce Data Sources and Limitations: Data for psychiatrists is from the American Board of Psychiatry and Neurology, Inc. and was retrieved from https://application.abpn.com/verifycert/verifycert.asp on July 15, 2014. Data for all other professions is as of June 2, 2014 and was provided by the Office of the Professions at the New York State Education Department. Licensees must be registered in order to practice and use a professional title in NYS; being registered, however, does not necessarily mean the licensee is actively engaged in practice. In addition, NYS licensing data show only "nurse practitioners-psychiatry" as a BH-psychiatric nurse specialty. All other nursing specialties that contribute to the licensed BH workforce are combined in the general category of "nurse" in the NYS licensing data and are not counted in the licensed BH workforce described here. This limitation also extends to other data sources such as professional nursing organizations, which also combine all nursing specialties in a general category of "nurse" in their data collection processes.

[8] HRSA Guidelines for Mental Health HPSA Designation. Retrieved May 24, 2016 from http://bhpr.hrsa.gov/shortage/hpsas/designationcriteria/mentalhealthhpsaguidelines.html

III. Health Status

This section describes the health status of individuals in the Adirondacks DSRIP region. Its findings should be considered with those in Sections V and VI of this report, which describe unmet service need by DSRIP region.

Note: Data presented in this section should be interpreted with Hamilton County's small population size (n=4,864, the smallest population in any NYS county) in mind; some data points may be unstable.

1. Disease Prevalence
Chronic Health Conditions
Among all DSRIP regions, the Adirondacks region has the highest average percentages of adults with angina, heart attack or stroke (9%), high blood pressure (31%), and asthma (12%). It has the second highest percentages of adults with diabetes (10%) and that are overweight or obese (67%). In the region, Franklin and Clinton counties have the highest percentage of adults with these chronic conditions, while Hamilton County has the lowest percentages of adults with all of these chronic conditions except obesity (Table 1).

Compared to all other NYS counties, Franklin County has the highest percentage with high blood pressure (37%), and Clinton County has the second highest percentages of adults with angina, heart attack or stroke (11%) and that are overweight or obese (71%).

Table 1. Adirondacks Region: Prevalence of Chronic Health Conditions Among Adults					
County	Age-adjusted Percentage of Adults				
	With physician diagnosed diabetes	With physician diagnosed angina, heart attack or stroke	Ever told they have high blood pressure	Overweight or obese (BMI 25 or higher)	With current asthma
Clinton	10	11	33	71	15
Essex	10	8	28	64	12
Franklin	12	10	37	69	13
Hamilton	8	5	25	68	9
Warren	10	9	30	63	13
Washington	8	9	30	68	10
Region Average	10	9	31	67	12
Data Source is the NYS Department of Health Community Health Indicator Reports (CHIRS): Latest Data. Retrieved May 2, 2016 from https://health.data.ny.gov/Health/Community-Health-Indicator-Reports-CHIRS-Latest-Da/54ci-sdfi					

HIV, AIDS and Cancer

Compared to other DSRIP regions, the average case rates of HIV and AIDS in the Adirondacks region (3 per 100,000 each) are the second lowest. The AIDS case rate per 100,000 ranges from one in Clinton County to four in Essex County (Table 2). The cancer incidence rate per 100,000 is highest in Washington County (n=565) and lowest in Essex County (n=464).

County	Age-adjusted case rate per 100,000		Age-adjusted all cancers incidence rate per 100,000
	HIV	AIDS	
Clinton	1	1	544
Essex	3	4	464
Franklin	2	2	486
Hamilton	3	3	491
Warren	4	2	521
Washington	4	3	565
Region Average	**3**	**3**	**512**

Table 2. Adirondacks Region: Rates of HIV, AIDS, and Cancer

Data Source is the NYS Department of Health Community Health Indicator Reports (CHIRS): Latest Data. Retrieved May 2, 2016 from https://health.data.ny.gov/Health/Community-Health-Indicator-Reports-CHIRS-Latest-Da/54ci-sdfi

2. Health Behaviors and Risk Factors

In the Adirondacks region, Franklin County has the highest percentage of adults that report they have experienced food (35%, the highest percentage in any NYS county) and housing insecurity (47%), are in poor health (6%), current smokers (27%), and did not receive medical care because of cost (18%, the highest percentage in any NYS county) (Table 3). Hamilton County has the lowest percentage of adults that report food (17%) and housing (30%) insecurity, lack of medical care because of cost (8%), and poor mental health (5%, the lowest percentage in any NYS county).

The percentage of adults that report binge drinking is highest in Clinton County (23%) and lowest in Washington (13%). Warren and Washington counties have the highest percentage reporting poor mental health for 14 or more days in the last month (12% each). In the region, 50% of those that report poor mental health are current smokers, which is the third highest percentage among all DSRIP regions.

Table 3. Adirondacks Region: Adult Self-Reported Health Behaviors and Risk Factors									
County	Survey Sample Size	Percentage of Adults Who Self-Reported:							
		Binge drinking during past month	Food insecurity in past 12 months	Housing insecurity in past 12 months	Poor health	Current smoker	Did not receive medical care because of cost in past 12 mos	Poor mental health for 14 or more days in last month	Cigarette smoking among those who report poor mental health
Clinton	3,711	23%	21%	30%	3%	23%	12%	11%	41%
Essex	3,213	17%	21%	38%	3%	17%	10%	10%	*
Franklin	2,955	17%	35%	47%	6%	27%	18%	10%	*
Hamilton	2,497	17%	17%	30%	4%	19%	8%	5%	*
Warren	2,841	15%	22%	34%	6%	19%	8%	12%	*
Washington	3,619	13%	20%	37%	5%	21%	11%	12%	59%
Region Total/Avg.	18,836	17%	23%	36%	5%	21%	11%	10%	50%

*Suppressed due to small sample size. Data is from the CDC Expanded Behavioral Risk Factor Surveillance System (BRFSS) 2013-14 Survey. Retrieved April 27, 2016 from https://health.data.ny.gov/Health/Expanded-Behavioral-Risk-Factor-Surveillance-Surve/jsy7-eb4n?_sm_au_=iVVnMrPRnsfs8P5M

3. Hospitalization Rates by Disease or Cause

In the Adirondacks region, cardiovascular disease is the leading cause for hospitalizations (Table 4). Franklin County has the highest hospitalization rates per 10,000 due to cardiovascular disease (n=148), diabetes (n=16), and drug-related (n=26). Hamilton County has the highest rate of hospitalizations for stroke (n=25) and Clinton County has the highest rate for asthma (n=14).

Table 4. Adirondacks Region: Hospitalization Rates by Disease or Cause								
County	Age-adjusted hospitalization rate per 10,000							Newborn drug-related diagnosis rate per 10,000 newborn discharges
	Total hospitalizations	Cardiovascular disease	Cerebrovascular disease (stroke)	Diabetes (primary diagnosis)	Asthma	Self-inflicted injury	Drug-related	
Clinton	1,056	143	18	14	14	13	23	41
Essex	783	100	15	9	6	8	13	93
Franklin	1,139	148	20	16	11	6	26	60
Hamilton	945	112	25	11	3	18	12	0
Warren	1,182	128	20	16	13	14	16	145
Washington	1,108	132	22	13	11	12	14	151
Region Average	1,035	127	20	13	10	12	17	82

Data Source is the NYS Department of Health Community Health Indicator Reports (CHIRS): Latest Data. Retrieved May 2, 2016 from https://health.data.ny.gov/Health/Community-Health-Indicator-Reports-CHIRS-Latest-Da/54ci-sdfi

In the region Essex County has the lowest hospitalization rates for cardiovascular disease (n=100), stroke (n=15) and diabetes (n=9), and Hamilton County has the lowest rates for asthma (n=3, the lowest rate in any NYS county) and drug-related (n=12). The rates of newborn drug-related diagnoses per 10,000 are highest in Washington County (n=151) and lowest in Hamilton (n=0).

Compared to all other DSRIP regions, the Adirondacks region has the highest average rate per 10,000 of self-inflicted injury (n=12). The rate is highest in Hamilton (n=18, the highest rate in any NYS county) and lowest in Franklin (n=6) County.

4. Mortality Rates

Premature Mortality

In the Adirondacks region the percentage of premature deaths (42%) is second highest in any DSRIP region (Table 5). Among all DSRIP regions, the Adirondacks region has the highest average rate per 100,000 of alcohol related motor vehicle injuries and deaths (n=72) and the second highest average premature death rate for stroke (n=14).

Table 5. Adirondacks Region: Percentage and Rates of Premature Death and Alcohol Related Motor Vehicle Injuries and Deaths				
County	Percentage premature deaths (aged less than 75 years)	Rate per 100,000		Alcohol related motor vehicle injuries and deaths
		Premature Death (aged 35-64 years)		
		Cardiovascular disease	Cerebrovascular disease (stroke)	
Clinton	41	85	9	38
Essex	38	126	10	65
Franklin	42	118	17	69
Hamilton	49	133	30	139
Warren	39	107	8	66
Washington	41	97	9	58
Average % or Rate	42	111	14	72
Data Source is the NYS Department of Health Community Health Indicator Reports (CHIRS): Latest Data. Retrieved May 2, 2016 from https://health.data.ny.gov/Health/Community-Health-Indicator-Reports-CHIRS-Latest-Da/54ci-sdfi				

In the region, premature deaths from all causes are highest in Hamilton County. Compared to all other NYS counties, Hamilton County has the highest rates of death due to cardiovascular disease (n=30) and alcohol related motor vehicle injuries and deaths (n=139).

Top Ten Causes of Death

Heart disease is the number one cause of death in all Adirondacks counties, except Hamilton and Warren, where the leading cause of death is malignant neoplasms (Table 6). Among all DSRIP regions, the region has the lowest average death rate per 100,000 due to AIDS (n=0) and pneumonia (n=11).

Washington County has the highest death rates due to heart disease (n=185) and suicide (n=14). Franklin County has the highest death rate due to cirrhosis of the liver (n=17) and Essex County has the highest death rate due to accidents (n=40). Essex County also had the lowest death rates in the region due to malignant neoplasms (n=131), stroke (n=16) and pneumonia (n=4).

Table 6. Adirondacks Region: 2014 Top Ten Causes of Death — Rates* per 100,000 Population by Resident County										
County	Heart Disease	Malignant Neoplasms	Cerebrovascular Disease (Stroke)	AIDS	Pneumonia	Chronic Lower Respiratory Disease	Accidents	Diabetes Mellitus	Homicide or Legal Intervention	Cirrhosis of Liver	Suicide
Clinton	180	173	33	0	12	32	34	16	4	9	8
Essex	166	131	16	0	4	40	40	30	0	2	7
Franklin	171	152	32	0	11	49	36	19	0	17	7
Hamilton	130	181	28	0	0	51	15	0	36	8	9
Warren	137	182	34	0	20	53	30	21	0	11	6
Washington	185	157	26	0	18	45	37	24	0	4	14
Region Average	161	163	28	0	11	45	32	18	7	8	9

Data is from the NYS Department of Health. Retrieved April 26, 2016 from https://www.health.ny.gov/statistics/vital_statistics/2014/table40.htm
*Age-Sex adjusted rates are directly standardized using the age-sex distribution for the United States 2000 Census.

5. Patients in the Public Mental Health System

Every other year, the NYS Office of Mental Health (OMH) collects information about patients served over a one week period in NYSOMH funded or licensed outpatient and inpatient facilities. Tables 7 and 8 report the chronic health conditions and behavioral health diagnoses of those served in 2015.

Chronic Health Conditions

Overall, smoking (27%) and obesity (19%) are the leading chronic health conditions for the public mental health population in the Adirondacks region (Table 7).

Table 7. Adirondacks Region: Chronic Health Conditions Among Those Served in the NYS Public Mental Health System							
Age Group	Percentage of Patients Served with Chronic Health Conditions						
	Current Smokers	Diabetes	Obesity	High Blood Pressure	Hyperlipidemia	Had a Heart Attack	Had a Stroke
Under 21	7	1	7	0	0	0	0
21-64	35	9	23	15	10	1	1
65+	23	21	22	37	26	10	3
Total Average	27	8	19	11	8	1	1

Data is from the NYS Office of Mental Health 2015 Patient Characteristics Survey. Data retrieved April 28, 2016.

Among all DSRIP regions, the Adirondacks region has the second highest percentage of patients served with obesity (19%) and the lowest percentages of patients served with high blood pressure (11%) and hyperlipidemia (8%).

- Among patients under the age of 21, the region has the second highest percentage with obesity (7%) in all DSRIP regions.

- For patients ages 21-64, it has the lowest percentage with diabetes (9%) and the second highest percentage of those with obesity (23%) in all DSRIP regions.

- For patients ages 65 and older, the Adirondacks region has the highest percentage of those that have had a heart attack (10%) and the second highest percentage of those with obesity (22%) in all DSRIP regions.

Behavioral Health Diagnoses
Overall, co-occurring disorder (25%) and depressive disorders (22%) are the leading behavioral health diagnoses for the public mental health population in the region (Table 8).

Table 8. Adirondacks Region: Behavioral Health Diagnoses Among Those Served in the NYS Public Mental Health System								
Age Group	Percentage of Patients Served by Diagnostic Category							
	Anxiety Disorder	Bipolar and related Disorders	Depressive Disorders	Disruptive Impulse Conduct Disorder	Neurodevelop-mental Disorders	Schizophrenia Spectrum & other Psychotic Disorders	Trauma Stress or Adjustment	Not a Mental Illness	With a Co-Occuring Disorder
Under 21	11	10	16	11	21	1	27	4	4
21-64	10	18	24	1	1	20	13	3	34
65+	6	18	35	3	0	23	4	0	16
Total Average	10	16	22	4	7	15	17	3	25
Data is from the NYS Office of Mental Health 2015 Patient Characteristics Survey. Data retrieved April 28, 2016.								

Among all DSRIP regions, the Adirondacks region has the highest percentages of patients served with trauma, stress, or adjustment disorder (17%) and with a co-occurring disorder (25%). The region has the second highest percentage of patients served with anxiety disorder (10%).

- Among patients under the age of 21, the region has the highest percentages of those with disruptive impulse conduct disorder (11%), trauma, stress, or adjustment disorder (27%) and with a co-occurring disorder (4%) in all DSRIP regions.

- For patients ages 21-64, it has the highest percentage of those with trauma, stress, or adjustment disorder (13%), and the second highest percentages of those with anxiety disorder (10%) and a co-occurring disorder (34%) in all DSRIP regions.

- For patients ages 65 and older, the Adirondacks region has the highest percentages of those with bipolar and related disorders (18%) and a co-occurring disorder (16%), and the second highest percentage of those with depressive disorders (35%) in all DSRIP regions.

IV. Behavioral Health Care Utilization

This section describes behavioral health care utilization in hospitals and emergency rooms in the Adirondacks DSRIP region. Its findings should be considered with those in Sections V and VI of this report, which describe unmet service need by DSRIP region.

1. Hospital Inpatient Admissions

Mental Health Diagnosis Inpatient Admissions
Total hospital inpatient admissions by the major diagnostic category of mental health (n=10,498) in the Adirondacks region are described in Table 1. Overall, the region had 342 mental health (MH) diagnosis inpatient admissions per 10,000 population. Admissions ranged from a high of 443 per 10,000 in Warren County to a low of zero in Hamilton. In the region, inpatient admissions for depressive disorders were most frequent (43%), followed by other mental health diagnoses (21%), chronic stress and anxiety diagnoses (13%), schizophrenia (10%), bi-polar disorder (8%) and PTSD (5%).

Table 1. Adirondacks Region: Total Inpatient Hospital Admissions by Mental Health Diagnosis															
	US Census ACS 2010-2014 Est. Population	Mental Health Diagnosis												Total Admissions	Total Admissions per 10,000
County		Bi-Polar Disorder		Depressive Disorders		Schizophrenia		Chronic Stress and Anxiety Diagnoses		Post Traumatic Stress Disorder		Other Mental Health Diagnoses			
		N	%	N	%	N	%	N	%	N	%	N	%		
Clinton	82,170	359	10%	1,412	40%	307	9%	397	11%	169	5%	876	25%	3,520	428
Essex	39,318	29	4%	404	61%	38	6%	140	21%	0	0%	54	8%	665	169
Franklin	51,695	100	5%	956	52%	192	10%	249	14%	94	5%	253	14%	1,844	357
Hamilton	4,864	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0
Warren	65,686	240	8%	1,124	39%	345	12%	375	13%	160	5%	669	23%	2,913	443
Washington	63,166	90	6%	666	43%	207	13%	209	13%	79	5%	305	20%	1,556	246
Totals	306,899	818	8%	4,562	43%	1,089	10%	1,370	13%	502	5%	2,157	21%	10,498	342

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

Depressive disorders accounted for the largest percentage of inpatient admissions in all counties, but were highest in Essex (61%, second highest in any NYS county). Admissions were highest for bipolar disorder in Clinton County (10%), for schizophrenia in Washington County (13%), for chronic stress and anxiety diagnoses in Essex County (21%), for other mental health diagnoses in Clinton County (25%), and were consistent for PTSD across all counties, except Essex and Hamilton (0% each).

Compared to all other DSRIP regions, the Adirondacks region had the smallest percentages of total inpatient admissions for bi-polar disorder and schizophrenia.

Table 2 describes Medicaid beneficiary inpatient admissions in this population. The Adirondacks region had 187 Medicaid MH diagnosis inpatient admissions per 10,000

population. These Medicaid admissions account for approximately 55% of all MH diagnosis inpatient admissions in the region. Medicaid MH diagnosis inpatient admissions per 10,000 population ranged from a high of 252 in Warren County to a low of zero in Hamilton County.

Table 2. Adirondacks Region: Medicaid Beneficiary Inpatient Hospital Admissions by Mental Health Diagnosis														
County	US Census ACS 2010-2014 Est. Population	Mental Health Diagnosis												Total Admissions	Total Admissions per 10,000
		Bi-Polar Disorder		Depressive Disorders		Schizophrenia		Chronic Stress and Anxiety Diagnoses		Post Traumatic Stress Disorder		Other Mental Health Diagnoses			
		N	%	N	%	N	%	N	%	N	%	N	%		
Clinton	82,170	186	9%	843	42%	171	9%	243	12%	84	4%	480	24%	2,007	244
Essex	39,318	14	4%	219	62%	20	6%	64	18%	0	0%	34	10%	351	89
Franklin	51,695	54	6%	444	51%	103	12%	106	12%	39	5%	118	14%	864	167
Hamilton	4,864	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0
Warren	65,686	126	8%	662	40%	191	12%	224	14%	88	5%	364	22%	1,655	252
Washington	63,166	52	6%	390	45%	107	12%	128	15%	44	5%	151	17%	872	138
Totals	306,899	432	8%	2,558	44%	592	10%	765	13%	255	4%	1,147	20%	5,749	187

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

In the region, MH inpatient admissions among Medicaid beneficiaries were most frequent for depressive disorders (44%), followed by other MH diagnoses (20%), chronic stress and anxiety diagnoses (13%), schizophrenia (10%), bi-polar disorder (8%), and PTSD (4%). These frequencies are similar to all inpatient admissions for MH diagnoses.

Depressive disorders accounted for the largest percentage of inpatient admissions in all counties, but were highest in Essex (62%). Admissions were highest for bipolar disorder in Clinton County (9%), for chronic stress and anxiety diagnoses in Essex County (18%), and for other mental health diagnoses in Clinton County (24%, the highest in any NYS county). Schizophrenia admissions were equally high in Franklin, Warren and Washington counties (12% each).

Compared to all other DSRIP regions, the Adirondacks had the smallest percentage of Medicaid inpatient admissions for schizophrenia and the largest percentage for some other MH diagnosis.

Substance Use Disorder Inpatient Admissions
Total hospital inpatient admissions by the major diagnostic category of substance use disorder (n=3,480) in the Adirondacks region are described in Table 3. Overall, the region had 113 substance use disorder (SUD) inpatient admissions per 10,000 population. Admissions ranged from a high of 175 per 10,000 in Clinton County to a low of zero in Hamilton County. In the region, SUD inpatient admissions for alcohol use disorder were most frequent (33%), followed by opioid use disorder (24%), drug abuse: cannabis/NOS/NEC (22%), other SUD diagnoses (14%), and cocaine use disorder (7%).

Table 3. Adirondacks Region: Total Inpatient Hospital Admissions by Substance Use Disorder Diagnosis													
County	US Census ACS 2010-2014 Est. Population	Substance Use Disorder Diagnosis										Total SUD Admissions	Total Admissions per 10,000
		Cocaine Use Disorder		Alchohol Use Disorder		Opioid Use Disorder		Drug Abuse: Cannabis/NOS/NEC		Other SUD Diagnoses			
		#	%	#	%	#	%	#	%	#	%		
Clinton	82,170	109	8%	377	26%	342	24%	379	26%	234	16%	1,441	175
Essex	39,318	0	0%	68	40%	42	25%	45	27%	13	8%	168	43
Franklin	51,695	34	5%	283	38%	159	21%	168	22%	107	14%	751	145
Hamilton	4,864	0	0%	0	0%	0	0%	0	0%	0	0%	0	0
Warren	65,686	85	10%	332	39%	201	24%	127	15%	110	13%	855	130
Washington	63,166	14	5%	95	36%	84	32%	47	18%	25	9%	265	42
Totals	306,899	242	7%	1,155	33%	828	24%	766	22%	489	14%	3,480	113

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

Alcohol use disorder accounted for the largest percentage of inpatient admissions in all counties, but was highest in Essex (40%). Inpatient admissions were highest for cocaine use disorder in Warren County (10%), for opioid use disorder in Washington County (32%), for drug abuse: cannabis/NOS/NEC in Essex County (27%), and for other SUD diagnoses in Clinton County (16%).

Compared to all other DSRIP regions, the Adirondacks had the smallest percentage of total inpatient admissions for cocaine use disorder.

Table 4 describes Medicaid beneficiary inpatient admissions in this population. The Adirondacks region had 58 Medicaid SUD inpatient admissions per 10,000 population. These Medicaid admissions account for approximately 50% of all SUD diagnosis inpatient admissions in the region. Medicaid SUD diagnosis inpatient admissions per 10,000 population ranged from a high of 91 in Clinton County to a low of zero in Hamilton County.

In the region, SUD inpatient admissions among Medicaid beneficiaries were most frequent for alcohol use disorders (33%), followed by drug abuse: cannabis/NOS/NEC (24%), opioid use disorder (22%), other SUD diagnoses (14%), and cocaine use disorder (7%). These frequencies are similar to those for all SUD inpatient admissions.

Table 4. Adirondacks Region: Medicaid Beneficiary Inpatient Hospital Admissions by Substance Use Disorder Diagnosis													
County	US Census ACS 2010-2014 Est. Population	Substance Use Disorder Diagnosis										Total SUD Admissions	Total Admissions per 10,000
		Cocaine Use Disorder		Alchohol Use Disorder		Opioid Use Disorder		Drug Abuse: Cannabis/NOS/NEC		Other SUD Diagnoses			
		#	%	#	%	#	%	#	%	#	%		
Clinton	82,170	48	6%	192	26%	209	28%	182	24%	117	16%	748	91
Essex	39,318	0	0%	37	39%	24	25%	27	28%	8	8%	96	24
Franklin	51,695	17	5%	126	39%	63	20%	69	22%	45	14%	320	62
Hamilton	4,864	0	0%	0	0%	0	0%	0	0%	0	0%	0	0
Warren	65,686	41	10%	168	39%	67	16%	99	23%	55	13%	430	65
Washington	63,166	12	7%	64	36%	29	16%	51	29%	20	11%	176	28
Totals	306,899	118	7%	587	33%	392	22%	428	24%	245	14%	1,770	58

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

Alcohol use disorder accounted for the largest percentage of inpatient admissions in all counties, except Clinton, and were highest in Essex, Franklin and Warren counties (39% each). Admissions were highest for cocaine use disorder in Warren County (10%), for opioid use disorder (28%) and other SUD diagnoses (16%) in Clinton County, and for drug abuse: cannabis/NOS/NEC in Washington County (29%).

Compared to all other DSRIP regions, the Adirondacks had the smallest percentage of Medicaid inpatient admissions for cocaine use disorder.

2. Emergency Room Visits

Mental Health (MH) Diagnosis Emergency Room Visits
Total emergency room visits by the major diagnostic category of MH (n=49,298) in the Adirondacks region are described in Table 5. Overall, the region had 1,606 MH diagnosis emergency room (ER) visits per 10,000 population. Visits ranged from a high of 2,091 per 10,000 in Clinton County to a low of 130 per 10,000 in Hamilton County. In the region, ER visits for depressive disorders were most frequent (37%), followed by other mental health diagnoses (24%), chronic stress and anxiety diagnoses (14%), schizophrenia (10%), bi-polar disorder (9%) and PTSD (6%).

Depressive disorders accounted for the largest percentage of MH diagnosis ER visits in all counties, except Hamilton, and were highest in Franklin County (42%). ER visits were highest for bipolar disorder in Clinton and Franklin counties (10% each), for schizophrenia (46%, the highest in any NYS county) and chronic stress and anxiety (21%, the highest in any NYS county) in Hamilton County, for PTSD in Washington County (7%, second highest in any NYS county), and for other mental health diagnoses in Clinton and Washington counties (26% each, second highest in any NYS county).

Table 5. Adirondacks Region: Total Patient Emergency Room Visits by Mental Health Diagnosis														
County	US Census ACS 2010-2014 Est. Population	Mental Health Diagnosis												Total Visits	Total Visits per 10,000
		Bi-Polar Disorder		Depressive Disorders		Schizophrenia		Chronic Stress and Anxiety Diagnoses		Post Traumatic Stress Disorder		Other Mental Health Diagnoses			
		#	%	#	%	#	%	#	%	#	%	#	%		
Clinton	82,170	1,678	10%	6,248	36%	1,401	8%	2,333	14%	969	6%	4,550	26%	17,179	2,091
Essex	39,318	401	7%	2,350	41%	510	9%	948	16%	223	4%	1,348	23%	5,780	1,470
Franklin	51,695	914	10%	3,968	42%	1,021	11%	1,345	14%	457	5%	1,670	18%	9,375	1,814
Hamilton	4,864	0	0%	21	33%	29	46%	13	21%	0	0%	0	0%	63	130
Warren	65,686	876	9%	3,292	35%	1,116	12%	1,293	14%	590	6%	2,373	25%	9,540	1,452
Washington	63,166	588	8%	2,544	35%	790	11%	1,006	14%	514	7%	1,919	26%	7,361	1,165
Totals	306,899	4,457	9%	18,423	37%	4,867	10%	6,938	14%	2,753	6%	11,860	24%	49,298	1,606

Data is from the NYS Department of Health Medicaid Chronic Conditions and Emergency Room Visits database, 2012 data. Retrieved May 4, 2016 from https://health.data.ny.gov/Health/Medicaid-Chronic-Conditions-Inpatient-Admissions-a/wybq-m39t

Compared to all other DSRIP regions, the Adirondacks had the smallest percentage of ER visits for schizophrenia and the highest percentages for PTSD and other mental health diagnoses.

Table 6 describes Medicaid beneficiary ER visits in this population. The Adirondacks region had 486 Medicaid MH diagnosis ER visits per 10,000 population. These Medicaid ER visits account for approximately 30% of all MH diagnosis ER visits in the region. In contrast, Medicaid MH diagnosis hospital inpatient admissions account for approximately 55% of all such admissions in the region.

Table 6. Adirondacks Region: Medicaid Beneficiary Emergency Room Visits by Mental Health Diagnosis														
County	US Census ACS 2010-2014 Est. Population	Mental Health Diagnosis												Total Visits	Total Visits per 10,000
		Bi-Polar Disorder		Depressive Disorders		Schizophrenia		Chronic Stress and Anxiety Diagnoses		Post Traumatic Stress Disorder		Other Mental Health Diagnoses			
		#	%	#	%	#	%	#	%	#	%	#	%		
Clinton	82,170	438	9%	1,896	37%	428	8%	749	15%	239	5%	1,389	27%	5,139	625
Essex	39,318	103	6%	759	41%	162	9%	279	15%	76	4%	468	25%	1,847	470
Franklin	51,695	211	9%	1,040	43%	287	12%	313	13%	102	4%	479	20%	2,432	470
Hamilton	4,864	0	0%	10	33%	12	40%	8	27%	0	0%	0	0%	30	62
Warren	65,686	255	8%	1,111	35%	363	11%	452	14%	203	6%	812	25%	3,196	487
Washington	63,166	168	7%	811	36%	256	11%	299	13%	160	7%	569	25%	2,263	358
Totals	306,899	1,175	8%	5,627	38%	1,508	10%	2,100	14%	780	5%	3,717	25%	14,907	486

Data is from the NYS Department of Health Medicaid Chronic Conditions and Emergency Room Visits database, 2012 data. Retrieved May 4, 2016 from https://health.data.ny.gov/Health/Medicaid-Chronic-Conditions-Inpatient-Admissions-a/wybq-m39t

In the Adirondacks region, Medicaid MH diagnosis ER visits per 10,000 population ranged from a high of 625 in Clinton County to a low of 62 in Hamilton. In the region ER visits among these Medicaid beneficiaries were most frequent for depressive disorders

(38%), followed by other mental health diagnoses (25%), chronic stress and anxiety (14%), schizophrenia (10%), bi-polar disorder (8%) and PTSD (5%). These frequencies are similar to those for all ER MH visits.

Depressive disorders accounted for the largest percentage of Medicaid MH diagnosis ER visits in all counties, except Hamilton, and were highest in Franklin County (43%). ER visits were highest for bipolar disorder in Clinton and Franklin counties (9% each), for schizophrenia (40%, the highest in any NYS county) and chronic stress and anxiety diagnoses (27%, the highest in any NYS county) in Hamilton County, for PTSD in Washington County (7%), and for other mental health diagnoses in Clinton County (27%).

Compared to all other DSRIP regions, the Adirondacks had the smallest percentage of Medicaid MH diagnosis ER visits for schizophrenia.

Substance Use Disorder (SUD) Emergency Room Visits
Total ER visits by the major diagnostic category of SUD (n=13,153) in the Adirondacks region are described in Table 7. Overall, the region had 429 SUD ER visits per 10,000 population. ER visits ranged from a high of 596 per 10,000 in Clinton County to a low of zero in Hamilton County. In the region, SUD ER visits for cocaine use disorder (28%) were most frequent, followed by drug abuse: cannabis/NOS/NEC (24%), opioid use disorder (23%), other SUD diagnoses (19%), and alcohol use disorder (6%).

| County | US Census ACS 2010-2014 Est. Population | Substance Use Disorder Diagnosis | | | | | | | | | | Total Visits | Total Visits per 10,000 |
| | | Cocaine Use Disorder | | Alcohol Use Disorder | | Opioid Use Disorder | | Drug Abuse: Cannabis/NOS/NEC | | Other SUD Diagnoses | | | |
		#	%	#	%	#	%	#	%	#	%		
Clinton	82,170	1,157	24%	328	7%	1,056	22%	1,345	27%	1,008	21%	4,894	596
Essex	39,318	511	38%	49	4%	307	23%	262	20%	201	15%	1,330	338
Franklin	51,695	812	28%	145	5%	571	19%	770	26%	653	22%	2,951	571
Hamilton	4,864	0	0%	0	0%	0	0%	0	0%	0	0%	0	0
Warren	65,686	783	32%	196	8%	588	24%	436	18%	436	18%	2,439	371
Washington	63,166	469	30%	95	6%	453	29%	325	21%	197	13%	1,539	244
Totals	306,899	3,732	28%	813	6%	2,975	23%	3,138	24%	2,495	19%	13,153	429

Table 7. Adirondacks Region: Total Patient Emergency Room Visits by Substance Use Disorder Diagnosis

Data is from the NYS Department of Health Medicaid Chronic Conditions and Emergency Room Visits database, 2012 data. Retrieved May 4, 2016 from https://health.data.ny.gov/Health/Medicaid-Chronic-Conditions-Inpatient-Admissions-a/wybq-m39t

Cocaine use disorder accounted for the largest percentage of ER visits in all counties, except Clinton. ER visits were highest for cocaine use disorder in Essex County (38%, the second highest among all NYS counties), for alcohol use disorder in Warren County (8%), for opioid use disorder in Washington County (29%), for drug abuse: cannabis/NOS/NEC in Clinton County (27%), and for other SUD diagnoses in Franklin County (22%).

Compared to all other DSRIP regions, the Adirondacks had the highest percentage of total ER visits for cocaine use disorder and the smallest percentage of ER visits for alcohol use disorder.

Table 8 describes Medicaid beneficiary ER visits in this population (n=3,739). The Adirondacks region had 122 Medicaid SUD diagnosis ER visits per 10,000 population. These Medicaid ER visits account for approximately 28% of all SUD diagnosis ER visits in the region. In contrast, Medicaid SUD diagnosis hospital inpatient admissions account for approximately 50% of all such admissions in the region.

In the Adirondacks region Medicaid SUD diagnosis ER visits per 10,000 population ranged from a high of 173 in Clinton County to a low of zero in Hamilton County.

Table 8. Adirondacks Region: Medicaid Beneficiary Emergency Room Visits by Substance Use Disorder Diagnosis													
County	US Census ACS 2010-2014 Est. Population	Substance Use Disorder Diagnosis										Total Visits	Total Visits per 10,000
		Cocaine Use Disorder		Alcohol Use Disorder		Opioid Use Disorder		Drug Abuse: Cannabis/ NOS/NEC		Other SUD Diagnoses			
		#	%	#	%	#	%	#	%	#	%		
Clinton	82,170	359	25%	95	7%	314	22%	376	26%	279	20%	1,423	173
Essex	39,318	157	38%	16	4%	93	22%	85	20%	64	15%	415	106
Franklin	51,695	252	35%	44	6%	131	18%	151	21%	147	20%	725	140
Hamilton	4,864	0	0%	0	0%	0	0%	0	0%	0	0%	0	0
Warren	65,686	247	34%	54	7%	170	23%	128	18%	128	18%	727	111
Washington	63,166	128	29%	39	9%	117	26%	94	21%	71	16%	449	71
Totals	306,899	1,143	31%	248	7%	825	22%	834	22%	689	18%	3,739	122

Data is from the NYS Department of Health Medicaid Chronic Conditions and Emergency Room Visits database, 2012 data. Retrieved May 4, 2016 from https://health.data.ny.gov/Health/Medicaid-Chronic-Conditions-Inpatient-Admissions-a/wybq-m39t

In the region, Medicaid SUD diagnosis ER visits for cocaine use disorder (31%) were most frequent, followed by drug abuse: cannabis/NOS/NEC and opioid use disorder (22% each), other SUD diagnoses (18%), and alcohol use disorder (7%).

Cocaine use disorder accounted for the largest percentage of Medicaid SUD diagnosis ER visits in all counties, except Clinton. Medicaid ER visits were highest for cocaine use disorder in Essex County (38%), for alcohol use disorder (9%) and opioid use disorder in Washington County (26%), for drug abuse: cannabis/NOS/NEC in Clinton County (26%), and for other SUD diagnoses in Clinton and Franklin counties (20% each).

Compared to all other DSRIP regions, the Adirondacks had the highest percentage of Medicaid ER visits for cocaine use disorder and the smallest percentage of ER visits for alcohol use disorder.

3. <u>Medicaid Beneficiary Hospital Inpatient Admissions and Emergency Room Visits</u>

Medicaid Beneficiaries by Eligibility Type
In the Adirondacks region 22% of the estimated population are Medicaid beneficiaries (Table 9). In the region's counties Medicaid beneficiaries range from a high of 25% of the estimated population in Franklin County to a low of 14% of the estimated population in Hamilton County.

Table 9. Adirondacks Region: Medicaid Beneficiaries by Eligibility Type							
County	US Census ACS 2010-2014 Est. Population	Total Medicaid Beneficiaries		Medicaid Only		Dual Medicaid and Medicare	
		#	% Total Pop	#	% Total Medicaid Bene.	#	% Total Medicaid Bene.
Clinton	82,170	19,355	24%	15,247	79%	4,108	21%
Essex	39,318	8,194	21%	6,277	77%	1,917	23%
Franklin	51,695	12,680	25%	10,097	80%	2,583	20%
Hamilton	4,864	684	14%	548	80%	136	20%
Warren	65,686	13,031	20%	10,060	77%	2,971	23%
Washington	63,166	12,088	19%	9,826	81%	2,262	19%
Totals	306,899	66,032	22%	52,055	79%	13,977	21%
Data is from the NYS Department of Health's Medicaid Beneficiaries Inpatient Admissions and Emergency Room Visits data base; 2012 data. Retrieved May 11, 2016 from https://health.data.ny.gov/Health/Medicaid-Beneficiaries-Inpatient-Admissions-and-Em/m2wt-pje4#About							

Medicaid beneficiaries include individuals that receive Medicaid only and dual-eligible individuals that receive both Medicare and Medicaid benefits by virtue of their age or disability and low incomes.[1] In the Adirondacks region 79% of Medicaid beneficiaries receive Medicaid only (the lowest percentage of any DSRIP region) and 21% are dual-eligible. Medicaid only beneficiaries range from a low of 77% each in Essex and Warren counties to a high of 81% in Washington County.

Medicaid Hospital Inpatient Admissions
Medicaid beneficiary hospital inpatient admissions in the Adirondacks region are described in Table 10.[2] In the region 10% of Medicaid only beneficiaries and 15% of Medicaid and Medicare dual-eligible beneficiaries experienced at least one hospital inpatient admission. In the Medicaid only population there were 1,399 inpatient admissions per 10,000. In comparison, in the Medicaid and Medicare dual-eligible population there were 1,974 inpatient admissions per 10,000.

Table 10. Adirondacks Region: Medicaid Hospital Inpatient Admissions by Beneficiary Type									
County	Number of Beneficiaries		Number of Beneficiaries with Inpatient Admissions				Total Inpatient Hospital Admissions		Total Admissions per 10,000 Medicaid Only Pop.	Total Admissions per 10,000 Dual Pop.
	Medicaid Only	Dual Medicaid and Medicare	Medicaid Only		Dual Medicaid and Medicare		Medicaid Only	Dual Medicaid and Medicare		
	#	#	#	%	#	%	#	#		
Clinton	15,247	4,108	1,562	10%	674	16%	2,101	884	1,378	2,152
Essex	6,277	1,917	616	10%	229	12%	834	299	1,329	1,560
Franklin	10,097	2,583	1,131	11%	379	15%	1,681	526	1,665	2,036
Hamilton	548	136	48	9%	11	8%	67	18	1,223	1,324
Warren	10,060	2,971	1,093	11%	465	16%	1,484	637	1,475	2,144
Washington	9,826	2,262	844	9%	283	13%	1,113	395	1,133	1,746
Totals	52,055	13,977	5,294	10%	2,041	15%	7,280	2,759	1,399	1,974

Data is from the NYS Department of Health's Medicaid Beneficiaries Inpatient Admissions and Emergency Room Visits data base; 2012 data. Retrieved May 11, 2016 from https://health.data.ny.gov/Health/Medicaid-Beneficiaries-Inpatient-Admissions-and-Em/m2wt-pje4#About

Percentages of Medicaid only beneficiaries with hospital inpatient admissions ranged from a low of 9% each in Hamilton and Washington counties to a high of 11% each in Franklin and Warren counties. In comparison, hospital inpatient admissions for the Medicaid and Medicare dual-eligible population ranged from a low of 8% in Hamilton County to a high of 16% each in Clinton and Warren counties.

In the Medicaid only population admissions per 10,000 ranged from a low of 1,133 in Washington County to a high of 1,665 in Franklin County. In contrast, admissions per 10,000 in the Medicaid and Medicare dual-eligible population were higher in every county, ranging from a low of 1,324 in Hamilton County to a high of 2,152 in Clinton County.

Medicaid Emergency Room Visits
Emergency room (ER) visits among Medicaid beneficiaries in the Adirondacks region are described in Table 11.[3] In the region 30% of Medicaid only beneficiaries and 19% of Medicaid and Medicare dual-eligible beneficiaries experienced at least one ER visit. In the Medicaid only population there were 6,634 ER visits per 10,000. In comparison, in the Medicaid and Medicare dual-eligible population there were 4,238 ER visits per 10,000.

Table 11. Adirondacks Region: Medicaid Emergency Room Visits by Beneficiary Type									
County	Number of Beneficiaries		Number of Beneficiaries with ER Visits				Total ER Visits		Total ER Visits per 10,000 Medicaid Only Pop.	Total ER Visits per 10,000 Dual Pop.
	Medicaid Only	Dual Medicaid and Medicare	Medicaid Only		Dual Medicaid and Medicare		Medicaid Only	Dual Medicaid and Medicare		
	#	#	#	%	#	%	#	#		
Clinton	15,247	4,108	5,185	34%	907	22%	12,043	1,938	7,899	4,718
Essex	6,277	1,917	2,144	34%	443	23%	4,592	980	7,316	5,112
Franklin	10,097	2,583	3,349	33%	529	20%	7,517	1,209	7,445	4,681
Hamilton	548	136	94	17%	9	7%	143	15	2,609	1,103
Warren	10,060	2,971	2,582	26%	476	16%	5,446	1,106	5,414	3,723
Washington	9,826	2,262	2,497	25%	293	13%	4,792	676	4,877	2,989
Totals	52,055	13,977	15,851	30%	2,657	19%	34,533	5,924	6,634	4,238

Data is from the NYS Department of Health's Medicaid Beneficiaries Inpatient Admissions and Emergency Room Visits data base; 2012 data. Retrieved May 11, 2016 from https://health.data.ny.gov/Health/Medicaid-Beneficiaries-Inpatient-Admissions-and-Em/m2wt-pje4#About

Percentages of Medicaid only beneficiaries with ER visits ranged from a low of 17% in Hamilton County to a high of 34% each in Clinton and Essex counties. In comparison, ER visits for the Medicaid and Medicare dual-eligible population ranged from a low of 7% in Hamilton County to a high of 23% in Essex County.

In the Medicaid only population ER visits per 10,000 ranged from a low of 2,609 in Hamilton County to a high of 7,899 in Clinton County. In contrast, ER visits per 10,000 in the Medicaid and Medicare dual-eligible population were lower in every county, ranging from a low of 1,103 in Hamilton County to a high of 5,112 in Essex County.

In conclusion, in the Adirondacks region the Medicaid only population has a higher rate of ER visits than the Medicaid and Medicare dual-eligible population, while the Medicaid and Medicare dual-eligible population has a higher rate of hospital inpatient admissions than the Medicaid only population.

[1] In this analysis dual status was based upon the last month of enrollment/eligibility during the year. If the Medicaid beneficiary was indicated as being eligible for Part A, B, C or D Medicare services they are classified as dual eligible. The dual-eligible Medicare and Medicaid population is diverse and includes individuals with multiple chronic conditions, physical disabilities, and cognitive impairments such as dementia, developmental disabilities, and mental illness. It also includes some individuals who are relatively healthy. Retrieved May 12, 2016 from http://www.medpac.gov/documents/data-book/january-2015-medpac-and-macpac-data-book-beneficiaries-dually-eligible-for-medicare-and-medicaid.pdf

[2] In this analysis inpatient utilization was based on all Medicaid inpatient admissions. To avoid duplication, admissions are counted per Medicaid beneficiary, per hospital, per admission.

[3] Emergency room utilization was based on all Medicaid fee-for-service and managed care emergency room visits. To avoid duplication with multiple provider claims on a single ER visit for a Medicaid beneficiary, visits were counted per unique recipient per day.

V. Unmet Service Needs

Access to an adequate amount of outpatient care and community resources can reduce hospitalizations and emergency room (ER) visits for both behavioral and physical health problems. For example, high rates of potentially avoidable ER visits and hospital admissions suggest a need for further outpatient resources in the community. This section describes the unmet service needs of individuals in the Adirondacks DSRIP region.

Quality indicators are one of several ways to measure the unmet needs of a community. Unmet service need is reported here using measures of initiation and engagement in behavioral health treatment and measures of potentially avoidable hospitalizations and ER visits. Further information about these measures is included below. Additional information about unmet need in the Adirondacks DSRIP region from needs assessments of local issues conducted by counties in the region is also included.

Note: Data presented in this section should be interpreted with Hamilton County's small population size (n=4,864, the smallest population in any NYS county) in mind; some data points may be unstable.

1. Behavioral Health Treatment
Mental Health Medication Adherence and Management
Adherence to Antipsychotic Medications for Individuals with Schizophrenia, and Antidepressant Medication Management are two Healthcare Effectiveness Data and Information Set (HEDIS)/New York State Quality Assurance Reporting Requirement (QARR) measures collected by Performing Provider Systems in the DSRIP program.

- Adherence to Antipsychotic Medications for Individuals with Schizophrenia refers to the percentage of members, ages 19 to 64 years, with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.
- Antidepressant Medication Management Effective Acute Phase Treatment refers to the percentage of members who remained on antidepressant medication during the entire 12-week acute treatment phase.
- Antidepressant Medication Management Effective Continuation Phase Treatment refers to the percentage of members who remained on antidepressant medication for at least six months.

For adults with schizophrenia, relative to other DSRIP regions, the Adirondacks region has the second highest antipsychotic medication adherence percentage (68%). In the region, 32% of adults with schizophrenia do not adhere to their antipsychotic medications. Adherence to antipsychotics ranges from a low of 57% in Clinton County to a high of 80% in Washington (Table 1).

Table 1. Adirondacks Region: Mental Health Medication Adherence and Management			
County	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	Antidepressant Medication Management	
		Effective Acute Phase Treatment	Effective Continuation Phase Treatment
Clinton	57%	52%	39%
Essex	*	60%	40%
Franklin	65%	59%	45%
Hamilton	*	*	*
Warren	74%	49%	34%
Washington	80%	52%	40%
Region Avg. %	68%	53%	39%

*Sample size too small to report. Notes and Data Sources: Data is from the NYS Department of Health - Medicaid clinical metrics for Clinical Improvement Projects (Domain 3) of the DSRIP Program database, measurement year 2014 data.

In the Adirondacks region, 53% of individuals remained on antidepressant medication during the acute treatment phase and 39% remained on antidepressant medication during the continuation phase (61% did not). Adherence to antidepressants are lowest in Warren County during both the acute (49%) and continuation (34%) phases. Adherence to antidepressants are highest in Essex County (60%) during the acute phase and in Franklin County (45%) during the continuation phase.

Compared to all DSRIP regions, the Adirondacks region has the highest percentage of adherence to antidepressants during the continuation phase (39%).

Mental Health Follow-up Care
This section presents HEDIS/QARR measures related to mental health follow-up care.

- Follow-up after Hospitalization for Mental Illness within 7 Days refers to the percentage of members who were seen on an ambulatory basis or who were in intermediate treatment with a mental health provider within 7 days of hospital discharge.
- Follow-up after Hospitalization for Mental Illness within 30 Days refers to the percentage of members who were seen within 30 days of hospital discharge.
- Follow-Up Care for Children Prescribed ADHD Medication Initiation Phase refers to the percentage of children with a new prescription for ADHD medication who had one follow-up visit with a practitioner within the 30 days after starting the medication.
- Follow-Up Care for Children Prescribed ADHD Medication Continuation & Maintenance Phase refers to the percentage of children with a new prescription for ADHD medication who remained on the medication for 7 months and who, in addition to the visit in the Initiation Phase, had at least 2 follow-up visits in the 9-month period after the initiation phase ended.

In the Adirondacks region, the percentage of follow-up within seven days after a mental illness hospitalization (53%) is second highest among DSRIP regions. The region's percentage of follow-up within 30 days is 66% (Table 2). Follow-up within seven days ranges from a low of 51% each in Warren and Washington counties to a high of 61% in Essex. Clinton and Washington counties have the lowest percentages of 30 day follow-up (63% each) and Essex has the highest (77%).

Table 2. Adirondacks Region: Mental Health Follow-Up Care				
County	Follow-up After Hospitalization for Mental Illness		Follow-Up Care for Children Prescribed ADHD Medication	
	Within 7 Days	Within 30 Days	Initiation Phase	Continuation Phase
Clinton	53%	63%	50%	49%
Essex	61%	77%	55%	*
Franklin	57%	68%	51%	*
Hamilton	*	*	*	*
Warren	51%	68%	64%	60%
Washington	51%	63%	54%	59%
Region Avg. %	53%	66%	54%	55%
*Sample Size Too Small to Report. Notes and Data Sources: Data is from the NYS Department of Health - Medicaid clinical metrics for Clinical Improvement Projects (Domain 3) of the DSRIP Program database, measurement year 2014 data.				

Region-wide the percentage of children prescribed ADHD medication that had follow-up care during the initiation phase is 54% and 55% during the continuation phase. The percentage of children with follow-up care after ADHD medication during both phases is lowest in Clinton County (50%, initiation phase; 49%, continuation phase) and highest in Warren (64%, initiation phase; 60%, continuation phase).

Alcohol and Other Drug Dependence Initiation and Engagement in Treatment
Performing Provider Systems in the DSRIP program also collect two Alcohol and Other Drug (AOD) Dependence Treatment HEDIS/QARR measures: Initiation and Engagement in treatment.

- The Initiation measure is the percentage of members who initiate treatment within 14 days of the diagnosis of AOD dependence.
- The Engagement measure is the percentage of members who engage in treatment within 30 days after initiation.

In the Adirondacks region, 53% of individuals initiate treatment within 14 days of AOD dependence diagnosis (Table 3) and 26% engage in treatment within 30 days after initiation (74% do not). The region's percentage of individuals in AOD initiation treatment is the highest in any DSRIP region.

Table 3. Adirondacks Region: Alcohol and Other Drug Dependence Treatment		
County	Alcohol and Other Drug Dependence Treatment	
	Initiation	Engagement
Clinton	48%	28%
Essex	62%	34%
Franklin	47%	21%
Hamilton	*	*
Warren	63%	27%
Washington	52%	25%
Region Avg. %	53%	26%

* Sample size too small to report. Notes and Data Sources: Data is from the NYS Department of Health - Medicaid clinical metrics for Clinical Improvement Projects (Domain 3) of the DSRIP Program database, measurement year 2013 data.

In the region, Franklin County has the lowest percentages of initiation of (47%) and engagement (21%) in AOD treatment. Among all NYS counties, Warren County has the highest percentage of AOD initiation (63%) and Essex has the highest percentage of AOD engagement (34%).

2. Potentially Avoidable Hospitalizations
The Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators (PQIs) are a set of population-based measures that can be used with hospital inpatient discharge data to identify conditions for which good outpatient care can potentially prevent the need for hospitalization, or for which early intervention can prevent complications. PQIs provide a good starting point for assessing quality of health services in the community.

- All PQIs apply only to adult populations (individuals over the age of 18 years).
- The Observed Rate (per 100,000 people) is the number of PQI discharges divided by the population, multiplied by 100,000.
- The Expected Rate (per 100,000 people) is the number of PQI discharges adjusted by age group, gender and race/ethnicity divided by the population, multiplied by 100,000. Lower ratios of observed to expected rates represent better results.

Diabetes Chronic Conditions
In the Adirondacks region Medicaid only population, ratios of diabetes short-term complications range from a high of 282/129 in Clinton County (the second highest in any NYS county) to a low of 66/123 in Essex County (Table 4a). All counties have a lower rate of observed than expected hospitalizations for diabetes long-term complications in this population. Among all DSRIP regions, the Adirondacks region has the second lowest observed to expected ratio of diabetes long-term complications in the Medicaid only population (65/113).

Table 4a. Adirondacks Region: Diabetes Short and Long-Term Complications Inpatient Prevention Quality Indicators by Medicaid Eligibility							
County	Diabetes Short-term Complications				Diabetes Long-term Complications		
	Medicaid Only		Dual Medicaid and Medicare		Medicaid Only		Dual Medicaid and Medicare	
	Rates per 100,000						
	Observed	Expected	Observed	Expected	Observed	Expected	Observed	Expected
Clinton	282	129	207	106	36	111	253	245
Essex	66	123	150	93	110	113	100	244
Franklin	85	134	344	99	85	122	103	256
Hamilton	241	122	0	94	0	123	0	286
Warren	131	119	31	104	91	103	184	240
Washington	154	126	40	100	70	106	282	230
Totals	160	126	129	99	65	113	154	250

Notes and Data Sources: Data is from the NYS Department of Health Quality Prevention Quality Indicators – Adult (AHRQ PQI) for Medicaid Enrollees database, discharge year 2014 data. Retrieved May 6, 2016 from https://health.data.ny.gov/Health/Medicaid-Inpatient-Prevention-Quality-Indicators-P/6kjt-7svn

For the dual Medicaid and Medicare population, Franklin County has the highest observed to expected ratio for diabetes short-term complications (344/99, the highest in any NYS county), while Washington County has the highest ratio for diabetes long-term complications (282/230). Among all DSRIP regions, the Adirondacks region has the third highest observed to expected ratio of diabetes short-term complications in the dual Medicaid and Medicare population (129/99).

Table 4b describes uncontrolled diabetes and lower-extremity amputation rates among patients with diabetes. Among all DSRIP regions, the Adirondacks region has the lowest observed to expected ratio of uncontrolled diabetes in the Medicaid only population (3/18). In the dual Medicaid and Medicare population, Franklin County has the highest observed to expected ratio for uncontrolled diabetes (103/36), while Essex and Hamilton counties both rates of zero.

Table 4b. Adirondacks Region: Diabetes Chronic Conditions Inpatient Prevention Quality Indicators by Medicaid Eligibility								
County	Uncontrolled Diabetes				Lower-Extremity Amputation among Patients with Diabetes			
	Medicaid Only		Dual Medicaid and Medicare		Medicaid Only		Dual Medicaid and Medicare	
	Rates per 100,000							
	Observed	Expected	Observed	Expected	Observed	Expected	Observed	Expected
Clinton	18	18	23	34	9	13	46	40
Essex	0	18	0	34	22	13	100	41
Franklin	0	21	103	36	12	13	0	42
Hamilton	0	19	0	41	0	15	0	49
Warren	0	17	31	34	0	12	61	39
Washington	0	18	40	34	0	12	81	37
Totals	3	18	33	35	7	13	48	41
Notes and Data Sources: Data is from the NYS Department of Health Quality Prevention Quality Indicators – Adult (AHRQ PQI) for Medicaid Enrollees database, discharge year 2014 data. Retrieved May 6, 2016 from https://health.data.ny.gov/Health/Medicaid-Inpatient-Prevention-Quality-Indicators-P/6kjt-7svn								

Essex County has the highest ratios in both the Medicaid only (22/13) and the dual population (100/41) for lower-extremity amputation among patients with diabetes.

Cardiac Chronic Conditions
As reported in Table 5a, in both the Medicaid only and dual Medicaid and Medicare populations, all counties have lower observed than expected hypertension hospitalizations, except for the dual population in Clinton County (69/69). Hamilton County has the highest observed to expected ratio for heart failure (241/123) in the Medicaid only population, while Clinton County has the highest ratio in the dual Medicaid and Medicare population (735/541).

Table 5a. Adirondacks Region: Cardiac Chronic Conditions Inpatient Prevention Quality Indicators by Medicaid Eligibility												
County	Hypertension				Heart Failure				Angina Without Procedure			
	Medicaid Only		Dual Medicaid and Medicare		Medicaid Only		Dual Medicaid and Medicare		Medicaid Only		Dual Medicaid and Medicare	
	Rate per 100,000											
	Observed	Expected	Observed	Expected	Observed	Expected	Observed	Expected	Observed	Expected	Observed	Expected
Clinton	9	40	69	69	91	108	735	541	0	13	23	23
Essex	0	40	0	73	132	110	502	587	0	13	0	23
Franklin	12	48	0	74	85	121	447	576	12	14	34	24
Hamilton	0	44	0	83	241	123	0	650	0	16	0	25
Warren	26	38	31	69	91	99	738	550	0	12	0	23
Washington	28	40	0	71	28	101	362	568	0	12	0	22
Total	13	42	17	73	111	110	464	579	2	13	10	23
Notes and Data Sources: Data is from the NYS Department of Health Quality Prevention Quality Indicators – Adult (AHRQ PQI) for Medicaid Enrollees database, discharge year 2014 data. Retrieved May 6, 2016 from https://health.data.ny.gov/Health/Medicaid-Inpatient-Prevention-Quality-Indicators-P/6kjt-7svn												

In the Medicaid only population, all counties have lower observed than expected angina without procedure hospitalizations. In the dual Medicaid and Medicare population, all counties have zero observed rates for angina without procedure except for Clinton (23/23) and Franklin (34/24) counties.

Asthma Chronic Conditions
Asthma chronic conditions are described in Table 5b. Among all DSRIP regions, the Adirondacks region has the highest observed to expected ratio for asthma in younger adults in the Medicaid only population (149/80), and it is highest in Hamilton County (418/76, the highest in any NYS county). In the dual Medicaid and Medicare population, all counties except Clinton (178/121) have a rate of zero observed asthma discharges in young adults.

Table 5b. Adirondacks Region: Asthma Chronic Conditions Inpatient Prevention Quality Indicators by Medicaid Eligibility				
County	Asthma in Younger Adults			
	Medicaid Only		Dual Medicaid and Medicare	
	Rate per 100,000			
	Observed	Expected	Observed	Expected
Clinton	57	80	178	121
Essex	73	76	0	106
Franklin	115	88	0	125
Hamilton	418	76	0	119
Warren	211	79	0	115
Washington	22	81	0	108
Total	149	80	30	116
Notes and Data Sources: Data is from the NYS Department of Health Quality Prevention Quality Indicators – Adult (AHRQ PQI) for Medicaid Enrollees database, discharge year 2014 data. Retrieved May 6, 2016 from https://health.data.ny.gov/Health/Medicaid-Inpatient-Prevention-Quality-Indicators-P/6kjt-7svn				

Composite PQIs
Tables 6 and 7 report observed and expected composite PQIs by county in the Adirondacks region.

- The *Chronic* Composite PQI includes: Diabetes Short-Term and Long-Term Complications Admission Rates, the Asthma in Younger and Older Adults Admission Rates, the Hypertension Admission Rate, the Congestive Heart Failure (CHF) Admission Rate, the Angina without Procedure Admission Rate, the Uncontrolled Diabetes Admission Rate, and the Rate of Lower-Extremity Amputation among Patients with Diabetes.

- The *Acute* Composite includes: the Dehydration Admission Rate, the Bacterial Pneumonia Admission Rate, and the Urinary Tract Infection Admission Rate.
- The *Overall* Composite PQI refers to all PQI measures within the Chronic and Acute Composites.

In the Adirondacks region, the observed to expected ratios for the overall composite and chronic composite indicators in both populations are highest in Clinton County (Table 6). In the region's Medicaid only population, Clinton County has the highest observed to expected ratios for the overall composite (1,244/990) and chronic composite (917/719) indicators. Warren County has the highest ratio for the acute composite indicator (352/273). The lowest ratios for these indicators are in Washington County (overall composite, 785/961) Hamilton County (acute composite, zero) and Franklin County (chronic composite, 640/758).

Table 6. Adirondacks Region: Prevention Quality Overall, Acute, and Chronic Composite Indicators by Medicaid Eligibility											
County	Overall Composite				Acute Composite				Chronic Composite			
	Medicaid Only		Dual Medicaid and Medicare		Medicaid Only		Dual Medicaid and Medicare		Medicaid Only		Dual Medicaid and Medicare	
	Rate per 100,000											
	Observed	Expected	Observed	Expected	Observed	Expected	Observed	Expected	Observed	Expected	Observed	Expected
Clinton	1,244	990	3,654	2,944	327	270	1,034	1,121	917	719	2,620	1,823
Essex	1,011	1,028	2,859	3,069	286	284	1,103	1,186	725	744	1,755	1,883
Franklin	882	1,024	3,680	3,040	242	266	1,204	1,143	640	758	2,476	1,896
Hamilton	964	1,098	1,515	3,285	0	295	1,515	1,208	964	803	0	2,078
Warren	1,044	968	3,320	2,957	352	273	1,168	1,135	692	695	2,152	1,822
Washington	785	961	2,537	2,968	196	266	926	1,157	589	695	1,611	1,812
Totals	988	1,012	2,927	3,044	234	276	1,158	1,158	754	736	1,769	1,886

Notes and Data Source: Data is from the NYS Department of Health Quality Prevention Quality Indicators – Adult (AHRQ PQI) for Medicaid Enrollees database, discharge year 2014 data. Retrieved May 6, 2016 from https://health.data.ny.gov/Health/Medicaid-Inpatient-Prevention-Quality-Indicators-P/6kjt-7svn

In the Adirondacks region's dual population, Clinton County also has the highest observed to expected ratios for the overall composite (3,654/2,944) and the chronic composite (2,620/1,823) indicators. Hamilton County has the highest ratio for the acute composite (1,515/1,208). The lowest ratios for these indicators are in Hamilton County (overall composite, 1,515/3,285 and chronic composite, zero; lowest for both in any NYS county) and Washington County (acute composite, 926/1,157).

Table 7 describes the all diabetes, circulatory and respiratory composite indicators. In the Adirondacks region's Medicaid only population, Clinton County has the highest all diabetes composite ratio (345/271) and all respiratory composite (472/292). Hamilton has the highest ratio for the all circulatory composite (241/183). The lowest ratios for these indicators are in Franklin County (all diabetes composite, 181/290) and Washington County (all circulatory composite, 56/153 and all respiratory composite, 308/286).

Table 7. Adirondacks Region: Prevention Quality All Diabetes, Circulatory, and Respiratory Composite Indicators by Medicaid Eligibility												
County	All Diabetes Composite				All Circulatory Composite				All Respiratory Composite			
	Medicaid Only		Dual Medicaid and Medicare		Medicaid Only		Dual Medicaid and Medicare		Medicaid Only		Dual Medicaid and Medicare	
	Rate per 100,000											
	Observed	Expected	Observed	Expected	Observed	Expected	Observed	Expected	Observed	Expected	Observed	Expected
Clinton	345	271	529	425	100	161	827	633	472	292	1,264	781
Essex	198	267	351	412	132	164	502	683	396	318	953	805
Franklin	181	290	550	432	109	183	481	674	350	291	1,444	807
Hamilton	241	279	0	470	241	183	0	758	482	347	0	869
Warren	222	251	307	416	117	149	769	641	352	299	1,076	780
Washington	224	261	443	401	56	153	362	661	308	286	846	764
Total	235	270	363	426	126	166	490	675	393	306	930	801

Notes and Data Sources: Data is from the NYS Department of Health Quality Prevention Quality Indicators – Adult (AHRQ PQI) for Medicaid Enrollees database, discharge year 2014 data. Retrieved May 6, 2016 from https://health.data.ny.gov/Health/Medicaid-Inpatient-Prevention-Quality-Indicators-P/6kjt-7svn

Among all DSRIP regions, the Adirondacks region has the highest all respiratory composite observed to expected ratio in the Medicaid only population (393/306).

In the Adirondacks region's dual population, Franklin County has the highest observed to expected ratio for the all diabetes composite (550/432) and the all respiratory composite (1,444/807). For the all circulatory composite, Warren County has the highest ratio (769/641). Hamilton County has a zero observed rate for all three indicators in the dual population.

3. Potentially Avoidable Emergency Room Visits
In the Adirondacks region, Essex County (29/18) has the highest observed to expected ratios of potentially preventable ER visits (Table 8). Franklin County has the lowest (8/17).

Table 8. Adirondacks Region: All Payers Potentially Preventable Emergency Room Visits		
County	ER Discharges 2013: Rate per 100,000	
	Observed	Expected
Clinton	30	19
Essex	29	18
Franklin	12	26
Hamilton	8	17
Warren	19	17
Washington	18	18
Total	19	19

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

4. Local Assessment of Need by Adirondacks Region Counties

New York State Mental Hygiene Law requires the Office of Mental Health (OMH) and the Office of Alcoholism and Substance Abuse Services (OASAS) to guide and facilitate the process of local planning. As part of the planning process, New York State counties and New York City (local governmental units [LGUs]) conduct a needs assessment of local issues impacting populations with mental illness and chemical dependency. These issues include prevention, treatment, and recovery support service needs, including other individualized person-centered supports and services. The issues of workforce retention and recruitment and coordination/integration with other systems are also included.

Table 9 summarizes the results of the LGUs' needs assessments for the Adirondacks region. The data were collected from LGUs from March 1, 2015 through June 1, 2015. For each need issue listed, the LGUs indicated the extent to which it is an area of need at the local level for each population by identifying high, moderate or low need. The DSRIP Adirondacks region includes Clinton, Essex, Franklin, Hamilton, Warren, and Washington counties. Warren and Washington are a single LGU in this analysis.

In both the mental illness and chemical dependency populations, the issues with the largest percentages of high need for both youth (<21) and adults (21+) are access to transportation and workforce recruitment and retention.

Table 9. Adirondacks Region: Assessment of Needs by Population and Issue								
	Assessment of Local Need (N=5 Counties)							
	Youth (<21)				Adults (21+)			
	High Need	Moderate Need	Low Need	Missing	High Need	Moderate Need	Low Need	Missing
Selected Issues	**Mental Illness Population**							
Access to Prevention Services	20%	40%	40%	0%	20%	60%	20%	0%
Access to Crisis Services	40%	60%	0%	0%	40%	60%	0%	0%
Access to Treatment Services	20%	40%	40%	0%	20%	40%	40%	0%
Access to Supported Housing	0%	20%	80%	0%	40%	60%	0%	0%
Access to Transportation	80%	20%	0%	0%	60%	40%	0%	0%
Access to Home/Community-based Services	0%	20%	80%	0%	0%	20%	80%	0%
Access to Other Support Services	0%	60%	40%	0%	0%	60%	40%	0%
Workforce Recruitment and Retention	60%	40%	0%	0%	60%	40%	0%	0%
Coordination/Integration with Other Systems	20%	40%	40%	0%	40%	20%	40%	0%
Selected Issues	**Chemical Dependency Population**							
Access to Prevention Services	20%	40%	40%	0%	20%	60%	20%	0%
Access to Crisis Services	20%	80%	0%	0%	20%	80%	0%	0%
Access to Treatment Services	0%	60%	40%	0%	0%	60%	40%	0%
Access to Supported Housing	0%	0%	100%	0%	20%	80%	0%	0%
Access to Transportation	80%	20%	0%	0%	60%	40%	0%	0%
Access to Home/Community-based Services	0%	0%	100%	0%	0%	20%	80%	0%
Access to Other Support Services	0%	60%	40%	0%	0%	60%	40%	0%
Workforce Recruitment and Retention	60%	40%	0%	0%	60%	40%	0%	0%
Coordination/Integration with Other Systems	20%	40%	40%	0%	40%	20%	40%	0%

VI. Consumer and Provider Input

This section summarizes the Adirondacks region's consumer and provider input regarding community behavioral health needs. Input for this region was collected by the clinic Citizen Advocates, Inc., which serves Franklin and portions of Clinton, Essex, and Hamilton counties.

Methods

To collect data, participating clinics used focus group templates and/or anonymous surveys created by NYSOMH. These instruments are included in Appendix IV. Collectively, these data collection instruments focus on behavioral health concerns, available programming and services, potential disparities in service access and use, evidence-based practices, trauma-informed services, and recommendations regarding strategies to promote improved community health.

Participating clinics utilized the instruments to collect consumer, family, caregiver and provider input. Once collected, the clinics aggregated and submitted the consumer and provider input to NYSOMH. The consumer survey was made available in English and Spanish.

Participating clinics were asked to gather input from consumers and providers in and outside of the clinic, including:

- Clinic consumers ages 15 and older; parents or guardians of consumers younger than 15; and family members or caregivers of consumers. Consumer information was also collected from Veterans and individuals in foster care or homeless shelters who receive services from secondary related agencies that make referrals to behavioral health services.

- Provider surveys were administered to and focus groups were conducted with both participating clinics and secondary related agency providers.

When reporting survey multiple choice item results to NYSOMH, participating clinics recorded the frequency for each response option. The percentages reported in the tables below are based on those numbers as indicated. For open-ended questions, Participating clinics recorded the most frequently occurring responses or "themes". All responses to open-ended survey questions are stated as they were submitted to NYSOMH by the clinics, and include response frequencies.

Participant Descriptions and Demographics

Demographics and information about participating consumers and providers are reported in Tables 1 and 2 respectively. Citizen Advocates surveyed 208 consumers and 39 providers. A majority of consumer respondents were ages 18-64 (80%), 18% are under age 18, and 1% are age 65 or older. More than a quarter (26%) of provider respondents do not practice at Citizen Advocates and 18% of consumer respondents are not patients there.

Table 1. Adirondacks Region: Consumer Input – Consumer Demographics	
Participant Information (n=208)	%
Survey Participants	100%
Focus Group Participants	0%
Not patients at the Clinic	18%
Live in the Clinic county	75%
Age (n=202)	
Under 18	18%
18-64	80%
65 or older	1%
Gender (n=207)	
Male	38%
Female	61%
Race/Ethnicity* (n=207)	
White	94%
Black/African-American	1%
Asian	0%
Native-American	5%
Other Race	2%
Hispanic/Latino Ethnicity	3%
*The race/ethnicity question was asked only in the survey, not in the focus groups. Participants were instructed to select all that apply. Percentage is the number within each group divided by the number who responded to the question.	

Table 2. Adirondacks Region: Provider Input	
Participant Information (n=39)	%
Survey Participants	100%
Focus Group Participants	0%
Do *not* practice at the Clinic	26%
Practice within the Clinic county	100%
Have a Master's degree or higher	82%

Findings

The consumer and provider input is organized into four domains:
1. Service Utilization, Perceived Service Needs, Barriers to Access, and Disparities in Access
2. Scope of Services in Treatment
3. Provider Training Needs
4. Participants Feel Welcome where they Receive Services

1. Service Utilization, Perceived Service Needs, Barriers to Access, and Disparities in Access

A. Service Utilization

Table 3 shows the distribution of behavioral health services that respondents reported using (question 6, consumer survey).

Table 3. Adirondacks Region: Consumer Survey Input (n=208) – Behavioral Health Services Used	%*
Service Category	
Mental Health Services	
a. Outpatient mental health services - (e.g., outpatient clinic)	60%
b. Inpatient treatment	31%
c. Medication for mental health problems	59%
d. Residential treatment	18%
Substance Use Disorder Services	
e. Outpatient substance use disorder services (e.g., outpatient clinic)	25%
f. Inpatient rehabilitation	12%
g. Detoxification	9%
h. Residential treatment	7%
i. Medication for substance use problems (e.g., methadone or buprenorphine to treat opioid addiction)	15%
Other Services	
j. Case managers or providers who will meet individuals outside of an agency setting as needed (e.g., community settings including homes, churches, schools, homeless shelters, foster care settings, ERs, recreational facilities, jails).	38%
k. Providers who will meet with patients via phone or webcam	17%
l. Help with finding or maintaining employment	13%
m. Help with advancing education or seeking job training	11%
n. Help with finding, maintaining, or improving housing	15%
o. Education about mental health and substance use issues	24%
p. 24-hour crisis phone line	22%
q. 24-hour mobile crisis teams	11%
r. Peer delivered services (services provided by people who have experienced behavioral health problems and who work to help others with behavioral health problems; e.g., self-help groups, warmlines, and peer specialist services)	12%
s. Education and supports (e.g., support groups) for families of individuals in behavioral health treatment	18%
*These service categories are not mutually exclusive; one individual could be receiving more than one service.	

The most frequently reported services received include outpatient mental health services (60%), medication for mental health problems (59%), and case managers or providers who will meet individuals in community settings (38%). The least frequently reported services include SUD residential treatment (7%), SUD detox (9%), help with advancing education or seeking job training and 24-hour mobile crisis team services (11% each). At least 25% of the consumer respondents reported receiving some form of SUD services.

B. Perceived Service Needs

Consumers reported the following unmet service needs (consumer survey, question 9).

- Anger management for children
- I live in southern St. Lawrence County and it is over an hour away from mental health

Providers reported the following types of behavioral health services that they thought would be beneficial in their communities, but are currently unavailable (provider survey, question 7).

- Ambulatory detox; Inpatient mental health; Housing (n=4 each)
- Intensive day programs (n=2)
- Inpatient detox; More social activities for clients; Children's Day Treatment - used to have it; Mobile Crisis Team; Crisis for DD/MH clients for ER diversion; Transportation in rural area with few population centers; Services and program specifically for pregnant teens; Continue to grow integration of behavioral health into primary care practices; The crisis stabilization project/ambulatory detox that is in process (n=1 each)

C. Barriers to Access

Table 4a presents the percentages of consumers and providers that reported barriers to accessing behavioral health treatment (consumer survey, question 7; provider survey, question 4).

Table 4a. Adirondacks Region: Consumer and Provider Input -- Barriers to Accessing Behavioral Health Treatment		
Perceived Barrier	Consumers (n=208)	Providers (n=39)
	%	
Problems with transportation	11%	100%
Took too long to get an appointment	7%	79%
Problems paying for services	6%	31%
Provider hours are not convenient	4%	10%
Service providers are not sensitive to other cultures	1%	10%
No service provider in the area	3%	5%
Nearest service provider is too far away	2%	5%
Services were not accessible to people with disabilities	1%	3%
Local provider does not serve individuals with these particular problems	1%	*
Services were not available to children or the elderly	1%	*
Services were not available to Veterans or members of the armed forces	0%	*
Service providers don't speak my (or the patient's) preferred language	0%	0%
Other	3%	5%
*Provider responses to questions about access for particular demographic groups are reported in Table 4b		

The barrier most frequently reported by providers and consumers is problems with transportation, followed by too long to get an appointment, problems paying for services, and inconvenient provider hours. Citizen Advocates noted that "many" providers clarified that "too long to get appointment" referred specifically to psychiatrists. Providers also responded that service providers are not sensitive to other cultures.

D. Disparities in Access

Table 4b describes disparities in access to behavioral health services reported by providers (provider survey, question 5) Three percent of providers reported that services are not available to Veterans, the elderly, and homeless individuals.

Table 4b. Adirondacks Region: Providers Input -- Access to Behavioral Health Services by Special Populations		
Special Population	Total # Respondents	% Answered "No"*
Veterans or members of armed forces	31	3%
Elderly	31	3%
Homeless	34	3%
Children	39	0%
Children in foster care	37	0%
Incarcerated	33	0%
*Percentage is the number who responded "No" divided by the total number of respondents.		

2. Scope of Services in Treatment

Table 5 describes consumers' experiences with evidence-based services, care coordination, and integrated care while receiving care from behavioral or physical health providers (consumer survey, question 8).

Table 5. Adirondacks Region: Consumer Survey Input -- Scope of Services in Treatment		
Provider Service	Total # Respondents	% Answered "Yes"*
a. Screen for history of traumatic life events or abuse?	160	64%
b. Screen for depression, anxiety, substance abuse, or another behavioral health problem?	169	82%
c. Screen for physical health problems?	154	77%
d. Assess your strengths, abilities, preferences, and goals?	156	77%
e. Talk with other providers about your care?	150	62%
f. Talk to you about the relationship between thoughts, behaviors, and feelings?	140	81%
g. Provide clear information about:		
i. How to get treatment for mental health and substance use issues?	158	82%
ii. How to cope with mental health and substance use issues?	146	79%
iii. Crisis management?	153	76%
h. Met all of your health care needs?	160	77%
*Percentage is the number that responded "Yes" divided by the total number of respondents.		

The most frequently provided services are screen for depression, anxiety, substance abuse, or another behavioral health problem, and provision of clear information about how to get treatment for mental health and substance use issues (82% each). The least frequently provided services are talk with other providers about your care (62%) and screen for history of traumatic life events or abuse (64%).

3. Provider Training Needs
Providers reported the following training needs (provider survey, question 6).

- All respondents said that additional training is always beneficial (n=39)
- Clinicians mentioned the challenge with trainings not being available in the north country and the inconvenience and cost associated with traveling downstate for specialized training (n=10)
- Cultural Competency training needed (n=4)
  - One respondent from a Native American reservation stated providers could benefit from training on cultural sensitivity and treatment for Native Americans
- While providers and several schools have done trauma informed care training, the community could benefit from education on trauma (n=3)
- LGBT training (n=2)

4. Participants Feel Welcome where they Receive Services
Only 3% of consumer survey respondents (Table 6) reported not feeling welcome in the places where they receive behavioral health services (consumer survey, question 10).

Table 6. Adirondack Region: Consumer Input (n=208) -- Feeling Welcome where you Receive Behavioral Health Services	
Total # Respondents	% Answered "No"*
160	3%
*Percentage is the number who responded "No" divided by the total number of respondents.	

Things that consumers reported that make them feel welcome are listed below.

- Friendly staff (n=42)
- Smiles (n=9)
- Helpful staff (n=6)
- Comfortable environment (n=4)
- Privacy (n=3)
- Feel welcome, Professional, Respected (n=2)
- Wonderful customer service (n=2)
- Someone is always available to see you; Good listeners; Easy to understand; Relaxing waiting area; More toys; Shorter wait time (n=1 each)

Summary
Citizen Advocates surveyed 208 consumers and 39 providers. Feedback was also obtained from secondary related agencies. For both consumers and providers, the most frequently reported needs are:
- Transportation to health care services
- Reduced wait times for an appointment

- Assistance with paying for services
- Clinical training in the north country; it is inconvenient and expensive to travel downstate for specialized training
- Ambulatory detox
- Inpatient mental health
- Housing
- Convenient provider hours (evenings and weekends)

Appendix A summarizes needs assessment findings that may impact providers meeting the health care service needs of the target consumer population in the Adirondacks region.

Note: Data presented in this section should be interpreted with Hamilton County's small population size (n=4,864, the smallest population in any NYS county) in mind; some data points may be unstable.

I. Population Characteristics Summary Highlights

Adirondacks Region: Population Characteristics		
Characteristic	Region	Region/County Comparison
Median household income	$49,751	• Significantly below state median of $58,687.
Education	13% of adults in region are without a high school diploma	• 3rd highest among all DSRIP regions.
Poverty	14% of region's population live below poverty level	• Franklin County's 20% poverty rate is second highest among all NYS counties outside of NYC. • Food stamps/SNAP beneficiaries comprise 15% of the population in Clinton and Franklin counties.
Public Health Insurance/ Medicaid/ Beneficiaries/ No Health Insurance	More than a third of the population in the region are on some type of public health insurance, 22% are Medicaid beneficiaries and 9% have no health insurance coverage.	• 21% of Clinton County's population have no health insurance: highest percentage of any NYS county.
Special Populations	14% of the region's population are disabled and 11% are Veterans.	• Among all NYS DSRIP regions 2nd highest percentages for both groups. • 15% of Essex County's population are disabled: 2nd highest percentage among all NYS counties. • 15% of Hamilton County's population are Veterans: 2nd highest percentage among all NYS counties.
Foreign Born	4% of the population are foreign born	
Primary Language other than English	6% of the region's population age 5 and older speak a primary language other than English.	• 94% of this population speak English as their primary language (the highest percentage in any DSRIP region), and 2% speak English less than "very well" (the lowest percentage in any DSRIP region).

Appendix A. Highlights of Adirondacks Region Needs Assessment Findings

II. Health Care Resources Summary Highlights

A. Adirondacks Region: Health Care Professional Supply and Shortages		
Domain	Region/County	Region/County Comparison
Supply of Primary Health Care Providers	1. The region has 1,062 primary care providers or 35 per 10,000 population.	1. Highest rate in any NYS DSRIP region. However, there is a mal-distribution of these providers (see HPSAs below)
Supply of Physical Health Care Specialists	2. The region has 274 physical medical health specialists or 9 providers per 10,000 population.	2. 2nd lowest ratio of any NYS DSRIP region.
Supply of Licensed Mental Health (MH) Professionals	1. The region has 617 licensed MH professionals or 20 per 10,000 population.	1. 3rd lowest rate in any NYS DSRIP region. ➢ Washington County's rate of 13 licensed MH professionals per 10,000 is 2nd lowest among all NYS counties. ➢ There are no psychiatrists in Essex, Hamilton and Washington counties.
Substance Use Disorder (SUD) Professionals	1. The region has a total of 158 certified and credentialed SUD professionals or five per 10,000 population.	1. The region has only 1 physician certified in addiction medicine: smallest number in any NYS DSRIP region. 2. Hamilton County has no SUD professionals and Washington County has no rehabilitation counselors.
	Region's HPSA County Designations	
Federal Health Professional Shortage Areas (HPSAs)	Primary Health Care: Clinton County has a HPSA whole county primary health care shortage designation and the five remaining counties have primary health care Medically Underserved Area/Population (MUA/P) designations. The Medicaid eligible population in five counties and the low income population in two counties have also been designated primary health care MUPs. Mental Health Professionals: Four counties have whole county shortage designations. All counties have Medically Underserved Area/Population (MUA/P) designations. Clinton County has shortage designations in each category, including its Medicaid eligible population.	

B. Adirondacks Region: Facility- and Program-based Health Care Supply, Service Rates and Constraints		
Facility/Program	Region	Region/County Comparison
Physical Health Acute Care Hospitals	1. The region's acute care hospitals have no chemical dependence beds. 2. The region's nursing homes have no behavioral health intervention beds.	2. Hamilton County has no nursing homes.
Mental Health Inpatient Facilities	1. Total psychiatric bed capacity in the region is 27 per 100,000 adults and 17 per 100,000 children. 2. In the region, the total inpatient average daily census (ADC) for child beds is 28, which is larger than the total number of child inpatient beds (n=12).	1. These psychiatric bed capacity rates are the second lowest in all NYS DSRIP regions. 2. The total child ADC is 39 per 100,000, the 2nd highest rate in any DSRIP region.
Substance Use Disorder (SUD) Inpatient Programs	1. The region has no SUD crisis programs.	
Mental Health Outpatient and Clinic Programs	1. Adult outpatient programs (other than clinic) in the region have 57 slots per 100,000 adults. 2. The region has no state-operated	1. This adult capacity is the 3rd lowest in any NYS DSRIP region. 2. Franklin County's locally-operated clinic service rate of 5,154 adults per 100,000

Appendix A. Highlights of Adirondacks Region Needs Assessment Findings

B. Adirondacks Region: Facility- and Program-based Health Care Supply, Service Rates and Constraints		
Facility/Program	Region	Region/County Comparison
	clinics. 3. There are no child outpatient programs other than clinic in the region. 4. In the region, 3,183 children received clinic treatment per 100,000 children.	is the second highest in any NYS county. 3. Hamilton County has no clinics. 4. This is the 2nd highest child clinic service rate in any DSRIP region.
MH Community Support Programs	1. In the region, 226 adults per 100,000 received services from community support programs. 2. Community support programs in the region served 268 children per 100,000.	1. This is the 3rd highest adult service rate in all DSRIP regions. 2. This is the 2nd highest child service rate in all DSRIP regions.
SUD Outpatient Programs	1. In the region all counties, except Hamilton, have SUD outpatient programs. The average daily enrollment (ADE) is 47 per 10,000. 2. The region has 1 opioid treatment program with a region-wide capacity of 3 per 10,000 and an ADE of 2 per 10,000.	1. This is the highest ADE in SUD programs in any DSRIP region. 2. These are the lowest such rates in any DSRIP region.

III.   Health Status

Adirondacks Region: Health Status Challenges	
Domain	Region/County Comparisons
Disease Prevalence Chronic Health Conditions	• Among all DSRIP regions, the region has the highest average percentages of adults with angina, heart attack or stroke, high blood pressure and asthma. It has the second highest percentages of adults with diabetes and that are overweight or obese. • Among all NYS counties, Clinton County has the highest percentages of adults with angina, heart attack or stroke and that are overweight or obese, and Franklin County has the highest percentage with high blood pressure.
Health Behaviors and Risk Factors	• Among all NYS counties, Franklin County has the highest percentage of adults that reported they did not receive medical care because of cost.
Hospitalization Rates by Disease or Cause	• Compared to all DSRIP regions, the region has the highest average rate of self-inflicted injury. The rate in Hamilton County is the highest rate among all NYS counties.
Premature Mortality	• Among all DSRIP regions, the region has the highest rate of alcohol related motor vehicle injuries and deaths and the 2nd highest premature death rate from stroke. • In the region the percentage of premature deaths is 2nd highest among all NYS DSRIP regions.
Patients in the Public Mental Health System	• Chronic Health Conditions: Among all NYS DSRIP regions, the region has the 2nd highest percentage of patients served with obesity. • Behavioral Health Diagnoses: Among all DSRIP regions, the region has the highest percentages of patients served with trauma, stress, or adjustment disorder and those with a co-occurring disorder. The region has the 2nd highest percentage of those with anxiety disorder.

Appendix A. Highlights of Adirondacks Region Needs Assessment Findings

IV.   Behavioral Health Care Utilization

A. Adirondacks Region: Medicaid Beneficiary Health Care Utilization by Behavioral Health Diagnosis		
Domain	Utilization by Diagnosis	Region/County Comparison
Medicaid Inpatient Admissions	Mental Health Diagnosis The region had 187 Medicaid MH diagnosis inpatient admissions per 10,000 population, which account for 55% of all MH diagnosis inpatient admissions in the region.	Across the region Medicaid MH admissions were most frequent for depressive disorder and some other MH diagnosis. Compared to all DSRIP regions, the region had the largest percentage for some other MH diagnosis.
	Substance Use Disorder The region had 58 Medicaid SUD inpatient admissions per 10,000 population, which account for approximately 50% of all SUD diagnosis inpatient admissions in the region.	Across the region SUD inpatient admissions among Medicaid beneficiaries were most frequent for alcohol use disorders, drug abuse: cannabis/NOS/NEC, and opioid use disorder.
Medicaid Emergency Room Visits	Mental Health Diagnosis The region had 486 Medicaid MH diagnosis ER visits per 10,000 population which account for approximately 30% of all MH diagnosis ER visits in the region.	Across the region Medicaid MH ER visits were most frequent for depressive disorders and other mental health diagnoses.
	Substance Use Disorder The region had 122 Medicaid SUD diagnosis ER visits per 10,000 population which account for approximately 28% of all SUD diagnosis ER visits in the region.	Across the region Medicaid SUD diagnosis ER visits for cocaine and opioid use disorders and drug abuse: cannabis/NOS/NEC were most frequent. Compared to all DSRIP regions, the region had the highest percentage of Medicaid ER visits for cocaine use disorder.

B. Adirondacks Region: Medicaid Beneficiary Health Care Utilization by Eligibility Type		
Domain	Utilization by Eligibility	Region
Medicaid Inpatient Admissions	In the region 10% of Medicaid only beneficiaries and 15% of Medicaid/Medicare dual-eligible beneficiaries experienced at least one hospital inpatient admission.	• In the Medicaid only population there were 1,399 inpatient admissions per 10,000. • In the Medicaid/Medicare dual-eligible population there were 1,974 inpatient admissions per 10,000.
Medicaid Emergency Room Visits	In the region 30% of Medicaid only beneficiaries and 19% of Medicaid/Medicare dual-eligible beneficiaries experienced at least one ER visit.	• In the Medicaid only population there were 6,634 ER visits per 10,000. • In the Medicaid/Medicare dual-eligible population there were 4,238 ER visits per 10,000.

Appendix A. Highlights of Adirondacks Region Needs Assessment Findings

V.   Unmet Service Needs

Adirondacks Region: Summary Highlights of Unmet Service Needs in Behavioral Health Treatment		
Domain	Measure	Region/County Comparison
Mental Health Medication Adherence and Management	1. Adherence to antipsychotic medications for individuals with schizophrenia for at least 80% of their treatment period.	1. Region-wide 68% of adults with schizophrenia are adhering to their antipsychotic medications and 32% are not.
	2. Antidepressant medication management effective acute phase treatment.	2. Region-wide 53% of individuals remain on their medication during the entire acute treatment phase.
	3. Antidepressant medication management effective continuation phase treatment.	3. Region-wide 39% of individuals remain on their medication during continuation phase treatment and 61% do not.
Mental Health Follow-up Care	1. Follow-up care after hospitalization for mental illness within 7 or 30 days of hospital discharge.	1. Region-wide 50% of individuals have follow-up care within 7 days and 66% follow-up within 30 days of discharge. ➢ Region-wide the percentage of follow-up care within 7 days is second highest in the state compared to other DSRIP regions.
	2. Follow-up care for children prescribed ADHD medication initiation phase.	2. Region-wide 54% of children prescribed ADHD medication have one follow-up visit with a practitioner within 30 days after starting the medication.
	3. Follow-up care for children prescribed ADHD medication continuation and maintenance phase.	3. Region-wide 55% of children with a new prescription for ADHD medication do not remain on the medication for 7 months and/or have at least 2 follow-up visits in the 9-month period after the initiation phase.
Alcohol and other Drug Dependence (AOD) Initiation and Engagement Treatment	1. AOD Initiation	1. Region-wide 53% of individuals initiate AOD treatment within 14 days of diagnosis.
	2. AOD Engagement	2. Region-wide 26% of individuals engage in AOD treatment within 30 days after initiation (74% do not).
Potentially Avoidable Hospitalizations *(Conditions for which good outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications)*	1. Diabetes Short-term Complications	1. Medicaid only population: Clinton County's 282/129 ratio of observed to expected diabetes short-term complications is the highest in any NYS county. ➢ Dual Medicaid and Medicare population: Franklin County's 344/99 observed to expected ratio for diabetes short-term complications is the highest in any NYS county. ➢ Among all DSRIP regions, the region has the 3rd highest observed to expected ratio of diabetes short-term complications in the dual population (129/99).
	2. Asthma Chronic Conditions	2. Among all NYS DSRIP regions, the region has the highest observed to expected ratio for asthma in younger adults in the Medicaid only population (149/80).
	3. Respiratory Composite Indicator	3. Among all NYS DSRIP regions, the region has the highest all respiratory composite observed to expected ratio in the Medicaid only population (393/306).

VI.   Summary of Consumer and Provider Input

The Adirondacks region counties' surveys of consumer and provider stakeholders to assess local needs indicate that transportation to health care services and workforce recruitment and retention are issues that need attention for the populations with mental health and/or chemical dependency concerns.

The participating clinic in the Adirondacks region surveyed 208 consumers and 39 providers regarding community behavioral health needs in its geographic service area. The needs most frequently reported by both consumers and providers include: transportation to health care services; reduced wait times for an appointment; assistance with paying for services; convenient provider hours (evenings and weekends); ambulatory SUD detoxification; and inpatient mental health.

**Understanding and Responding to Adverse Childhood Experiences
in New York State**

May 2018

Understanding and Responding to Adverse Childhood Experiences in NYS

List of Figures

Understanding and Responding to Adverse Childhood Experiences in New York State

Executive Summary

Background

Adverse Childhood Experiences (ACEs) are potentially traumatic events in childhood that can have negative, lasting effects on health and well-being throughout life and to the next generation.[1] These experiences range from physical, emotional, or sexual abuse to parental divorce or incarceration, or violence, or substance abuse, or mental illness among others. The traumatic experiences are referred to as "toxic stress" because they can affect brain architecture and brain chemistry.[2] In the seminal ACEs Study by the Centers for Disease Control and Prevention (CDC) and Kaiser Permanente, researchers Felitti and Anda were the among the first to quantify the effects of ACEs on negative health outcomes later in life such as obesity, alcoholism and depression in adults.[1] The study retrospectively looked at ACEs among more than 17,000 Kaiser Permanente members in San Diego. Findings showed that two-thirds of the study participants reported having at least one ACE, and one in eight reported having four or more ACEs. The higher the number of ACEs experienced, the higher the risk of having negative health risk behaviors and outcomes such as obesity, ischemic heart disease, chronic obstructive pulmonary disease (COPD), suicide, substance use disorder, and depression.[1,2,3] Subsequently, a growing body of research has shown that ACEs can be prevented, and reduced, and that traumatic effects of ACEs can be reversed by building and strengthening resilience.[4,5]

Methods

In 2016, for the first time, the New York State (NYS) Department of Health (DOH) collected regional and state-level ACEs data from over 9,000 adults through the Behavioral Risk Factor Surveillance System (BRFSS). The BRFSS[6] is an annual statewide telephone survey of adults developed by the CDC and administered by DOH. The BRFSS is designed to provide information on behaviors, risk factors, and utilization of preventive services related to chronic and infectious diseases, disability, injury and death among the non-institutionalized, civilian population aged 18 years and older. ACEs were examined both individually, and scored as a sum of total ACEs. An ACE score prevalence of 3 or more ACEs was examined among key demographics, along with the effects on selected health risk behaviors and outcomes, and the clustering or co-occurrence of multiple ACEs.

Key Findings

ACEs are common in NYS. Six out of 10 adults (59.3 %) reported having experienced at least one ACE, and 13.1% reported 4 or more ACEs. Most reported ACEs are: emotional abuse (24.6%), parental separation (23%) and substance abuse in the home (22.2%).

Figure: Prevalence of ACEs in New York

59.3% experienced at least one ACE

13.1% of New York Adults experience 4 or more ACEs

40.7%
23.7%
13.6%
8.9%

Ace Score
0   1   2   3   4   5   6   7   8
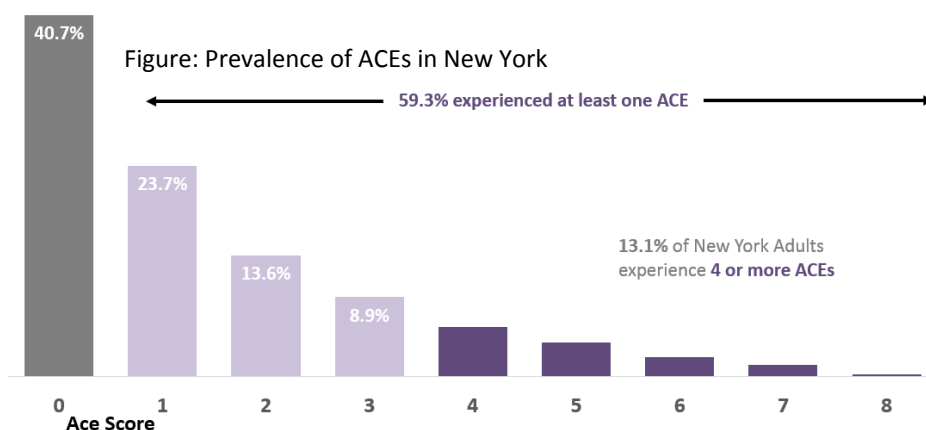
ACE scores are significantly lower among adults aged 65 years and older. ACE scores of 3 or more are higher among those who identified as Lesbian-Gay-Bisexual-Transgender (LGBT) and people with household incomes less than $15,000, and lower for those who graduated from college or technical school. Adults in households with children are more likely to have reported ACEs than households that had no children. ACEs are higher among women, Hispanics and multiracial groups, though not statistically significant due to small sample size in the survey.

Participants who reported three or more ACEs are six times more likely to report being depressed, four times more likely to report HIV risk behaviors, three times more likely to have arthritis or be current smokers, and twice as likely to be obese, ever have asthma or report binge drinking.

ACEs occur in clusters. Abuse related ACEs were strongly correlated with each other, as was domestic violence with household member substance use. Reporting of incarceration as part of ACEs was correlated strongly with substance abuse and mental illness in the home.

Action Steps

Five action steps are recommended.
1 **Facilitate cross-sectoral engagement in developing, implementing and evaluating the action plan**
   Share the ACEs data and report with a variety of sectors including survivors of ACEs, healthcare providers, local health departments, schools and after school programs, law enforcement community-based organizations, social services, mental health and substance treatment agencies, to develop a robust plan of action that will be included in the Prevention Agenda 2019-2024, the state health improvement plan.
2 **Offer technical support on best practice to prevent, reduce and respond to ACEs**
   Disseminate a list of evidence-based and best practice program and policy interventions, and offer guidance on how to track changes in policy, attitudes and behaviors due to these efforts.
3 **Support alignment of actions to address ACEs**
   ACEs science is about the prevalence and consequences of ACEs, and what to do to prevent them or mitigate their impact. Facilitate working with partners to integrate the science of ACEs in their programs and policies.
4 **Strengthen capacity for training and communications**
   Work with partners on ACEs culturally-sensitive training and to develop a communication strategy, and use existing web platforms to share experiences and lessons learned.
5 **Collect data and information on ACEs and resilience periodically**
   Continue to collect ACEs data with other health risk behaviors and outcomes such as substance use, obesity, mental illness, tobacco use, injuries, disabilities to inform policy and program to support healthier communities. In addition, collect information on change brought about policies and program that address ACEs and build resilience.

<div align="center">**Detailed Report**</div>

1. Why focus on ACEs?

Adverse Childhood experiences (ACES) are potentially traumatic events that can have negative, lasting effects on health and well-being.[1] These experiences range from physical, emotional, or sexual abuse, parental divorce, or living at home with someone who was incarcerated, abused substances, or had a mental illness.

Some stress in life is normal, and even necessary for development. However, when a child experiences "strong, frequent, or prolonged activation of the body's stress response systems in the absence of the buffering protection of a supportive, adult relationship", [2] this stress may turn toxic. The traumatic experiences are referred to as "toxic stress" because they can affect brain architecture and brain chemistry. A growing body of research has quantified the prevalence of toxic stress in children with negative behavioral and health outcomes, such as obesity, alcoholism, and depression later when they grow into adults, and to the next generation.[1,2,3] A CDC study found the total lifetime estimated financial costs associated with one year of confirmed cases of child abuse and neglect is approximately $124 billion.[4] ACEs can be prevented, reduced, and traumatic effects of ACEs can be reversed by building and strengthening resilience.[5,6]

2. The ACE Study

The term "ACE", was coined in 1998 following the release of the seminal large-scale Adverse Childhood Experiences' Study by the Centers for Disease Control and Prevention (CDC) and Kaiser Permanente. Led by researchers Dr. Vincent Felitti and Dr. Robert Anda, the ACE Study surveyed 17,337 adult patients of Kaiser Permanente in San Diego, California for 10 ACEs: childhood stressors, such as physical, emotional and sexual abuse, emotional and physical neglect, household substance abuse and mental illness, parental discord, witnessing domestic violence, and incarceration in the home.[1]

This methodology was different from most at that time as it examined the contributions of several forms of abuse with health outcomes. The ACE Study was one of the first epidemiologic studies demonstrating that exposures to each of the ten categories of childhood abuse, neglect, and family dysfunction are common, cumulative and are highly interrelated.[1]

Patients were asked about their medical history and traumatic experiences in childhood. Most of the participants were white (74.8%) and had attained a college-level education or higher (75.2%). The study found that ACEs were common among study participants. Almost two-thirds (63.9%) of participants reported having at least one adverse childhood experience.[1] One in eight participants (12.5%) reported having four or more ACEs. Moreover, researchers found that high ACE scores significantly increased the risk for poor health outcomes and negative health behaviors among study participants.[1] Additionally, there was a strong dose-response relationship between ACEs and poor outcomes. As the number of ACEs increased, the risk of negative health outcomes increased as well. In fact, subsequent studies have found that the life expectancy of a person with six or more ACEs is 20 years shorter than a person with no ACEs.[4]

3.New York State BRFSS ACEs Methodology

The BRFSS is an annual statewide telephone survey of adults developed by the CDC and administered by DOH. The BRFSS is designed to provide information on behaviors, risk factors, and utilization of preventive services related to the leading causes of chronic and infectious diseases, disability, injury and death among the non-institutionalized, civilian population aged 18 years and older.[7]

The 2016 Expanded BRFSS survey was designed to collect county-level data and used a larger sample that included three parts: 1) core questions that are asked by every state; 2) optional CDC modules, and 3) state-added questions. The ACEs questions were one of the optional modules included in the 2016 Expanded BRFSS survey. To maximize the topics included in the survey, there were three questionnaire versions used, each of which included the core questions. Each version was used by approximately 10,000 respondents statewide. While the ACEs module was part of the 2016 Expanded BRFSS, it was only included in one of the questionnaire versions and due to sample size issues, data are reported at regional and state levels.[8]

The New York State BRFSS ACEs module (Figure 1) consisting of 11 questions was administered for the first time in 2016. The 11 questions assessed eight categories of ACEs: three related to childhood abuse, and five related to household dysfunction. The BRFSS ACEs module does not include questions related to childhood neglect, and NYS did not add these on to the survey.

Data collected are "weighted" to address non-response or non-coverage bias, and adjusted to reflect the number of people in the state who are 18 years and older based on standard valid statistical methodology. An ACE score is a tally of the number of "yes," "once" or "more than once" for questions in each category. In the instance of "emotional abuse", the response is

Adverse Childhood Experiences Module

Household dysfunction

Mentally ill household member

1. Did you live with anyone who was depressed, mentally ill or suicidal? [Yes/No]

Substance abuse in household

2. Did you live with anyone who was a problem drinker or alcoholic? [Yes/No]
3. Did you live with anyone who used illegal street drugs or who abused prescription medications? [Yes/No]

Incarcerated household member

4. Did you live with anyone who served time or was sentenced to serve time in a prison, jail or other correctional facility? [Yes/No]

Parental separation/divorce

5. Were your parents separated or divorced? [Yes/No]

Violence between adults in household

6. How often did your parents or adults in your home ever slap, hit, kick, punch or beat each other up? [Never/Once/More than once]

Childhood abuse

Physical abuse

7. How often did a parent or adult in your home ever hit, beat, kick or physically hurt you in any way? Do not include spanking. [Never/Once/More than once]

Emotional abuse

8. How often did a parent or adult in your home ever swear at you, insult you or put you down? [Never/Once/More than once]

Sexual abuse

9. How often did anyone at least 5 years older than you or an adult touch you sexually? [Never/Once/More than once]
10. How often did anyone at least 5 years older than you or an adult, force you to have sex? [Never/Once/More than once]
11. How often did anyone at least 5 years older than you or an adult, try to make you touch them sexually? [Never/Once/More than once]

Figure 1: BRFSS ACEs Module Questions

counted as an ACE if the response is "more than once". The highest ACE score in the ACE module is eight as there are eight categories.

ACE scores were computed for those who completed the ACEs module with affirmative or negative responses. Persons who refused, missing, or unknown to the question set were excluded. These scores were categorized into three levels '0 ACEs', '1-2 ACEs', and '3+ ACEs', for analysis with pertant demographics, behaviors, and health outcomes. Information on '4+ ACEs' is presented in some places for comparibility to other studies, however the threshold of '3+ ACEs' was generally used for the 'upper bound' category to increase statistical power, consistent with reports of limited sample size.

Logistic regression is a statistical method to check for independent associations between one variable and outcome while being able to control for other variables that may play a role in the outcome. Here, logistic regression was used to see the effects of having an ACE score of 3 or more (vs no ACE score) independent of race, ethnicity, income, education, age and gender. Odds ratios, which show the odds of the outcome happening among people with 3 or more ACEs compared to no ACE score, are presented for risk behaviors and health conditions for which there was a statistically significant (a p-value of less than .05) effect.

3.1 BRFSS ACEs Module: Notes to keep in mind
When reviewing data from the BRFSS ACEs module, note that:
- BRFSS estimates apply only to adults 18 years and older
- Data does not apply to individuals without telephone service, those who reside on military bases or within institutions or who are unable to complete a telephone survey
- BRFSS prevalence estimates are self-reported and subject to bias due to respondents' inability or unwillingness to provide information about their behaviors or characteristics
- ACEs data only measures categories of ACEs, not frequency or severity of each ACE

3.2 Three questions explored with BRFSS ACEs data
Three questions were explored with the BRFSS ACEs data: 1) What is the prevalence of ACEs ? (2) How are ACE categories connected? (3) How do ACEs affect health outcomes and risk behaviors?

4. NYS BRFSS ACEs Findings

4.1 BRFSS ACEs Module Response

NYS 2016 BRFSS survey combined landline and cellphone weighted response rates was 36.3% for a total response of 35,334.[9] The questionnaire with the ACEs module was used with 11,236 residents. Of these, 80.3% (n=9,028) answered all 11 ACEs questions and were included in the analysis. Of the 19.6% (n=2,208) excluded, 14.1% (n=1,586) dropped off the telephone call before getting to the ACE questions, and 5.5% (n=622) provided partial responses, that is responses were missing, "refused" to answer, or responded with "don't know/not sure". (Figure 2)
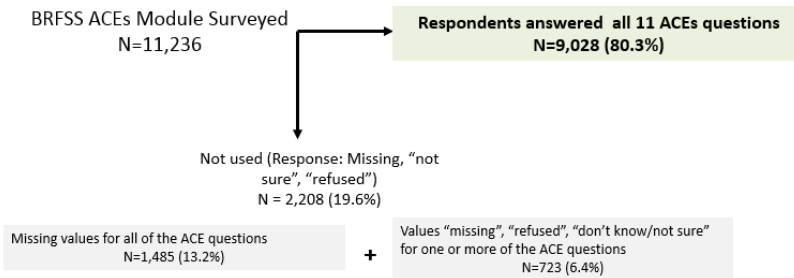
Figure 2: 2016 BRFSS ACE Module Response

4.2 Prevalence of ACEs in NYS

A. ACEs are common in NYS.
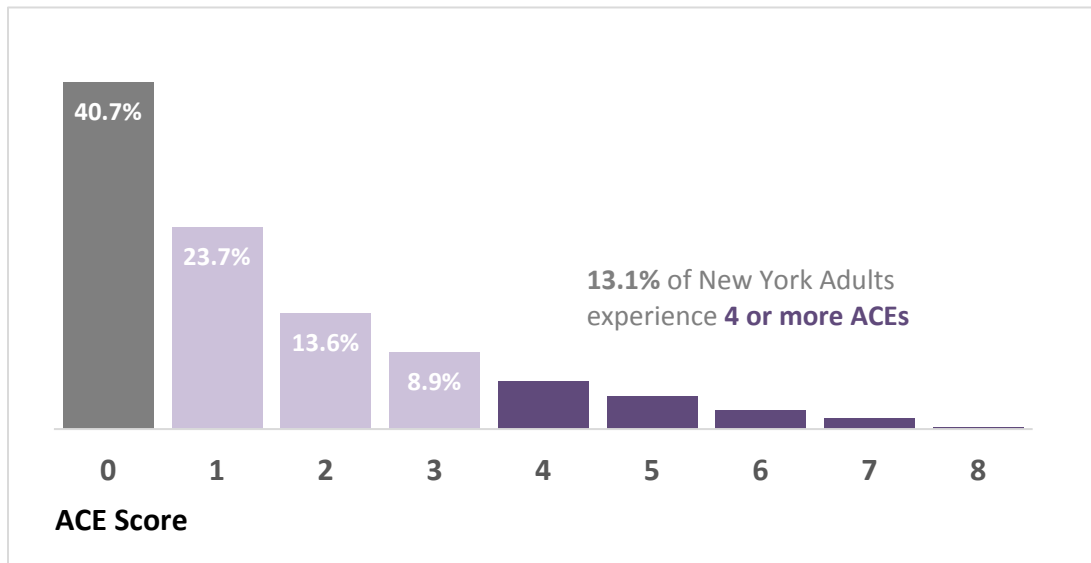
About six out 10 adults, 59.3%, in NY report experiencing at least one ACE, and 13.1% experienced 4 or more ACEs. (Figure 3)

13.1% of New York Adults experience **4 or more ACEs**

- 40.7%
- 23.7%
- 13.6%
- 8.9%

ACE Score: 0 1 2 3 4 5 6 7 8

Figure 3: Prevalence of ACEs in NYS, 2016 BRFSS

B. Most reported ACEs

Emotional abuse, parental separation/divorce, and substance abuse are the most reported ACEs.

Emotional abuse	27.3%
Parental separation/divorce	25.2%
Substance abuse in household	24.4%
Physical abuse	20.8%
Violence between adults in household	16.8%
Mentally ill household member	14.5%
Sexual abuse	10.9%
Incarcerated household member	5.7%
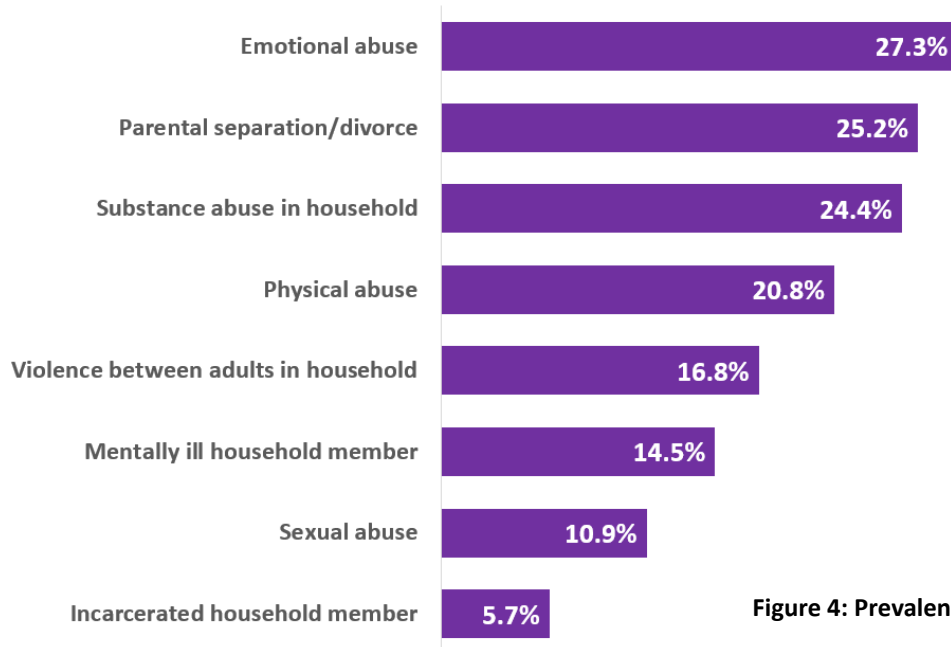
Figure 4: Prevalence of ACEs types

C. ACEs Demographics

ACE scores are significantly lower in the 65 years and older age group (Figure 5). ACE scores of 3 and greater are higher among people with household incomes less than $15,000, and lower for those who graduated from college or technical school. Adults in households with children are more likely to have reported ACEs than households that had no children. ACEs are higher among women, Hispanics and multiracial groups, though not statistically significant.

18-24	28.8%
25-34	25.5%
35-44	21.5%
45-54	26.5%
55-64	22.7%
65+	11.1%
Non-Hispanic White	20.5%
Non-Hispanic Black	22.1%
Non-Hispanic, Other race only	12.1%
Multiracial, Non-Hispanic	30.8%
Hispanic	28.6%
Female	23.4%
Male	20.3%
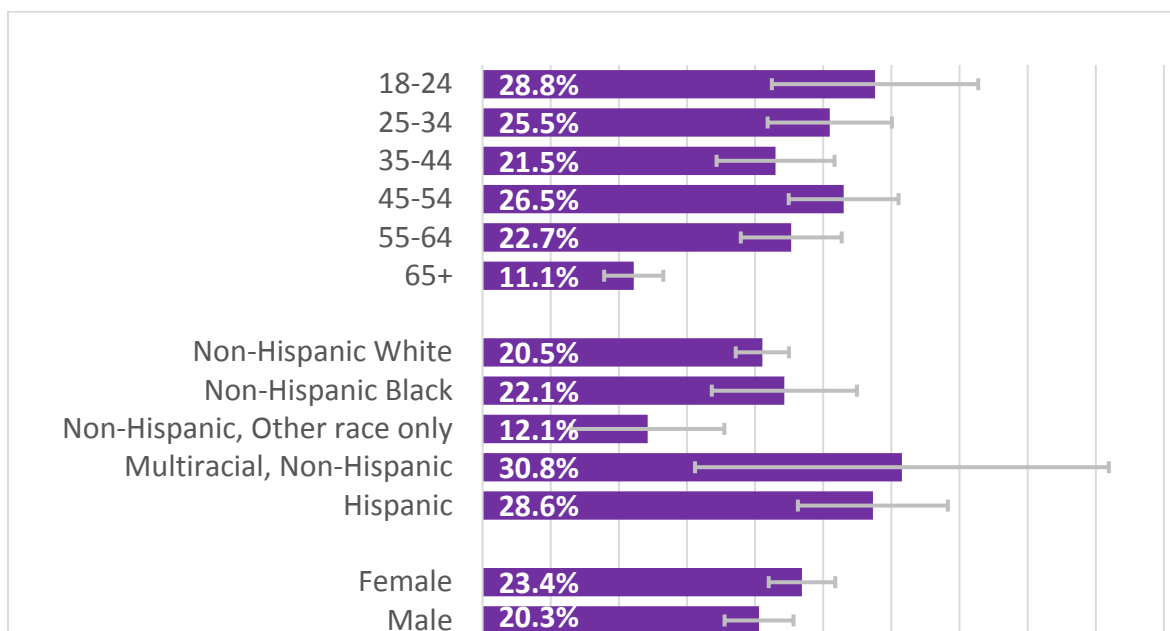
Figure 5: Among Adults (Age 18+ Years) in New York State with ACE Scores ≥3

D. Prevalence of ACEs by sexual orientation/transgender status

An ACE score of 3 or higher is significantly higher among the LGBT group (36.3%) as compared to the heterosexual group (21.6%) as seen in Figure 6.
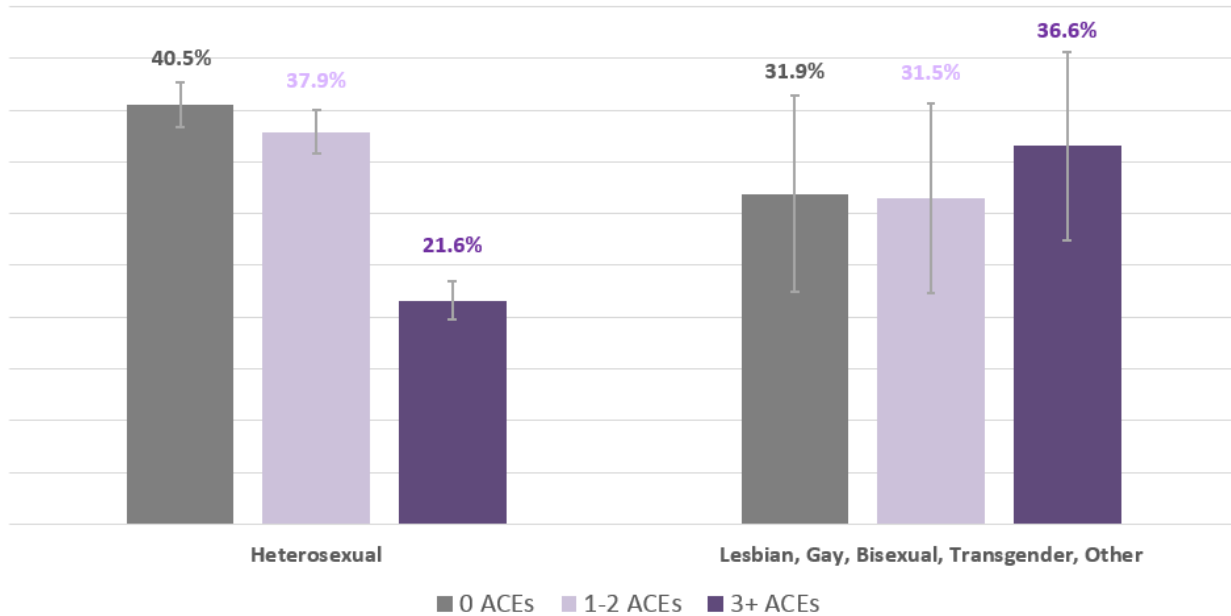
Figure 6: Prevalence of ACE Score by sexual orientation/transgender status

E. Prevalence of ACEs by Income groups

An ACE score of 3 and more is highest among the household income group of less than $15,000 at 30.3%, and stayed consistent at 21% across other income groups as seen in Figure7.
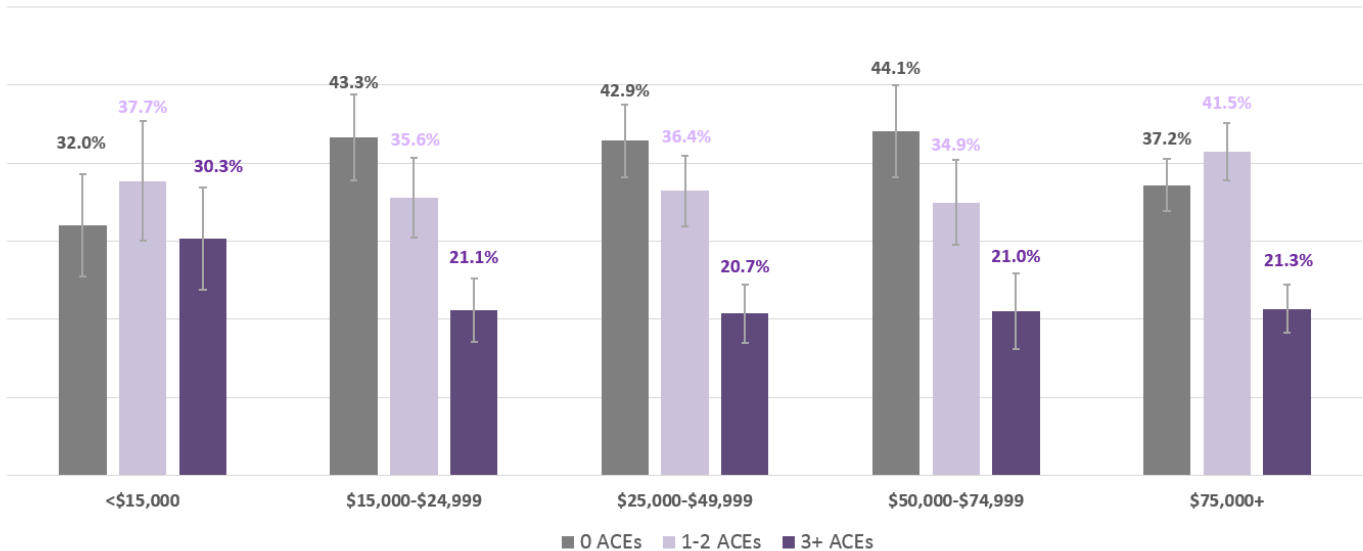
Figure 7: Prevalence of ACEs by Income

F. Prevalence of ACEs by Educational Level

An ACE score of 3 or higher is higher among those who did not graduate from college or technical schools at 26.1%, and lowest for college or technical school graduates at 16.8% as shown in Figure 8.
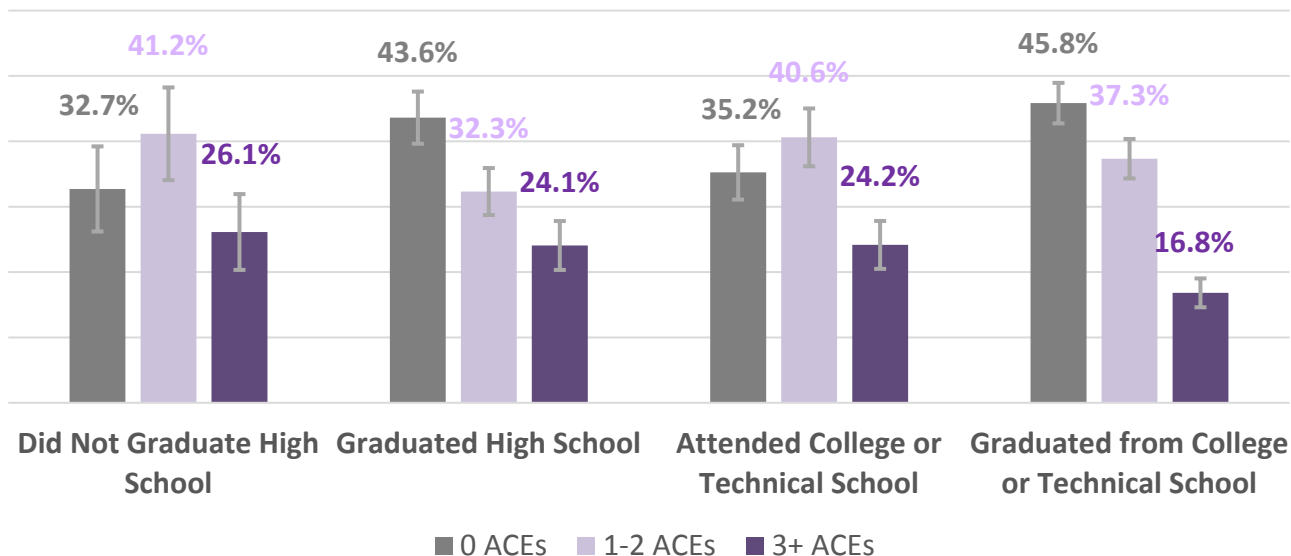
Figure 8: Prevalence of ACEs by Educational Level

G. Prevalence of ACEs by number of children in the household

The prevalence of 3 or more ACEs in households with children is between 23.7% to 25.2%, and is higher than in households with no children (20.4%) (Figure 9).
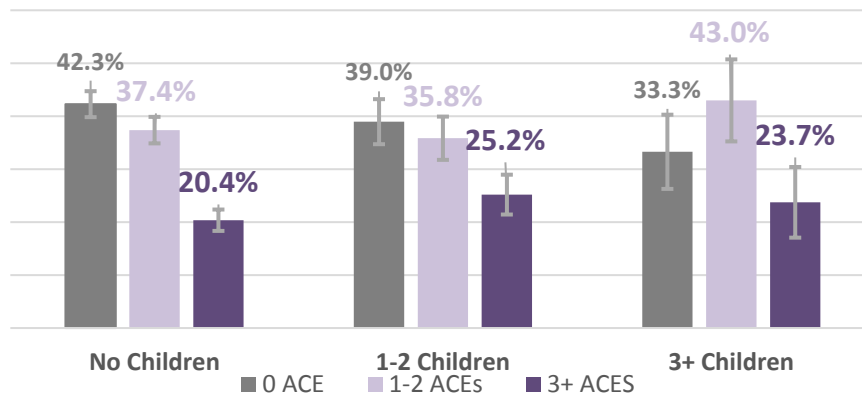
Figure 9: Prevalence of ACEs compared among household by number of children in the household

H. Prevalence of ACEs by Delivery System Reform Incentive Payment (DSRIP) Region

ACEs were analyzed by DSRIP regions. DSRIP is the main mechanism by which the states is restructuring the health healthcare delivery system by reinvesting in the Medicaid program. While there were no significant differences, ACE Scores of 3+ are higher (23.7%) and ACE Scores of 0 (49.5%) are higher in the Tug Hill Seaway. New York City reported slightly lower percentage of ACE 3+ score (19.7%).

Figure 10: Delivery System Reform Incentive Payment (DSRIP) Regions in NY

	No ACE	Low ACE	High ACE
Long Island	40.4%	35.3%	24.2%
New York City	40.9%	39.4%	19.7%
Mid-Hudson	39.7%	37.3%	23.0%
Capital District	35.9%	38.9%	25.2%
Mohawk Valley	44.0%	33.2%	22.8%
North Country	42.3%	33.7%	24.0%
Tug Hill Seaway	49.5%	23.7%	26.7%
Central New York	44.5%	32.0%	23.5%
Southern Tier	39.8%	35.9%	24.3%
Finger Lakes	42.0%	37.3%	20.8%
Western Region	39.3%	39.8%	20.9%
Statewide	40.7%	37.3%	22.0%
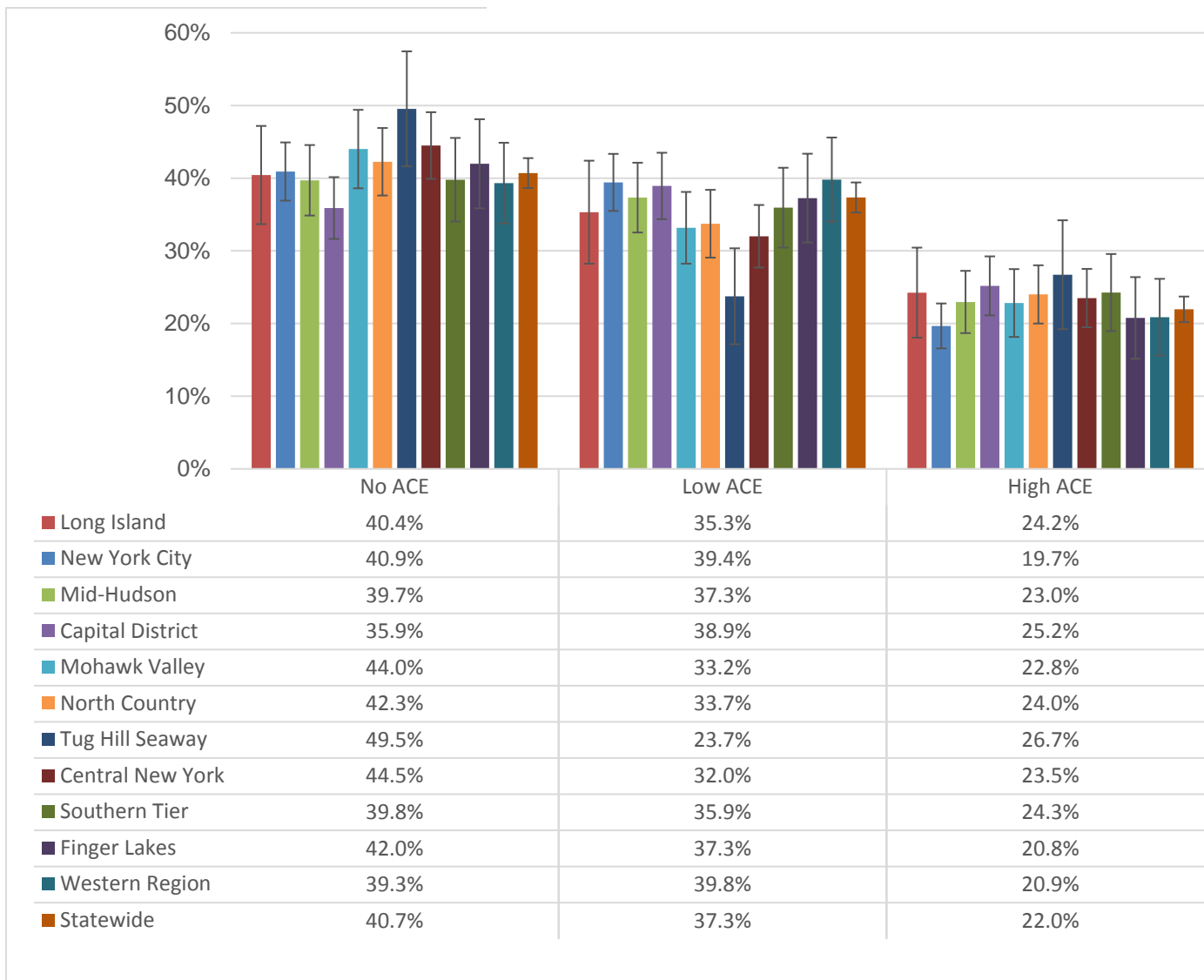
Figure 11: Prevalence of ACEs by DSRIP regions in NYS

Prevalence of ACEs by DSRIP Region and Urbanicity
There are no significant differences in ACE scores between urban and rural areas within DSRIP regions
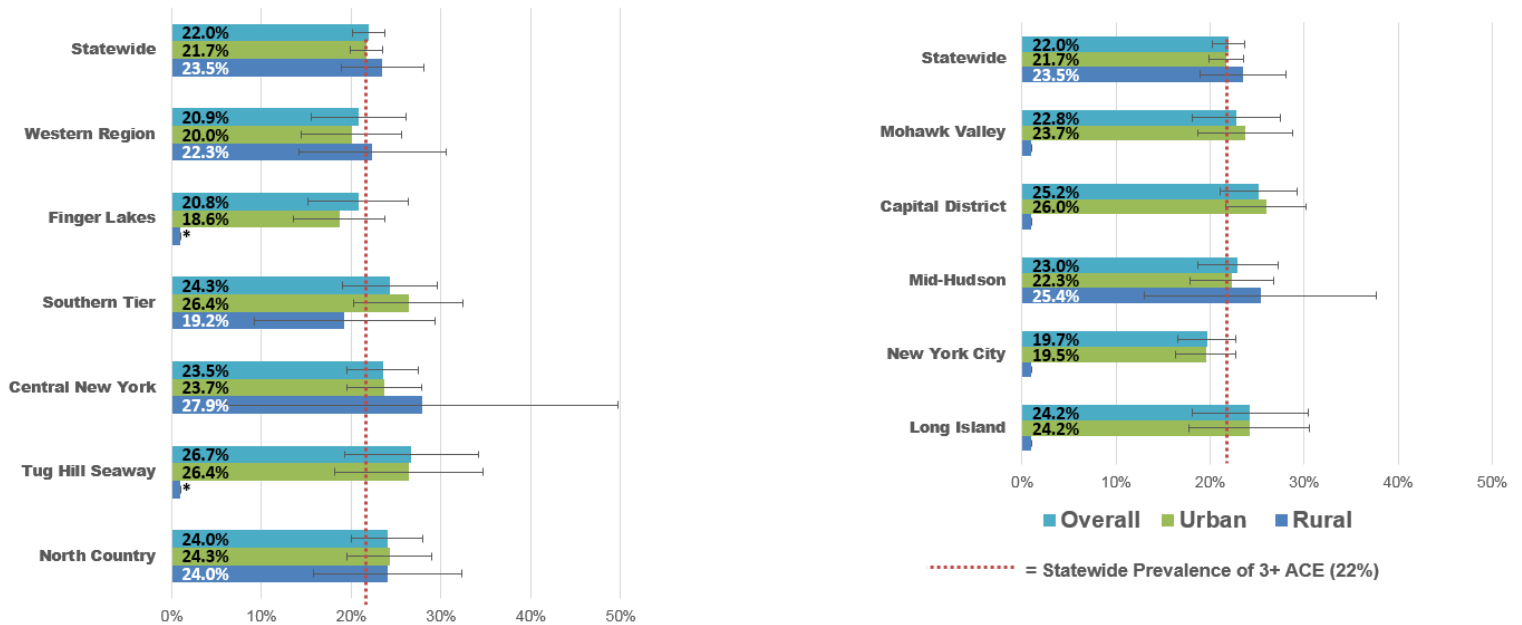
*Percentages based on denominators of less than 50 or with relative standard errors of greater than 30% are suppressed
Rural/Urban status determined using zip code level *Rural - Urban Commuting Areas (RCA)*

Figure 12: Prevalence of 3+ ACEs by DSRIP Regions and Urbanicity among adults (age 18+ Years) in New York State

4.3 ACEs and Health conditions or risk behaviors

Several health outcomes have increased odds of occurrence among individuals with 3 or more ACEs. A person with an ACE score of 3 or more is 6 times more likely to be at risk for depression (Fig. 13), and 3 times more likely be living with a disability.

	Adjusted Odds Ratio	95% Confidence Interval
Depression	**6.23**‡ times more likely	(4.48-8.65)
Had more than 14 bad mental health days	**4.67**‡ times more likely	(3.24-6.71)
Vision impaired	**3.59**‡ times more likely	(2.10-6.12)
Non-asthma lung diseases	**3.50**‡ times more likely	(2.12-5.76)
Disabled	**2.90**‡ times more likely	(2.17-3.90)
Physical impairment	**2.89**‡ times more likely	(2.09-3.98)
Arthritis	**2.88**‡ times more likely	(2.19-3.78)
Kidney disease	**2.67**† times more likely	(1.47-4.86)
Had more than 14 bad physical health days	**2.59**‡ times more likely	(1.85-3.63)
Fall in past 12 months (people 45+)	**2.49**‡ times more likely	(1.85-3.34)
Ever had asthma	**1.81**† times more likely	(1.31-2.50)
Obesity	**1.73**† times more likely	(1.33-2.24)

Controlled for:
Income
Education
Age
Race
Ethnicity
Gender

Figure 13: Adjusted Odds Ratio for Selected Health Outcomes by ACE scores of 3 and over

A person with an ACE score of 3 or greater is almost four times more likely to engage in HIV risk behaviors, which includes intravenous drug use, a sexually transmitted disease, transactional sex for drugs or money, unprotected anal sex or having four or more sexual partners in the last year as compared to a person with no ACE (Figure 14).

	Adjusted Odds Ratio	95% Confidence Interval
HIV risk behaviors*	3.67[‡] times more likely	(2.23-6.04)
E-cigarette ever used	2.70[‡] times more likely	(1.95-3.75)
Current smokers	2.84[‡] times more likely	(2.00-4.03)
Ever smokers	2.68[‡] times more likely	(2.09-3.44)
Binge drinking**	1.50[†] times more likely	(1.08-2.06)
Poor sleep	1.67[‡] times more likely	(1.30-2.13)
Not eating fruit every day	1.4[†] times more likely	(1.11-1.82)

Controlled for:
Income
Education
Age
Race
Ethnicity
Gender

*HIV risk behaviors include history of any (within the past year): IV drug use, a venereal disease or sexually transmitted disease, transactional sex for drugs or money, unprotected anal sex, or having four or more sexual partners.
[†] = significant at $p < .05$; [‡] = significant at $p < .01$

Figure 14: Adjusted Odds Ratio for Selected Health Risk Behaviors by ACE scores of 3 and over

Some of the health conditions and risk behaviors did not appear to be affected by an ACE score of 3+. This may be due to small sample size. For example, "heavy drinking" only 5% of the sample reported being heavy drinkers, hence did not show up in the analysis (Fig. 15).

Health Conditions	Risk Behaviors
Diabetes	Current other tobacco use (snuff, snus, chewing tobacco)
Cancer (skin and other)	Current E-cigarette use
Current asthma	Always wearing a seatbelt while in the car
Stroke	Drinking and driving
Cardiovascular Disease	Heavy drinking*
Heart attack	Eating Vegetables every day
High blood pressure	
Exercise	
Perceived poor health	
Hearing impairment	
Having an injury from a fall in the past 12 months	

*Heavy drinking is considered 14+ drinks per week for men or 7+ drinks per week for women, while binge drinking is having 5+ drinks on one occasion for men or 4+ drinks on one occasion for women

Figure 15: Health Outcomes not significantly affected by ACEs

4.3 *Correlation Among Different ACEs*

A correlation matrix was created to show a summary of the co-occurrence, or relationship, between different ACEs. The number shown is the Pearson correlation coefficient, this is a decimal between 0 and 1 which reflects the relationship between two ACEs happening together all the time (1) and never happening together (0). For easier interpretation, the coefficients have been shaded to show the strongest correlations (shaded darker), down to the weakest correlations (no shading or lighter shading). Among ACEs, physical abuse is strongly correlated with emotional abuse. Domestic violence is strongly correlated with physical and emotional abuse, and substance use. Substance use is also correlated strongly with incarceration and mental illness. See Figure 16.

		Household Dysfunction					Abuse		
		Mental Illness	Substance Use	Incarceration	Separation/ Divorce	Domestic Violence	Physical	Emotional	Sexual
Household Dysfunction	Mental Illness	-	0.30	0.20	0.14	0.24	0.21	0.28	0.19
	Substance Use		-	0.27	0.19	0.35	0.26	0.29	0.20
	Incarceration			-	0.17	0.19	0.13	0.16	0.09
	Separation/Divorce				-	0.20	0.13	0.13	0.08
	Domestic Violence					-	0.41	0.37	0.20
Abuse	Physical						-	0.45	0.26
	Emotional							-	0.20
	Sexual								-

Figure 16: Correlation among ACEs

Figure 17 illustrates another way to view the correction. Among those who identified as living with a household member who had been incarcerated (2nd row), 71% identified as also using substances. Of the respondents who responded as identifying living with a household member with domestic violence (2nd row), 63% identified as experiencing emotional abuse.

Rank	Household Members (HM)				Parents	Abuse (A.)		
	Mental Illness	Substance Use	Incarcerated	Violence Between Adults	Separated or Divorced	Physical Abuse	Emotional Abuse	Sexual Abuse
1	Emotional A. 59%	Emotional A. 50%	Substance Use 71%	Emotional A. 63%	Substance Use 39%	Emotional A. 68%	Physical A. 52%	Emotional A. 53%
2	Substance Use 56%	Parent Sep/Div 40%	Emotional A. 57%	Substance Use 58%	Emotional A. 38%	Substance Use 47%	Substance Use 45%	Physical A. 51%
3	Physical A. 42%	HM Violence 40%	Parent Sep/Div 56%	Physical A. 57%	HM Violence 30%	HM Violence 46%	HM Violence 40%	Substance Use 47%
4	Parent Sep/Div 40%	Physical A. 40%	HM Violence 45%	Parent Sep/Div 45%	Physical A. 30%	Parent Sep/Div 37%	Parent Sep/Div 35%	HM Violence 38%

Figure 17: Co-reporting among ACEs

4.4 Comparing NYS ACEs with other states and related surveys

4.4.1 Comparing ACEs in NYS with other states

Rates of no ACEs and 3+ ACEs in NYS are comparable to other states with about 3 out of 5 (59%) respondents in NYS experiencing one ACE, and 13 percent experiencing 4 or more ACEs as seen in Figure 18. Many of the states have larger samples, and several states combined data from multiple years to get a larger sample size.[10] Small sample sizes made it difficult to conduct analysis of ACEs with some of the health outcomes and health risks.

State (Years)	Sample Size	% of adults with at least 1 ACE	% of adults with 4 or more ACEs
California, (2008, 2009, 2011, 2013),	24,745	62%	17%
Iowa (2012-2014)	19,000	56%	14.5%
Kansas (2014-2015)	29,686	55%	13.5%
Minnesota (2011)	13,520	55%	13%
New York (2016)	**9,028**	**59%**	**13%**
Washington (2009)	7,471	62%	17%
Wisconsin (2011, 2012)	9,039	56%	14%

Figure 18: ACEs in NYS and Selected States

4.4.2 Other ACEs data on NYS

A telephone ACEs survey of 807 adults in the state was conducted by the New York Council of Children and Families in 2009.[11] This survey added a question on exposure to neighborhood violence drawn from the questionnaire My Child's Exposure to Violence, version 3—a data collection instrument used

for the Project on Human Development in Chicago Neighborhoods.[12] The survey also found 59% of adults had at least one ACE, and the most common ACE experienced was exposure to neighborhood violence.

More recently, the 2016 National Survey of Children's Health[13] telephone survey of households with at least one 17 years old or younger living in the household, found that 45.3% 0-17 years had experienced with at least one ACE. The sampling methodology is different from the BRFSS survey, and cannot be compared. Though the NYS BRFSS did find that ACEs among adults with three or more children living in households were higher than in household with no children (Figure 10).

In some counties, Monroe[14], Warren and Washington[15] counties surveyed students on ACEs, and the findings have been used to advocate for trauma-informed approaches in schools.

5. Discussion

The NYS BRFSS survey findings are consistent with the findings from national and other states' ACEs studies and shows ACEs are common. ACE scores are significantly lower in the 65 years and older age group. ACE scores of 3 and older are higher among those who identified as Lesbian-Gay-Bisexual-Transgender (LGBT), people with incomes less than $15,000, and lower for those who graduated from college or technical school. Adults in households with children are more likely to have reported ACEs than households that had no children. ACEs are higher among women, Hispanics and multiracial groups, though not significantly significant.

ACEs tend to co-occur or cluster. There are stronger correlations among emotional, physical abuse, domestic violence, substance use and mental illness. Significantly lower rates of ACEs were observed in the 65 years and older age groups. It has been suggested that older people may report fewer ACEs because they have more limited recall or are less willing to acknowledge potentially stigmatizing experiences.[1]

5.1 Neglect questions were not included in 2016 BRFSS survey

The validated BRFSS ACE survey module was used, and this did not include emotional and physical neglect questions. Hence the maximum ACE score based on the module used was 8. The ACE rates may have been higher if neglect questions were included. It should be noted that many states did not include neglect questions because they were not part of a module. A few states added one or two neglect questions. In addition, ACEs data only measure categories of ACEs, not frequency or severity of each ACE. There are also many additional types of ACES, such as the occurrence of neighborhood violence, and natural disasters, which are not accounted for in this questionnaire, though they have been associated with similar health outcomes and risk behaviors. Hence, it is likely ACE scores are under reported, and more complex then summarized in this report.

5.2 ACEs data are to be interpreted and addressed as a group

The ACE study was one of the first epidemiologic studies to demonstrate that exposures to each of the ten categories of childhood abuse, neglect, and family dysfunction are common, and highly interrelated. It also indicated that the effects of the ACEs were cumulative, the higher the ACE score, the greater the likelihood of a negative health outcome or risk behavior. Traditionally, policies and

programs have focused on a one risk behavior or health outcome. The ACEs data support the rationale for using an integrative approach. For example, a program or policy focusing on reducing obesity could also integrate social emotional needs in interventions and data collection.

5.3 Biology of ACEs

The ACE study demonstrated that abuse, neglect, and serious forms of household dysfunction are associated with multiple social, physical, behavioral, and mental health problems that emerge in adolescence and persist into adulthood. There are at least seven ways ACEs affects brain architecture.[4, 5, 16]

Cause Epigenetic Shifts: ACEs induce epigenetic shift, changes in markers that influence our genes. Through a process known as gene methylation, a small chemical marker, or methyl groups, adheres to the genes involved in regulating the stress response, interfering with their function. This causes the stress response to re-set on "high" for life, promoting inflammation and disease. This causes over reaction to everyday stresses.

Changes size and shape of brain: A developing brain, when chronically stressed releases a hormone that shrinks the size of the hippocampus, an area of the brain responsible of processing emotion and memory and managing stress. Magnetic resonance imaging (MRI) studies suggest that individuals with high ACE scores have less gray matter in other key areas of the brain. This causes over-reaction to even minor stressors.

Unregulated neural pruning: Children are born with many neurons and synaptic connections which are pruned as they grow. Neurons and synaptic connections that are not used are "lost". Non-neuronal cells, called the microglia also help with the pruning by engulfing and digesting entire cells and cellular debris. When a child experience continuous unpredictable stress, these microglia cells release neurochemicals that lead to neuroinflammation which could lead to development of mood disorders or contribute to poor executive functioning and decision-making skills.

Shortened telomeres: Telomeres are protective caps found on the ends of DNA strands. They keep the genome healthy and intact. Childhood adversity has been found to erode telomeres erode, making it more likely for individuals to develop disease, and cause cells to age faster.

Disengage default neural network: Our brains are connected by a network of neurocircuitry, called the "default mode network". It connects parts of the brain associated with memory, thought integration, and help our brains react to situations. In children whose brains are always in a state of fight-or-flight, there is less connectivity. As a result, they have less capacity to respond to changing situations.

Pathway between brain and body: When a child experiences adversity, the inflammatory chemicals that are produced in the body travel throughout the body though the lymphatic system. The brain is part of and connected to the immune system. Hence, stress affects the mind and the body.

Weaker neural connections: Children who experience chronic childhood adversity show weaker neural connections between the prefrontal cortex, the hippocampus and the amygdala. The prefrontal-cortex-amygdala relationship determines regulations of emotions. This increases the propensity for mood disorders such as anxiety and depression.

5.4 Biology of Resilience

Resilience is the capacity to cope with stress, overcome adversity, and thrive despite challenges in life. If ACEs affects brain architecture, how does resilience work? For many years, people thought that an adult brain was unchangeable and static. In recent years, a major development in the field of neuro

science has been the discovery of neuroplasticity – the fact that the brain is a dynamic organ that changes at any age. Repeated exposure to social messages not only influences our belief systems, but also the biology of our brain. Resilience can now be measured in terms of how our brains, immune systems, and genes all respond to stressful experiences.[17]

A landmark study by Dr. Michael Meany[18] and his colleagues at McGill University on the behavior of rat mother and pups illustrates the effect of early nurturing. Meaney and his team observed nurturing behaviors of two groups of rat mothers and pups. They noticed that after the pups were handled by researchers, their mother would soothe their stressed-out pups by licking and grooming them. Some displayed high levels of licking and grooming behavior, and some low levels. Pups from "high-licker" moms showed low levels of stress hormones, including corticosterone, when they were handled by researchers or placed in stressful situations. In contrast, pups from low-licker mom not only showed higher spikes of corticosterone in response to a stressor, such as being placed in a restraint for 20 minutes, they also had a harder time shutting off their stress response than did the pups of high-licker mom. Researchers found that the licking and grooming during the pups first 10 days not only predicted changes in their stress response for a lifetime, but also continued into the next generation. To understand this process further, Meaney's research team switched some of the rat pups at birth. They placed pups of high-licker moms with moms who were low lickers and vice versa. They found biological pups of high-licker mums who were fostered by low-licker moms grew up to be stressed adults, and became low-lickers as moms. Licking and grooming in the first 10 days of a pup's life made a difference throughout the lifespan, and through the next generation.

Biologically, there are at least three ways that early nurturing affects the neurological function, and later nurturing helps repair some of the damage. [5,17,18,19]
Epigenetic regulation: There are chemical markers which are situated on top of the DNA determine which genes get read and transcribed into proteins and which don't. These epigenetic markers are subject to experience, and can be rewritten by the environment. This process of epigenome working with the genome in response to the environment is called epigenetic regulation. Different epigenetic patterns determined stress levels, and these patterns were determined by the nurturing in the early years.
Maintaining healthy telomeres: Telomeres are non-coding sequences at the ends of DNA strands, like protective bumpers. Early childhood adversity predicts shorter telomeres in adults, an indication of cellular aging and disease process. When telomeres are hurt and get too short, the cells age and retire. Hence in young people, collagen in the skin is supple and prevent wrinkle, and with age retire, and the skin starts to wrinkle. Telomeres can be protected by boosting levels of telomerase, an enzyme that lengthen telomeres. Telomerase can be boosted by meditation and exercise, and this would slow the decline.
Neuroplasticity: Critical and sensitive periods are times of maximal neuroplasticity, the brain's ability to rewire or reorganize in response to a stimulus. Even outside the sensitive period, the wind does not totally close, it just gets smaller. There are two types of neuroplasticity. Cellular plasticity is a change in the number of brain cells that are talking to each other, and occurs most rapidly in the first years of life. About 90 percent occurs by the time a child turns six, but the rest stretches out until about age 25. Synaptic plasticity is a change in the strength of the connection between the junctions from one brain cell to the next, the synapse, and occurs over the lifespan. The most effective way to rewire the brain

is to intervene in early childhood, preventing the stress response from being dysregulated, and supporting practices that buffer the stress response, as in child-parent psychotherapy. Hormonal changes in adolescence, pregnancy and new parenthood are sensitive periods of neuroplasticity, and provide special opportunities for healing. Activities that boost synaptic plasticity are sleep, exercise, nutrition and meditation.

Resilience is born from the interplay between internal disposition and external experience. It derives from supportive relationships, adaptive capacities, and positive experiences. Learning to cope with manageable threats to our physical and social well-being is critical for the development of resilience.

5.5 Critique of ACEs

There are several critiques of the ACEs study and surveillance related to the retrospective nature of the study, not understanding how ACEs is damaging, and concerns over the capacity to respond to ACEs.

5.5.1 Retrospective nature of ACEs study

The main critique of the ACEs study is that it is retrospective, relying on the memory and the credibility of the original respondents. Some respondents may not remember, or some may recharacterize trauma, or some may be blame external factors. Drs. Anda and Felitti have responded to this criticism in subsequent papers, saying that underreporting of trauma is more likely than overreporting; people are often uncomfortable acknowledging childhood sexual abuse or an alcoholic parent.[19]

One important source of corroboration for the ACEs study is a prospective study done by researchers in Dunedin, New Zealand.[20] For more than thirty years, they have been following a group of one thousand people born there between April 1972, and March 1973. They found the incidence of early trauma among the Dunedin cohort is similar to that of the Kaiser respondents. The adverse experiences data in the Dunedin study, were reported by children or parents, or observed by researchers, as they happened, rather than recalled by adult patients. The Dunedin researchers didn't include some of the most common adverse experiences counted by Anda and Felitti, like the alcoholism of a family member, but they still found that 40 percent of the children encountered one or more adverse experiences. They found similar relationships between early trauma and later health problems. Children who were victims of maltreatment, including maternal neglect and physical and sexual abuse, were almost three times as likely to experience major depression by their early thirties, and they were almost twice as likely to have an elevated risk of heart disease.

5.5.2 Lack of understanding of biology of ACEs and Resilience

Another reason for skepticism is not understanding of how ACEs is linked emotional, behavioral and physical problems later in life. [19] Since the ACEs study, researchers are beginning to unravel the answers through research with rats and primates, though it is still work in progress. The key pathway is the intricately interconnected system that our brain deploys in reaction to stressful events.

5.5.3 ACEs makes people feel vulnerable

A pediatrician who helps families heal at her clinic in Oakland, California says one reason for the push-back against ACEs is that it makes people feel vulnerable. When people understand the science behind ACEs, how it affects us at the biological and cellular level, and are given a ACE score based on adversity,

people realize that it is about each one of us. "*We are all equally susceptible and equally in need of help when adversity strikes. And that is what a lot of folks don't want to hear. Some want to stand back and pretend that this is just a poor-person problem. Others take fierce ownership of the problem and say, "This is killing my community," but what they mean is - It's killing my people more than yours.*"[21]

After synthesizing findings from eight qualitative studies of professionals[22], one recent study concluded that "professionals felt that they lacked the means necessary to explore child adversity, that they were apprehensive of worsening the child's situation, and that their work with child adversity induced emotional discomfort." The concerns revolved around three themes: "feeling inadequate", "fear of making it worse", and "facing evil."[20] The authors recommended developing professionals' ability to build relationships, skills in emotion regulation, and proficiency in reflective practice.

6. Action Steps

While 2016 was the first year that ACEs data were collected through BRFSS, local partnerships have been working with ACEs. As we move forward, it will be important to work with them in five areas:

1 **Facilitate cross-sectoral engagement in developing, implementing and evaluating the action plan**
Share the ACEs data and report with a variety of sectors including survivors of ACEs, healthcare, local health departments, schools and after school programs, law enforcement, community-based organizations, social services, mental health and substance treatment agencies, to develop a robust plan of action that will be included in the Prevention Agenda 2019-2024, the state health improvement plan.[23]

2 **Offer technical support on best practice to prevent, reduce and respond to ACEs**
Disseminate information on trauma-specific evidence-based and best practice programs and policy, and offer guidance on how to track changes in policy, attitudes and behaviors. Some examples include Trauma, Addiction, Mental Health and Recovery,[24] Collaborative Learning for Educational Achievement and Resilience,[25] Pediatric medical home screening tools for parents, children and adolescents who have been exposed to violence,[26] and Hague Protocol for identifying children at risk by interviewing parents in the Emergency Room.[27,28]

3 **Support alignment of actions to address ACEs**
ACEs science is about the prevalence and consequences of ACEs, and what to do to prevent them. Facilitate working with partners to integrate the science of ACEs in their programs and policies

4 **Strengthen capacity for training and communications**
Work with partners on culturally-sensitive ACEs training and to develop a communication strategy, and use existing web platforms to share experiences and lessons learned.

5 **Collect data and information on ACEs and resilience periodically**
Continue to collect ACEs data with other health risk behaviors and outcomes such as substance use, obesity, mental illness, tobacco use, injuries, disabilities to inform policy and program to support healthier communities. In addition, collect information on change brought about policies and program that address ACEs and build resilience.

Appendices
Appendix 1: ACEs Workgroup members

New York State Department of Health

AIDS Institute
Sean Ball, JD

Division of Chronic Disease Prevention
Ian Brissette, PhD
Barbara Wallace, MD

Bureau of Family Health
Lauren Tobias, MPA
Eric Zasada, MPA

Bureau of Occupational Health and Injury Prevention, Center for Environmental Health
Emily Haner, MPH
Leah Hines, MPH
Glynnis Hunt, MS
Alexis Lucero, MPH

Bureau of Social Determinants of Health
Denard Cummings
Rachel Baron-VanCleve

Center for Community Health
Nora Yates, MPA

Division of Nutrition
Lynn Edmunds, PhD
Loretta A. Santilli, MPH

Office of Minority Health and Health Disparities Prevention
Wilma Alvarado-Little, MA, MSW

Office of Public Health Practice
Jan Chytilo, MS
Christopher Maylahn, MPH
Sylvia Pirani, MPH, MS

Office of Public Health
Rachel DeLong, MD, MPH
Brad Hutton, MPH

Office of Rural Health
Karen Madden, MA

Other State Partners

Council on Children and Families
Mary DeMasi, PhD

Office of Alcoholism and Substance Abuse Services
Kathy Dixon, MA
Andrew Heck, MPP
Sherie Williams, MPH

Office of Mental Health
Michael Compton, MD, MPH
Jeremy Darman, MSW, MA
Mary McHugh, LCSW-R
Mathew Perkins, MD

ACEs Study Staff, New York State Department of Health
Mycroft Sowizral, PhD
Bureau of Chronic Disease Evaluation and Research
Michael Bauer, MS
Bureau of Occupational Health and Injury Prevention
Mathew Garnett, MPH
Bureau of Occupational Health and Injury Prevention
Brynn Lape
Bureau of Occupational Health and Injury Prevention
Colleen Baker
Office of Public Health Practice, Public Health Information Group
Priti Irani, MSPH
Office of Public Health Practice

Appendix 2: Survey questions

BRFSS Adverse Childhood Experience (ACE) Module

Prologue: I'd like to ask you some questions about events that happened during your childhood. This information will allow us to better understand problems that may occur early in life, and may help others in the future. This is a sensitive topic and some people may feel uncomfortable with these questions. At the end of this section, I will give you a phone number for an organization that can provide information and referral for these issues. Please keep in mind that you can ask me to skip any question you do not want to answer. All questions refer to the time period before you were 18 years of age. Now, looking back before you were 18 years of age---.

1) Did you live with anyone who was depressed, mentally ill, or suicidal?

2) Did you live with anyone who was a problem drinker or alcoholic?

3) Did you live with anyone who used illegal street drugs or who abused prescription medications?

4) Did you live with anyone who served time or was sentenced to serve time in a prison, jail, or other correctional facility?

5) Were your parents separated or divorced?

6) How often did your parents or adults in your home ever slap, hit, kick, punch or beat each other up?

7) Before age 18, how often did a parent or adult in your home ever hit, beat, kick, or physically hurt you in any way? Do not include spanking. Would you say—

8) How often did a parent or adult in your home ever swear at you, insult you, or put you down?

9) How often did anyone at least 5 years older than you or an adult, ever touch you sexually?

10) How often did anyone at least 5 years older than you or an adult, try to make you touch sexually?

11) How often did anyone at least 5 years older than you or an adult, force you to have sex?

Response Options

Questions 1-4	Question 5	Questions 6-11
1=Yes	1=Yes	1=Never
2=No	2=No	2=Once
7=DK/NS	8=Parents not married	3=More than once
9=Refused	7=DK/NS	7=DK/NS
	9=Refused	9=Refused

8. References

[1] Felitti, V.J., Anda, R.F., Nordenberg, D., Williamson, D.F., Spitz, A.M., Edwards, V., & Koss, M. P. (1998) Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood.

[2] Shonkoff JP, Garner AS; American Academy of Pediatrics Committee on Psychosocial Aspects of Child and Family Health; Committee on Early Childhood, Adoption, and Dependent Care; Section on Developmental and Behavioral Pediatrics. The lifelong effects of early childhood adversity and toxic stress. Pediatrics. 2012;129(1):e232– e246. http://pediatrics.aappublications.org/content/129/1/e232.full. Accessed March 8, 2018

[3] Center on the Developing Child at Harvard University. Key concepts: toxic stress. http://developingchild.harvard.edu/topics/ science_of_ early_childhood/toxic_stress_response.

[4] Fang X, Brown DS, Florence CS, Mercy JA. The economic burden of child maltreatment in the United States and implications for prevention. Child Abuse & Neglect. 33(2), 2012. Pp.156-165.

[5] Harris, Nadine Burke. The Deepest Well: Healing the Long-Term Effects of Childhood Adversity. Houghton Mifflin Harcourt Publishing Company. 2018

[6] National Research Council and Institute of Medicine. Preventing Mental, Emotional and Behavioral Disorders Among Young People: Progress and Possibilities, 2009. Washington, DC: The National Academies Press. Available online: http://www.nap.edu/catalog.php?record_id=12480. Accessed March 22, 2018.

[7] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. https://www.cdc.gov/brfss/

[8] New York State Department of Health. Expanded Behavior Risk Factor Surveillance System (Expanded BRFSS) https://www.health.ny.gov/statistics/brfss/expanded/

[9] BRFSS Combined Landline and Cell Phone Weighted Response Rates by State, 2016 https://www.cdc.gov/brfss/annual_data/2016/pdf/2016_ResponseRates_Table.pdf

[10] Prewitt, E. State ACE Survey Results. ACEs Connection. http://www.acesconnection.com/g/state-aces-action-group/blog/state-ace-survey-reports Accessed March 27. 2018.

[11] Council on Children and Families. Adverse Childhood Experiences Among New York's Adults, 2010. http://ccf.ny.gov/files/4713/8262/2276/ACE_BriefTwo.pdf

[12] Inter-University Consortium for Political and Social Research. Project on Human Development in Chicago Neighborhoods. https://www.icpsr.umich.edu/icpsrweb/PHDCN/instruments.jsp Accessed March 23, 2018.

[13] Bethell, CD, Davis, MB, Gombojav, N, Stumbo, S, Powers, K. Issue Brief: A national and across state profile on adverse childhood experiences among children and possibilities to heal and thrive. Johns Hopkins Bloomberg School of Public Health, October 2017. http://www.cahmi.org/projects/adverse-childhood-experiences-aces/

[14] 2017 Monroe County Youth Risk Behavior Survey Report. https://www2.monroecounty.gov/files/health/DataReports/MC%20YRBS%202017.pdf

[15] Conversation with Council for Prevention. http://councilforprevention.org/

[16] Nakazawa, DJ. Seven Ways Childhood Adversity Can Change the Brain. Psychology Today. 2015. https://www.psychologytoday.com/us/blog/the-last-best-cure/201508/7-ways-childhood-adversity-can-change-your-brain. Accessed March 22, 2018

[17] Center on the Developing Child at Harvard University (2015). Supportive Relationships and Active Skill-Building Strengthen the Foundations of Resilience: Working Paper No. 13. Retrieved from www.developingchild.harvard.edu.

[18] Meaney MJ. Maternal care, gene expression and the transmission of individual differences in stress reactivity across generations. Annual. Review of Neuroscience 2001. 24:1161–192

[19] Tough, Paul. The Poverty Clinic – Can a stressful childhood make you a sick adult? The New Yorker. March 21, 2011. https://www.newyorker.com/magazine/2011/03/21/the-poverty-clinic. Accessed March 22, 2018.

[20] Danese A, Moffitt TE, Harrington H, Milne BJ, Polancyzk G, Pariante CM. Poulton R, Caspi A. Adverse Childhood Experiences and Adult Risk Factors for AgeRelated Disease: Depression, Inflammation, and Clustering of Metabolic Risk Markers. Arch Pediatr Adolesc Med. 2009 December;163(12): 1135–1143. doi:10.1001/archpediatrics.2009.214.

[21] Harris, Nadine Burke. The Deepest Well: Healing the Long-Term Effects of Childhood Adversity. Houghton Mifflin Harcourt Publishing Company. 2018. p.194

[22] Albaek AU, Kinn LG, Milde AM. Walking Children Through a Minefield. Qualitative Health Research, 2018, Vol 28(2) 231-244. http://journals.sagepub.com/doi/10.1177/1049732317734828

[23] New York State Department of Health. Updating the Prevention Agenda for 2019-2014. https://www.health.ny.gov/prevention/prevention_agenda/2019-2024/background.htm

[24] SAMHSA. Trauma-Informed Approach and Trauma-Sensitive Interventions. https://www.samhsa.gov/nctic/trauma-interventions

[25] Ko, S. & Sprague, C. (2007). Service System Brief: Creating Trauma-Informed Child-Serving Systems. http://www.nctsnet.org/sites/default/files/assets/pdfs/Service_Systems_Brief_v1_v1.pdf

[26] American Academy of Pediatrics. The Resilience Project. https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/resilience/Pages/Clinical-Assessment-Tools.aspx

[27] Augeo Foundation. The Hague Protocol: a scientific approach to detect child maltreatment based on parental characteristics at the hospital Emergency Department. https://www.augeo.nl/-/media/Files/Bibliotheek/Engels/Project-Description-Parental-Child--Check-2016-Norway.ashx?la=en

[28] Waters, R. The Hague Protocol: Identifying Kids at risk by interviewing parents in the ER. ACES TOO HIGH News. https://acestoohigh.com/2017/09/12/the-hague-protocol-identifying-kids-at-risk-by-interviewing-parents-in-the-er/

Mental Hygiene Goals and Objectives Form
Warren/Washington County Community Services (70220)
Certified: Robert York (9/17/20)

Mental Hygiene Law, § 41.16 "Local planning; state and local responsibilities" states that "each local governmental unit shall: establish long range goals and objectives consistent with statewide goals and objectives." The Goals and Objectives Form allows LGUs to state their long-term goals and shorter-term objectives based on the local needs identified through the planning process and with respect to the State goals and objectives of each Mental Hygiene agency.

The information input in the 2020 Goals and Objectives Form is brought forward into the 2021 Form. LGUs can use the 2020 information as starting point for the 2021 Plan but should ensure that each section contains relevant, up-to-date responses.

Please indicate below if the overall needs of each disability population got better or worse or stayed about the same over the past year. Completion of these questions is required for submission of the form.

New To assist LGUs in the assessment of local substance use disorder (SUD) needs, OASAS Planning has developed a county-level, core-dataset of SUD public health data indicators. These reports are based on the recommendations of the Council of State and Territorial Epidemiologists and the regularly updated county-level datasets available in New York State. Each indicator compares county-level population-based rates to statewide rates. Reports for all counties are available in the County Planning System Under **Resources -> OASAS Data Resources -> Substance Use Disorder Key Indicators**

1. Overall Needs Assessment by Population (Required)

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

The question below asks for an overall assessment of unmet needs; however certain individual unmet needs may diverge from overall needs. Please use the text boxes below to describe which (if any) specific needs have improved, worsened, or stayed the same.

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

Please describe any unmet **mental health** service needs that have **improved**:

Prior to the Covid-19 pandemic, we were seeing an expansion of school based clinics in our two county region. Improvements in the area of mental services seem to be more centered around the reduction of stigma, the continued appreciation and value of having peer based services and giving voice to those with lived experience is apparent in our two county region and is reflected in the larger cultural context as a country. The trends and science around what it is to be healthy and how we care for our most vulnerable populations is also supporting a much more holistic view, including well documented research on racial, gender and cultural disparities as well as the relationship to how social determinants of health impact all facets of health. This shift in moving away from mental health existing separate from overall health along with the integration of trauma informed care and harm reduction models has the ability to profoundly impact how we provide care and services as the system re-evaluates how we provide care during this pandemic.

According to data from Adirondack Health Institute for the period of July 2018 to June 2019, with the aid of DSRIP funds and AHI's Performing Provider System, **Warren County saw improvements on these metrics:**
- Preventable Emergency Department visits (Behavioral Health visits)
- 7-Day and 30-Day Follow-Ups after a Mental Health discharge
- Antidepressant Medication Management
- ADHD Medication Management at the 9 month mark
Washington County saw improvements on these metrics:
- 7-Day Follow Ups for Mental Health discharges
- Antidepressant Medication Management after 6 months

Please describe any unmet **mental health** service needs that have **stayed the same**:

According to a survey of local health service providers conducted by our office, there is still a high level of unmet need for integration between different kinds of care, including mental health, substance use, developmental disability, and primary provider care. 50% of behavioral health providers surveyed also indicated that negative interactions between residents and law enforcement because law enforcement agencies did not understand the conditions or experiences of residents was a "very common problem", and 71% of respondents indicated it was a common problem. The availability and access to affordable housing units, both with and without disability supports, continue to be major unmet needs in our counties. Specifically, there is still a large need for affordable housing units located near bus routes, grocery stores, centers for various treatments, social opportunities, and other community sites for residents with mental health needs. Transportation itself also remains a huge area of unmet need - low- or no-cost transportation, both medical and non-medical, and transportation

access in rural areas is sorely lacking and actively prevents maintenance of appointments, thus harming population health overall. There is also a lack of information among both service providers and individuals seeking services about housing options, different types of services, funding options, Medicare and Medicaid options, and the general availability of services. Workforce recruitment and retention remains a massive problem, partially due to the low wages provided in the field. Respondents to the survey also specifically indicated a huge need in the mental health community for not only integrated care, but different types of care being offered in the same location/setting, care conferences among providers, and sharing of health records among providers to be able to coordinate care. **It was expressed that long-standing confusing, rigid, and siloed restrictions from OMH, OASAS, OPWDD, and DOH around information sharing consistently have made it more difficult for providers to provide the best care possible. The siloed, separatist quality of OMH, OASAS, and OPWDD continues to be a barrier to both care provision and access.**

Please describe any unmet **mental health** service needs that have **worsened**:

Warren and Washington Counties are rural counties located in Northeastern New York State. The two counties have a combined population of approximately 130,000. Both Warren and Washington Counties have a higher percentage of residents who are aged 65 and older as well as a higher percentage of disabled individuals under the age of 65, when compared to statewide averages. In addition, Washington County has a higher than average rate of completed suicide and it appears to be on an upward trend. Warren County's rate of completed suicide, while slightly higher than the statewide rate, appears to be decreasing over the past 3 years.

These factors, combined with the rural nature of both counties along with the added mental, emotional, physical and economic stressors of the current Covid-19 pandemic all have quickly contributed to multiple challenges in the delivery of mental health services. The culture of self-sufficiency, hesitancy on the part of residents to seek behavioral health care in traditional ways and the large number of employment opportunities that are often seasonal and lack health benefits all presented unique challenges to the delivery of mental health services in the region before the pandemic. Glens Falls Hospital behavioral health services is also transitioning away from their outpatient mental health services and substance use services. The slated transition to another community based provider has recently fallen through and at this time Behavioral Health Services North is interested in providing the services. BHSN is an integrated care provider that has had much success in the Plattsburgh region and is well established in the ever changing landscape of value based payments and integration of overall mental health and substance use services.

With the unprecedented closure of many services and institutions due to the pandemic, our current systems and community are being taxed in ways that were impossible to prepare for. It is difficult to fully comprehend what the lasting impact will be on the community and the residents at such an early stage. While buisnesses and services are re-opening in NYS, there are many unknowns that we will continue to need to assess and remain flexible in order to best determine how to meet the needs of our communities and how services are delivered. The use of tele-health has become much more widely accepted as it became a necessity during the closures and the use of these technologies will continue to grow. We are hopeful that as tele-health becomes more widley used and accepted, it will be able to ease some of the additional mental health needs, allowing for a more diverse workforce and ease of access for individuals that might not have transportation.

Our office has solicited feedback from our local mental health providers and various community stakeholders, most of whom indicated that their perception is that the level of unmet mental health service needs has increased over the past year, even prior to the pandemic. Our Children's SPOA coordinator has also reported an increased need for wrap around services for children and youth, also pre-pandemic, which has only been excarbated by the current circumstances. Our region has the highest number of residential treatment facility applications which is a high level of care. This is reflective of a variety of factors but continues to highlight our need to de-stigmatize mental health care and expand community and natural supports as well as actual services provided by community based agencies. We continue to work on the Systems of Care model and integrating those principles of family-driven, youth-guided, community-based, and linguistically and culturally competent supports for our children and youth.

According to data from Adirondack Health Institute for the period of July 2018 to June 2019, **Washington County saw a worsening of the following metrics:**
- Preventable Emergency Department Visits (Behavioral Health visits)
- Antidepressant Medication Management at the 3 Month Mark
- Child ADHD Medication Management after 30 Days
- ADHD Medication Management after 9 months
- Antipsychotic Medication Adherence

b) Indicate how the level of unmet **substance use disorder (SUD) needs**, overall, has changed over the past year: ⦿

Improved ◯ Stayed the Same ◯ Worsened

Please describe any unmet **SUD** service needs that have **improved**:

Addictions Care Center of Albany has opened a new women's residence and is also closing on a property for a new men's residence,both located in Queensbury, NY. Based on the increase in chemical dependency services and the feedback from stakeholders, the increased need for housing programs is a significant issue for those in need of SUD services.

Locally, our two largest outpatient SUD providers have expanded hours and service availability by implementing specific open access clinic times and some additional programming that allows substance use treatment to be conducted in the community and counselors to travel to individual homes for service delivery, pre-pandemic. This has been very succesful however due to the onset of the pandemic and subsequent closures of many office spaces, tele-health has been the primary mode of service delivery. While there were discussions of combining the Hometown vs. Heroin and Addiction Coalition with our Criminal Justice and Community Task force, in part because of dwindling particpation and the overlap of many of the same stakeholders, the Hometown group has grown several smaller sub-commitees that continue to operated independently. Most notably, the neo-natal abstinence group that is gaining state wide particpation in addressing the concerns for newborns and opiate addicted mothers. The group has successfully garnered the support of local legislators as well as key community and healthcare stakeholders.

The Council for Prevention has also continues to oversee the local recovery center, which has a part time staff/peer counselor. OASAS has strategically planned to enhance treatment and recovery as well as improve the effectiveness of prevention and recovery services. There has been a cultural shift in recent years that has embraced recovery and encouraged a more person-centered, holisitic lens around the nature of recovery.Feedback from our two county SUD services and recovery community indicated that there is an increase demand for peer-based services. Peer-based services have great value and there is evidence to indicate that these services can be very effective in supporting individuals throughout the various phases of recovery. There is a focus on integrated services and health in a much broader context. Warren/Washington Friends of Recovery has done a wonderful job advocating and creating a more public forum to bring attention to how pervasive substance use disorders are in our area.

The LGU continues to work and advance the use of MAT services in our two local jails as well as increase the access to SUD services in the local jails. The Addictions Care Center of Albany also is utilizing their mobile treatment van and while they are less mobile these days, they are able to provide tele-health services to get individuals engaged in MAT.

Please describe any unmet **SUD** service needs that have **stayed the same**:

According to a survey of local health service providers conducted by our office, there is still a high level of unmet need for integration between different kinds of care, including mental health, substance use, developmental disability, and primary provider care. 54% of recovery providers surveyed also indicated that negative interactions between residents and law enforcement because law enforcement agencies did not understand the conditions or experiences of residents was a "very common problem", and 81% of respondents indicated it was a common problem. The availability and access to affordable housing units, both with and without disability supports, continue to be major unmet needs in our counties. Specifically, there is still a large need for affordable housing units located near bus routes, grocery stores, centers for treatment, social opportunities, and other community sites for residents with substance use issues. Transportation itself also remains a huge area of unmet need - low- or no-cost transportation, both medical and non-medical, and transportation access in rural areas is sorely lacking and actively prevents maintenance of appointments, thus harming population health overall. There is also a lack of information among both service providers and individuals seeking services about housing options, different types of services, funding options, Medicare and Medicaid options, and the general availability of services. There remains a lack of detox and inpatient treatment locally, and there is a consistent need for more recovery providers. Workforce recruitment and retention remains a massive problem, partially due to the low wages provided in the field. Respondents to the survey also specifically indicated a huge need in the recovery community for not only integrated care, but different types of care being offered in the same location/setting, care conferences among providers, and sharing of health records among providers to be able to coordinate care. **It was expressed that long-standing confusing, rigid, and siloed restrictions from OMH, OASAS, OPWDD, and DOH around information sharing consistently have made it more difficult for providers to provide the best care possible. The siloed, separatist quality of OMH, OASAS, and OPWDD continues to be a barrier to both care provision and access.**

Please describe any unmet **SUD** service needs that have **worsened**:

The continued lack of detox, inpatient and MAT programs are also a notable gap in service needs for our area. Within our larger Adirondack region, which encompasses Clinton, Essex, Franklin, Hamilton, Warren and Washington Counties, we have only two inpatient rehabilitation programs, which are both located in Franklin County. The lack of essential SUD treatment and crisis services make it difficult for individuals with acute needs to access timely services due to increased travel and limited openings across the region.

Demand for SUD treatment and prevention services continues to increase, particularly with the onset of the pandemic and added stressors that could not be avoided. While our region is starting to open back up, we have many challenges that continue to require attention and innovation. Since we are still early on in the pandemic and the future of the virus continues to be unknown, we have not yet been able to fully comprehend the lasting impact on our region and specifically, those with substance use disorders. Feedback from our local providers report that there has been a significant increase in children and youth substance use disorders, which may have been present all along, however they have become more visible since schools were closed and the structure and routine that may have masked some of the concerns have become more obvious to parents.

Warren and Washington County continue to have higher incidences of alcohol use disorders and health related complications.

c) Indicate how the level of unmet needs of the **developmentally disabled** population, overall, has changed in the past year:

◯ Improved ⦿ Stayed the Same ◯ Worsened

Please describe any unmet **developmentally disability** service needs that have **improved**:

One of the most pressing issue in the arena of disability services is the need for residential options as well as workforce recruitment and retention. This concern is one that cuts across all three disability areas but has had a profound impact on developmental/intellectual disability services due to the large number of direct care staff these services employ. Several programs noted that the increasing minimum wage has made recruitment more difficult, particularly for such nuanced work that requires a high level of dedication and empathy. Providers indicate that they are competing with employers in the fast food industry as they are able to provide similar wages for job duties that typically require much less responsibility on the part of the employees when compared to those of a direct care support staff.

The other priority within disability needs is the lack of residential services. **From 2014-2016 there was a twenty percent increase in residential enrollments for Warren County. Within Washington County there has been a slight decrease in the residential enrollments.** Also notable is the access to disability services, due in part to the OPWDD transformation, which has a greater emphasis on moving individuals from day support options into employment-based opportunities. The concern is that while employment can be an important piece of supportive services, not all individuals are interested in or able to maintain employment. Those opportunities that are available are limited and highly competitive. Additionally, the eligibility process for OPWDD services continues to be a long process that often times causes frustration to the families and individuals that are in need of support.

CWI, our local contract provider for individuals with developmental disabilities is working with Katy Cook, the telehealth coordinator from AHI, to explore telehealth opportunities and options for their services and are awaiting guidance from OPWDD on the participation of the Article 16 clinics in this process. CWI indicates that they are anticipating support from OPWDD on the matter. CWI has also connected to the local FQHC, HHHN, to explore telemedicine for individuals that reside in their community residences, which does not look as promising but is allowing for more conversation on the issue.

Please describe any unmet **developmentally disability** service needs that have **stayed the same**:

According to a survey of local health service providers conducted by our office, there is still a high level of unmet need for integration between different kinds of care, including mental health, substance use, developmental disability, and primary provider care. 44% of respondents indicated that negative interactions with law enforcement because law enforcement agencies did not understand the conditions or experiences of residents was a "very common problem", and 66% of respondents indicated it was a common problem. It cannot be stressed enough the magnitude of the lack of affordable housing units, both with and without disability supports, located near bus routes, grocery stores, treatment centers, and other community sites. Transportation itself also remains a huge area of unmet need - low- or no-cost transportation, both medical and non-medical, and transportation access in rural areas is sorely lacking and actively prevents maintenance of appointments, thus harming population health overall. There is also a lack of information among both service providers and individuals seeking services about housing options, different types of services, funding options, Medicare and Medicaid options, and the general availability of services. Workforce recruitment and retention remains a massive problem, partially due to the low wages provided in the field.

Please describe any unmet **developmentally disability** service needs that have **worsened**:

residential opportunities—there are limited existing spots and all efforts are being made to support people in apartments. Unfortunately that does not meet the majority of people's needs and has not freed up enough spots in certified homes with access to 24/7 staff supports for them. Families are in a position of keeping their loved one home for more years and/or waiting until they are in crisis to be "eligible" for placement—and not able to be placed near their family. Even if agencies were permitted/supported to develop more certified options, there is such a staffing shortage that we can not reasonably expect we could staff more than we currently have. Open positions are >25% and daily open shifts (attributed to planned and unplanned absences) are closer to 50%.

Staffing in general—many people have been authorized for community based services to support them in their homes, in their home communities; however, the needs remain un-served/under-served due to lack of staff. Funding for services has not kept up pace with the increases in minimum wage so many of the traditional community service workers are drawn to these positions vs positions where they have responsibility for someone's welfare for comparable wages. Our organization and sister agencies statewide have advocated for the funding via #bFair to Direct Care campaigns; however, have not yet achieved increases that would sustain our field at a commensurate wage (higher than minimum wage increases). Clinical personnel are always a tough category to recruit and retain—nursing has been a critical area of need for the past couple of years. Due to shortages, resources are focused on priority cases and regulatory requirements, leaving a void in proactive nursing supports.

The second section of the form includes; goals based on local need; goals based on state initiatives and goals based in other areas. The form allows counties to identify forward looking, change-oriented goals that respond to and are based on local needs and are consistent with the goals of the state mental hygiene agencies. County needs and goals also inform the statewide comprehensive planning efforts of the three state agencies and help to shape policy, programming, and funding decisions. For county needs assessments, goals and objectives to be most effective, they need to be clear, focused and

achievable. The following instructions promote a convention for developing and writing effective goal statements and actionable objectives based on needs, state or regional initiatives or other relevant areas.

2. Goals Based On Local Needs

Please select any of the categories below for which there is a **high level of unmet need** for LGU and the individuals it serves. (Some needs listed are specific to one or two agencies; and therefore only those agencies can be chosen). When considering the level of need, compare each issue category against all others rather than looking at each issue category in isolation.

- **For each need identified you will have the opportunity to outline related goals and objectives, or to discuss the need more generally if there are no related goals or objectives.**
- **You will be limited to one goal for each need category but will have the option for multiple objectives.** For those categories that apply to multiple disability areas/state agencies, please indicate, in the objective description, each service population/agency for which this unmet need applies. (At least one need category must be selected).

Issue Category		Applicable State Agenc(ies)		
		OASAS	OMH	OPWDD
a)	Housing	☑	☑	☑
b)	Transportation	☐	☐	☐
c)	Crisis Services	☐	☐	☐
d)	Workforce Recruitment and Retention (service system)	☑	☑	☑
e)	Employment/ Job Opportunities (clients)	☐	☐	☐
f)	Prevention	☐	☐	☐
g)	Inpatient Treatment Services	☐	☐	☐
h)	Recovery and Support Services	☑	☑	☐
i)	Reducing Stigma	☐	☐	☐
j)	SUD Outpatient Services	☑	☐	☐
k)	SUD Residential Treatment Services	☐	☐	☐
l)	Heroin and Opioid Programs and Services	☐	☐	☐
m)	Coordination/Integration with Other Systems for SUD clients	☑	☑	☐
n)	Mental Health Clinic	☐	☑	☐
o)	Other Mental Health Outpatient Services (non-clinic)	☐	☑	☐
p)	Mental Health Care Coordination	☐	☐	☐
q)	Developmental Disability Clinical Services			☐
r)	Developmental Disability Children Services			☐
s)	Developmental Disability Student/Transition Services			☐
t)	Developmental Disability Respite Services			☐
u)	Developmental Disability Family Supports			☐
v)	Developmental Disability Self-Directed Services			☐
w)	Autism Services			☐
x)	Developmental Disability Front Door			☐
y)	Developmental Disability Care Coordination			☐
z)	Other Need 1(Specify in Background Information)	☑	☑	☑
aa)	Other Need 2 (Specify in Background Information)	☑	☑	☑
ab)	Problem Gambling	☐	☐	☐
ac)	Adverse Childhood Experiences (ACEs)	☐	☐	☐

(After a need issue category is selected, related follow-up questions will display below the table)

2a. Housing - Background Information

The Background Information box is a free-text box for LGUs to provide any additional information or more details related to the need and the Goal, such as:

- Data sources used to identify need (e.g. hospital admission data)
- Assessment activities used to indicate need or formulate goal (e.g. community forum)
- Narrative describing importance of goal

This form will allow attachments, so in the Background Information box you could reference an attached document for more information.

Housing continues to be a major concern across all three disability areas. WWAMH is continuing to make progress in the construction of the Housing First project in Glens Falls, as the Hudson Falls model has been so successful. Locally, our OASAS residential housing options have expanded with the Addictions Care Center of Albany opening up a women's residence and also preparing to get planning approval for a men's residence that was recently purchased. Both residences are centrally loated in Queensbury. 820 River St. continues to operate the Crandall Street residence, despite a long court battle with NYS OASAS, which was won by the agency. They are setting up access to grants gateway in order to be eligible for OASAS funding again, which they had been unable to access for the last few years per OASAS legal department.

Housing for developmentally disabled individuals also continues to be a concern, as OPWDD is updating and monitoring their review of the Residential Request List (RRL). Over the past three years the RRL reflects a statewide reduction of approximately 1,000 individuals. OPWDD has also revised their approach to determine access to certified residential opportunities after concerns were made that there was not a provision for individuals whose family members were no longer able to, or would soon be unable to, continue caring for them. This helped address some of the individuals that may have never received services but reside with an aging parent/s or caretaker. Additionally, OPWDD continues to work on expanding more community integrated housing options, which are not viable for all individuals. There continue to be extended waiting periods for individuals trying to attain housing/residential services. The North Country branch of the Saratoga-North Country Continuum of Care is working closely with CARES to implement a coordinated entry system that will allow individuals in need of housing to allocate our community resources as effectively as possible, regardless of which agency an individual presents at. HUD has made the coordinated entry process a mandate as of January 2018 for all CoC funded agencies.

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

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

The Goal Statement should be a specific, clear, and succinct statement of a desired outcome. It should be focused on a change that is tangible, achievable and within the control of the LGU. Avoid vague statements that focus on "maintaining" or "continuing" activity that simply maintains the status quo.

Improve Coordination coordination and access to housing services across all three disability areas

Objective Statement

Objective Statements should describe a shorter-term action the LGU will take to achieve the longer-term goal. Each goal should have at least one objective. You may have multiple objectives for each goal. The objective should identify the approach to be taken to help achieve the desired outcome. It answers the question, "How will the goal be achieved?"

Add an Objective (Maximum 5 Objectives per goal) | Remove Objective

Objective 1: Faciliate a meeting with state oversight agencies and local service providers to promote information-sharing regarding housing options and resources

    Applicable State Agency: (check all that apply): ☑ OASAS ☑ OMH ☑ OPWDD

Objective 2: The Office of Community Services and the CSB will continue to support options available to expand housing in our region.

    Applicable State Agency: (check all that apply): ☑ OASAS ☑ OMH ☑ OPWDD

Objective 3: Expand normalization and use of the Coordinated Entry system through our North Country Continuum of Care

    Applicable State Agency: (check all that apply): ☑ OASAS ☑ OMH ☑ OPWDD

Change Over Past 12 Months (Optional)

This optional, free-text box allows LGUs to describe any change in the need driving the goal or any progress made towards the goal in the last year. Where possible, include specific measurable accomplishments and milestones achieved. You may also want to identify barriers to achieving stated goals and objectives and describe the rationale for any changes made to the goal statement or associated strategies.

The local branch of the Saratoga-North Country Continuum of Care continues to work diligently with members and the community to address unmet housing needs. The North Country CoC now has a shared Coordinated Entry system that is available through the CARES HMIS system. The Coordinated Entry process is a mandate that has been a HUD requirement since January 2018 and MOU's with participating agencies have already been executed. WWAMH is in the process of a new Housing First project in the Glens Falls area.

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

The Background Information box is a free-text box for LGUs to provide any additional information or more details related to the need and the Goal, such as:

- Data sources used to identify need (e.g. hospital admission data)
- Assessment activities used to indicate need or formulate goal (e.g. community forum)
- Narrative describing importance of goal

This form will allow attachments, so in the Background Information box you could reference an attached document for more information.

Workforce recruitment and retention continues to be an ongoing issue in our two counties across all three mental hygiene areas. This category of unmet needs was most widely noted on the provider and stakeholder surveys that were collected by the LGU. This difficulty, combined with the raise in minimum wage, continues to tax the human services sector as industries such as fast food service are able to compete with direct care jobs. Direct care employment typically carries more responsibility and accountability for similar pay. Our local PPS, Adirondack Health Institute, has worked collaboratively with the community to ensure that all appropriate agencies and staff are aware of the workforce recruitment and retention funds which have been an asset to a number of our contract agencies.

As of late 2016, both Warren and Washington Counties have been determined to qualify as a health professional shortage area (HPSA), due to the work of the Center for Health Workforce Studies out of SUNY Albany, who applied for the designation on behalf of the LGU. This HPSA designation allows certain behavioral health providers to become National Health Service Corp. sites, which then allows certain licensed mental health professionals to apply for their loan forgiveness program. Benefits such as loan repayment are a valuable resource for rural areas looking to attract and retain a qualified professional workforce.

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

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

The Goal Statement should be a specific, clear, and succinct statement of a desired outcome. It should be focused on a change that is tangible, achievable and within the control of the LGU. Avoid vague statements that focus on "maintaining" or "continuing" activity that simply maintains the status quo.

Support and expand telehealth opportunities across all three disability areas.

Objective Statement

Objective Statements should describe a shorter-term action the LGU will take to achieve the longer-term goal. Each goal should have at least one objective. You may have multiple objectives for each goal. The objective should identify the approach to be taken to help achieve the desired outcome. It answers the question, "How will the goal be achieved?"

Add an Objective (Maximum 5 Objectives per goal) | Remove Objective

Objective 1: Organize a training session with AHI telehealth specialists and local service providers to encourage the effective expansion of these services
    Applicable State Agency: (check all that apply): ☑ OASAS ☑ OMH ☑ OPWDD

Objective 2: Explore the use of telehealth to expand access to behavioral health services in local school districts
    Applicable State Agency: (check all that apply): ☑ OASAS ☑ OMH ☑ OPWDD

Objective 3: Explore options and opportunities to expand teleheath services into local jails
    Applicable State Agency: (check all that apply): ☑ OASAS ☑ OMH ☑ OPWDD

Change Over Past 12 Months (Optional)

This optional, free-text box allows LGUs to describe any change in the need driving the goal or any progress made towards the goal in the last year. Where possible, include specific measurable accomplishments and milestones achieved. You may also want to identify barriers to achieving stated goals and objectives and describe the rationale for any changes made to the goal statement or associated strategies.

2h. Recovery and Support Services - Background Information

The Background Information box is a free-text box for LGUs to provide any additional information or more details related to the need and the Goal, such as:

- Data sources used to identify need (e.g. hospital admission data)

- Assessment activities used to indicate need or formulate goal (e.g. community forum)
- Narrative describing importance of goal

This form will allow attachments, so in the Background Information box you could reference an attached document for more information.

Our office is looking to increase the use of certified peers in both the OMH and OASAS systems to support and engage those in recovery. Several of our local programs have expanded the use of peers in their work, namely the Rose House, and the Hope and Healing Recovery Center, which has hired a CRPA. Glens Falls Hospital currently has a bedside consultant program through the Center for Recovery which was funded by SOR monies, however that funding is ending at the end of September. Our office has advocated that the new contract agency, Behavioral Health Services North, consider integrating that position when these services are transitioned from GFH as the program has been well received and utilizied by the hospital staff. In addition the Criminal Justice and Community Services Task Force continues to prioritize and send out any additional CRPA training opportunities and scholarships that might be useful for stakeholders to be aware of as the process typically is associated with a fee. Our communities are still limited in the number of peers available to act in this capacity and we are seeing an increase in the need for substance use and behavioral health services as a result of the pandemic.

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

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

The Goal Statement should be a specific, clear, and succinct statement of a desired outcome. It should be focused on a change that is tangible, achievable and within the control of the LGU. Avoid vague statements that focus on "maintaining" or "continuing" activity that simply maintains the status quo.

Promote and aid the growth of OMH and OASAS peer delivered services

Objective Statement

Objective Statements should describe a shorter-term action the LGU will take to achieve the longer-term goal. Each goal should have at least one objective. You may have multiple objectives for each goal. The objective should identify the approach to be taken to help achieve the desired outcome. It answers the question, "How will the goal be achieved?"

Add an Objective (Maximum 5 Objectives per goal) | Remove Objective

Objective 1: Work to expand the use of peers and resources for peer delivered services.
 Applicable State Agency: (check all that apply): ☑ OASAS ☑ OMH ☐ OPWDD

Objective 2: Continue to coordinate with our local recovery centers to disseminate information on scholarship and training opportunities for peer certifications.
 Applicable State Agency: (check all that apply): ☑ OASAS ☑ OMH ☐ OPWDD

Objective 3: Partner with the Warren County Office of Employment and Training as a potential funding source for those interested in peer based certification.
 Applicable State Agency: (check all that apply): ☑ OASAS ☑ OMH ☐ OPWDD

Change Over Past 12 Months (Optional)

This optional, free-text box allows LGUs to describe any change in the need driving the goal or any progress made towards the goal in the last year. Where possible, include specific measurable accomplishments and milestones achieved. You may also want to identify barriers to achieving stated goals and objectives and describe the rationale for any changes made to the goal statement or associated strategies.

2j. SUD Outpatient Services - Background Information

The Background Information box is a free-text box for LGUs to provide any additional information or more details related to the need and the Goal, such as:

- Data sources used to identify need (e.g. hospital admission data)
- Assessment activities used to indicate need or formulate goal (e.g. community forum)
- Narrative describing importance of goal

This form will allow attachments, so in the Background Information box you could reference an attached document for more information.

The community continues to work through a variety of coalitions and agenicies to increase awareness of SUD issues in our communities as well as to expand knowledge of the Hope and Healing Recovery Center and local resources for individuals and families in need of assistance. The Addictions Care Center of Albany is now operating mobile treatment services for MAT and is seeing an increase in referrals now that they are back up and running more effectively since COVID-19. Behavioral Health Services North is also working with the two outpatient substance use clinics through Glens Falls Hospital to transition services, hopefully by October - November of 2020.

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

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

The Goal Statement should be a specific, clear, and succinct statement of a desired outcome. It should be focused on a change that is tangible, achievable and within the control of the LGU. Avoid vague statements that focus on "maintaining" or "continuing" activity that simply maintains the status quo.

Increase access to flexible behavioral health and substance abuse services

Objective Statement

Objective Statements should describe a shorter-term action the LGU will take to achieve the longer-term goal. Each goal should have at least one objective. You may have multiple objectives for each goal. The objective should identify the approach to be taken to help achieve the desired outcome. It answers the question, "How will the goal be achieved?"

Add an Objective (Maximum 5 Objectives per goal) | Remove Objective

Objective 1: Advocate and support the expansion of mobile crisis services to a 24hr./7 day a week model
    Applicable State Agency: (check all that apply): ☐ OASAS ☑ OMH ☐ OPWDD

Objective 2: Expand availability and outreach of substance use mobile treatment services
    Applicable State Agency: (check all that apply): ☑ OASAS ☐ OMH ☐ OPWDD

Objective 3: Explore new opportunities for behavioral health and recovery service connections in local school districts to develop at least two additional school-based clinics.
    Applicable State Agency: (check all that apply): ☑ OASAS ☑ OMH ☐ OPWDD

Objective 4: Promote and work to expand the use of behavioral health and substance use screenings in pediatric offices.
    Applicable State Agency: (check all that apply): ☑ OASAS ☑ OMH ☑ OPWDD

Objective 5: Expand the capacity of outpatient behavioral health services for the SPMI population with the transition to BHSN
    Applicable State Agency: (check all that apply): ☑ OASAS ☑ OMH ☑ OPWDD

Change Over Past 12 Months (Optional)

This optional, free-text box allows LGUs to describe any change in the need driving the goal or any progress made towards the goal in the last year. Where possible, include specific measurable accomplishments and milestones achieved. You may also want to identify barriers to achieving stated goals and objectives and describe the rationale for any changes made to the goal statement or associated strategies.

Addictions Care Center has launched their mobile treatment services which provide tele-health and MAT treatment along with counseling and additional supports. While services were limited with COVID-19 the program has ramped back up and is receiving new referrals. The program director is accessible and always receptive to referrals and the needs of our communities. The on-going impact of the pandemic continues to tax a system that already was struggling to meet the community needs now that state aid and funidng have significantly decreased but the needs and rates of overdoses, etc. have increased quite dramatically. We continue to assess the unintended consequences across our communities and the systems that serve the most vulnerable populations.

In addition, our largest behavioral health provider, Glens Falls Hospital is now transitioning their outpatient services for both mental health and substance use services to Behavioral Health Services North, a process that will not be completed until October or November of 2020. This has greatly impacted our two counties as the outpatient clinics have not been accepting new clients, leaving one main mental health clinic to lift the burden of numerous referrals from a wide variety of systems.

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

The Background Information box is a free-text box for LGUs to provide any additional information or more details related to the need and the Goal, such as:

- Data sources used to identify need (e.g. hospital admission data)
- Assessment activities used to indicate need or formulate goal (e.g. community forum)
- Narrative describing importance of goal

This form will allow attachments, so in the Background Information box you could reference an attached document for more information.

The need for ongoing collaboration between multiple systems for SUD clients was stressed through a survey instrument our office put out to a wide variety of community stakeholders. The two main systems that intersect with this population and highlighted the need for better integration were the mental health system and the criminal justice/probation system. Integration and collaboration across all of these systems has been a focus of our office even prior to the COVID-19 pandemic, however the pandemic has greatly emphasized the cracks in the system and where we need to focus our energies and resources. This is also challenged now by the drastic cuts across the board in state aid.

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

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

The Goal Statement should be a specific, clear, and succinct statement of a desired outcome. It should be focused on a change that is tangible, achievable and within the control of the LGU. Avoid vague statements that focus on "maintaining" or "continuing" activity that simply maintains the status quo.

Integration and coordination across the disability areas and among local stakeholders.

Objective Statement

Objective Statements should describe a shorter-term action the LGU will take to achieve the longer-term goal. Each goal should have at least one objective. You may have multiple objectives for each goal. The objective should identify the approach to be taken to help achieve the desired outcome. It answers the question, "How will the goal be achieved?"

Add an Objective (Maximum 5 Objectives per goal) | Remove Objective

Objective 1: Utilize our standing mental health/substance use subcommittee and the developmental disability subcommittee to work on the development and implementation of services in our two counties
    Applicable State Agency: (check all that apply): ☑ OASAS ☑ OMH ☑ OPWDD

Objective 2: Utilize the Criminal Justice/Community Services Task Force to improve integration of community based services for justice involved individuals.
    Applicable State Agency: (check all that apply): ☑ OASAS ☑ OMH ☑ OPWDD

Objective 3: Support and normalize the use of NY Connects to promote coordination and resource availability among community resources.
    Applicable State Agency: (check all that apply): ☑ OASAS ☑ OMH ☑ OPWDD

Objective 4: Address identified issues and challenges through continued participation in the North Country Regional Planning Consortium
    Applicable State Agency: (check all that apply): ☑ OASAS ☑ OMH ☑ OPWDD

Change Over Past 12 Months (Optional)

This optional, free-text box allows LGUs to describe any change in the need driving the goal or any progress made towards the goal in the last year. Where possible, include specific measurable accomplishments and milestones achieved. You may also want to identify barriers to achieving stated goals and objectives and describe the rationale for any changes made to the goal statement or associated strategies.

2n. Mental Health Clinic - Background Information

The Background Information box is a free-text box for LGUs to provide any additional information or more details related to the need and the Goal, such as:

- Data sources used to identify need (e.g. hospital admission data)
- Assessment activities used to indicate need or formulate goal (e.g. community forum)
- Narrative describing importance of goal

This form will allow attachments, so in the Background Information box you could reference an attached document for more information.

The lack of psychiatric prescribers available has compounded the limits on outpatient treatment options, particularly with the shut-downs and limitations that the pandemic presented us with as a community. Additionally, the transition of Glens Falls Hospital outpatient mental health services to a new contract provider has taxed the system and the access to these services as the hospital has not been taking new clients. The increase in need combined with the decrease in service availability and funding has been a huge challenge for our communities to deal with. The pandemic has contributed to the overall mental health of many individuals that may have not required or tried to access services in the past, however the stressors that this has added to the lives of many individuals has been unprecendented. Behavioral Health Services North (BHSN) has projected that the transition of these outpatient services will be complete by Octover-November 2020 and also has plans to increase capacity. BHSN has integrated clinics that allow for SUD, MH and primary care services to be accessed in one location, which is critical to whole person, coordinated care. BHSN also is utilizing tele-health regularly and is familiar with the hurdles and value of offering this service effectively.

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

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

The Goal Statement should be a specific, clear, and succinct statement of a desired outcome. It should be focused on a change that is tangible, achievable and within the control of the LGU. Avoid vague statements that focus on "maintaining" or "continuing" activity that simply maintains the status quo.

Individuals will have timely access to flexible, appropriate behavioral health supports and services.

Objective Statement

Objective Statements should describe a shorter-term action the LGU will take to achieve the longer-term goal. Each goal should have at least one objective. You may have multiple objectives for each goal. The objective should identify the approach to be taken to help achieve the desired outcome. It answers the question, "How will the goal be achieved?"

Add an Objective (Maximum 5 Objectives per goal) | Remove Objective

Objective 1: Expand open-access model of treatment.
     Applicable State Agency: (check all that apply): ☑ OASAS ☑ OMH ☐ OPWDD

Objective 2: school based sites/integration?
     Applicable State Agency: (check all that apply): ☐ OASAS ☑ OMH ☐ OPWDD

Objective 3: The Office of Community Services will work with providers to expand outpatient behavioral health clinic access
     Applicable State Agency: (check all that apply): ☑ OASAS ☑ OMH ☑ OPWDD

Change Over Past 12 Months (Optional)

This optional, free-text box allows LGUs to describe any change in the need driving the goal or any progress made towards the goal in the last year. Where possible, include specific measurable accomplishments and milestones achieved. You may also want to identify barriers to achieving stated goals and objectives and describe the rationale for any changes made to the goal statement or associated strategies.

The transition of Glens Falls Hospital out of behavioral health and substance use services has created a capacity issue which has been magnified by the COVID-19 pandemic. We are hopeful that Behavioral Health Services North will be able to smoothly transition into the community and expand services. There is an increase in demand for both mental health and substance abuse treatment brought on by the socio-economic factors that were excerbated by the lock-down and closure of schools. Many individuals that may not have accessed services in the past are not in need of support during these dynamic and challenging times.

2o. Other Mental Health Outpatient Services (non-clinic) - Background Information

The Background Information box is a free-text box for LGUs to provide any additional information or more details related to the need and the Goal, such as:

- Data sources used to identify need (e.g. hospital admission data)
- Assessment activities used to indicate need or formulate goal (e.g. community forum)
- Narrative describing importance of goal

This form will allow attachments, so in the Background Information box you could reference an attached document for more information.

Survey results and stakeholder input indicated the support and need for additional peer services in both mental health and substance use fields.

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

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

The Goal Statement should be a specific, clear, and succinct statement of a desired outcome. It should be focused on a change that is tangible, achievable and within the control of the LGU. Avoid vague statements that focus on "maintaining" or "continuing" activity that simply maintains the status quo.

Promote and aid the growth of OMH and OASAS peer delivered services

Objective Statement

Objective Statements should describe a shorter-term action the LGU will take to achieve the longer-term goal. Each goal should have at least one objective. You may have multiple objectives for each goal. The objective should identify the approach to be taken to help achieve the desired outcome. It answers the question, "How will the goal be achieved?"

Add an Objective (Maximum 5 Objectives per goal) | Remove Objective

Objective 1: Work to expand the use of peers and resources for peer delivered services.
    Applicable State Agency: (check all that apply): ☑ OASAS ☑ OMH ☐ OPWDD

Objective 2: Partner with the Warren County Office of Employment and Training as a potential funding source for those interested in peer based certification.
    Applicable State Agency: (check all that apply): ☑ OASAS ☑ OMH ☐ OPWDD

Objective 3: Continue to work with our local recovery centers to disseminate scholarship opportunities for peer certification
    Applicable State Agency: (check all that apply): ☐ OASAS ☐ OMH ☐ OPWDD

Change Over Past 12 Months (Optional)

This optional, free-text box allows LGUs to describe any change in the need driving the goal or any progress made towards the goal in the last year. Where possible, include specific measurable accomplishments and milestones achieved. You may also want to identify barriers to achieving stated goals and objectives and describe the rationale for any changes made to the goal statement or associated strategies.

2z. Other Need (Specify in Background Information) - Background Information

The Background Information box is a free-text box for LGUs to provide any additional information or more details related to the need and the Goal, such as:

- Data sources used to identify need (e.g. hospital admission data)
- Assessment activities used to indicate need or formulate goal (e.g. community forum)
- Narrative describing importance of goal

This form will allow attachments, so in the Background Information box you could reference an attached document for more information.

We are working to develop a Systems of Care framework in our communities, particularly now during the increased needs of the community due to the pandemic. Our stakeholder survey indicated there is a rising incidence of substance use in youth, particularly with the lack of structure and community resources necessary to meet the needs of the children in our community at this time. There has been a sharp increase in the number of crisis calls and crisis visits to the Glens Falls Hospital for children and youth.

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

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

The Goal Statement should be a specific, clear, and succinct statement of a desired outcome. It should be focused on a change that is tangible, achievable and within the control of the LGU. Avoid vague statements that focus on "maintaining" or "continuing" activity that simply maintains the status quo.

 Encourage the Systems of Care model and wraparound services

Objective Statement

Objective Statements should describe a shorter-term action the LGU will take to achieve the longer-term goal. Each goal should have at least one objective. You may have multiple objectives for each goal. The objective should identify the approach to be taken to help achieve the desired outcome. It answers the question, "How will the goal be achieved?"

Add an Objective (Maximum 5 Objectives per goal) | Remove Objective

Objective 1: Develop a Systems of Care framework to form communities that engage in problem solving and sharing of resources across systems to impact the best outcomes for children, youth and families in Warren and Washington Counties
      Applicable State Agency: (check all that apply): ☑ OASAS ☑ OMH ☑ OPWDD

Objective 2: To utilize the Systems of Care framework in the implementation of community collaboration utilizing a model of shared values and principles across all servces and every process within each service.
      Applicable State Agency: (check all that apply): ☑ OASAS ☑ OMH ☑ OPWDD

Objective 3: Explore and continue to support local transportation programs, such as Uplift and other innovative ideas
      Applicable State Agency: (check all that apply): ☑ OASAS ☑ OMH ☑ OPWDD

Change Over Past 12 Months (Optional)

This optional, free-text box allows LGUs to describe any change in the need driving the goal or any progress made towards the goal in the last year. Where possible, include specific measurable accomplishments and milestones achieved. You may also want to identify barriers to achieving stated goals and objectives and describe the rationale for any changes made to the goal statement or associated strategies.

2aa. Other Need 2 (Specify in Background Information) - Background Information

The Background Information box is a free-text box for LGUs to provide any additional information or more details related to the need and the Goal, such as:

- Data sources used to identify need (e.g. hospital admission data)
- Assessment activities used to indicate need or formulate goal (e.g. community forum)
- Narrative describing importance of goal

This form will allow attachments, so in the Background Information box you could reference an attached document for more information.

The local stakeholder survey that our office created and reviewed indicated that one of the biggest needs was bringing together mental health and substance use providers and training, to ensure that the our service delivery system has a base of trauma informed, person-centered, harm-reduction models. Also of concern and highlighted was the intersection of those with mental health and substance use issues and how they intersect and engage with the law enforcement and publc safety organizations. There is a clear perception from the community that continued training for law enforcement, corrections and probation agencies would increase the level of engagement and appropriate services for those individuals that often cycle in and out of the criminal justice system.

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

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

The Goal Statement should be a specific, clear, and succinct statement of a desired outcome. It should be focused on a change that is tangible, achievable and within the control of the LGU. Avoid vague statements that focus on "maintaining" or "continuing" activity that simply maintains the status quo.

Facilitate cross-training and continuing education for service providers and relevant local organizations

Objective Statement

Objective Statements should describe a shorter-term action the LGU will take to achieve the longer-term goal. Each goal should have at least one objective. You may have multiple objectives for each goal. The objective should identify the approach to be taken to help achieve the desired outcome. It answers the question, "How will the goal be achieved?"

Add an Objective (Maximum 5 Objectives per goal) | Remove Objective

Objective 1: Explore options for regulalry scheduled trainings in trauma-informed practices, Crisis Intervention Training and de-escalation techniques for providers as well as the criminal justice professionals
      Applicable State Agency: (check all that apply): ☑ OASAS ☑ OMH ☑ OPWDD

Objective 2: Engage in continuing education and in-service trauma-informed practices with the local magistrate meetings

    Applicable State Agency: (check all that apply): ☑ OASAS ☑ OMH ☑ OPWDD

Objective 3: Encourage the sharing of training resources between providers and the possible creation of a training resource database,

    Applicable State Agency: (check all that apply): ☑ OASAS ☑ OMH ☑ OPWDD

Change Over Past 12 Months (Optional)

This optional, free-text box allows LGUs to describe any change in the need driving the goal or any progress made towards the goal in the last year. Where possible, include specific measurable accomplishments and milestones achieved. You may also want to identify barriers to achieving stated goals and objectives and describe the rationale for any changes made to the goal statement or associated strategies.

Office of Addiction Services and Supports

Accessibility   **Contact**

Disclaimer   **Language Access**

Privacy Policy

COMPLETE

Thursday, September 17, 2020 4:04:47 PM

Page 1

Q1

Contact Information

Name	**Carrie Wright**
Title	**Program Analyst**
Email	**wrightc@warrencountyny.gov**

Q2

LGU:

Warren County Community Services

Q3

a.   Indicate how your local mental hygiene service system (i.e., mental health, substance use disorder and problem gambling, and developmental disability populations), overall, has been affected by the COVID-19 pandemic: Please specifically note, Any cross-system issues that affect more than one population; Any specific racial/ethnic groups or populations that have been disproportionately impacted by COVID-19; and Any differences between adult services and children's services.

Our health network provides outpatient behavioral health and substance use disorder services, mostly to an adult population. Initially,our biggest challenge overall had been the reduction in in-person encounters with our behavioral health and substance use disorder patients, both due to state-wide orders regarding in-person visits and to patient cancelations. While that issue has initially addressed
through the use of telehealth and, more recently, through the resumption of in-person encounters when appropriate, we have seen an increase in the nature and frequency of acute events.
In addition, due to the economic effects of the economic shutdown, many of our patients have lost their primary employer-provided health insurance. They are now on public insurance or uninsured. While we do have outreach and enrollment services to help those who lack coverage and provide treatment on a sliding scale based on current income, this has affected the timing of care as well as reimbursement rates.
Finally, we have seen an increase in incidents where patients have abused of staff, mostly verbal but sometimes minor physical altercations. Most common are reports of frustrated and angry patients swearing at staff. Still, occasionally we receive verbal threats of harm to self, staff, or others that require intervention by local law authorities.

We also received feedback that mental health services for those dually diagnosed with I/DD and mental health challenges were and continue to be limited. In addition, the closure of schools created a huge need for services and treatment in the youth population as there was no structure and/or intervention from school staff to observe children that might need assistance. This was reported multiple times by various stakeholders.

The closure of many site based services without reasonable alternatives impacted everyone, service recipients, staff, etc. and the loss of structure and increase in social isolation had a huge and continued impact on individual and community mental health.

Substance use providers indicated that there were limitations to some agencies who chose not to launch a tele-health platform, therefore providing all call via telephone and some in-person appointments was a limitation.

Bed access across the service system slowed due to precautions around the pandemic and several smaller detox/inpatient facilities were very restrictive in accepting new individuals. The need for SUD services for children and youth also became increasingly more prevalent as children were w/o supervision or normal structural systems that typically had been available for support.

As the crisis progressed, housing and increased crisis needs presented and have continued to be significant issues.

Q4

b.   Indicate how your mental health service needs, overall, have been affected by the COVID-19 pandemic:Please specifically note, Any specific racial/ethnic groups or populations that have been disproportionately impacted by COVID-19; and Any differences between adult services and children's services.

Across the board, it was clear that the need for services increased as the mental health challenges of anxiety and depression continued to take a toll for a variety of reasons. Many agencies were able to transition to telephonic or an electronic telehealth platform that allowed services to continue being delivered. This was a huge cultural and service delivery shift that was embraced by so many stakeholders in the community, although there still continues to be a need for expansion of services.

The availability of services and times that clinical staff were available also dramatically shifted due to work schedules and at home virtual learning. There were also some furloughs and staffing cuts that affected the pool of clinical treatment providers.

Q5

c.   Indicate how your substance use disorder (SUD) and problem gambling needs, overall, have been affected by the COVID-19 pandemic:Please specifically note, Any specific racial/ethnic groups or populations that have been disproportionately impacted by COVID-19; and Any differences between adult services and children's services.

It was reported across the board that the changes to current state and federal regulations around the use of telehealth to treat substance use disorders made it possible for many agencies to continue to provide some level of care, including medication-assisted treatment.

Numerous providers indicated that they saw and continue to see an increase in positive drug screens and relapse, along with an increase in overdoses of illicit substances, reported suicidal ideation along with self-harming behaviors and additional need for law enforcement intervention.

Q6

d.   Indicate how the needs of the developmentally disabled population, overall, have been affected by the COVID-19 pandemic:Please specifically note, Any specific racial/ethnic groups or populations that have been disproportionately impacted by COVID-19; and Any differences between adult services and children's services.

Due to the closures of community-based programs access to services for those dually diagnosed with I/DD and MH/SUD continue to be challenged.

Q7

a. Mental Health providers

The need for telehealth service delivery training was reported across all disability areas. In addition, the need for increased de-escalation and crisis response training across the systems and within law enforcement was also highlighted, due to the increased cases were LE needs were necessary.

Q8

b. SUD and problem gambling service providers:

The need for telehealth service delivery training was reported across all disability areas. In addition, the need for increased de-escalation and crisis response training across the systems and within law enforcement was also highlighted, due to the increased cases were LE needs were necessary.

Q9

c. Developmental disability service providers:

The need for telehealth service delivery training was reported across all disability areas. In addition, the need for increased de-escalation and crisis response training across the systems and within law enforcement was also highlighted, due to the increased cases were LE needs were necessary.

Page 2

Q10

a. Since March 1, 2020, how would you describe DEMAND for mental health services in each of the following program categories?

INPATIENT (State PC, Article 28/31 Inpatient, Residential Treatment Facilities)	**Increased**
OUTPATIENT (Clinic, ACT, Day Treatment, PROS, Continuing Day Treatment, Partial Hospitalization)	**Increased**
RESIDENTIAL (Support, Treatment, Unlicensed Housing)	**Increased**
EMERGENCY (Comprehensive Psychiatric Emergency Programs, Crisis Programs)	**Increased**
SUPPORT (Care Coordination, Education, Forensic, General, Self-Help, Vocational)	**Increased**

Q11   **Respondent skipped this question**

If you would like to add any detail about your responses above, please do so in the space below:

Q12

b.   Since March 1, 2020, how would you describe ACCESS to mental health services in each of the following program categories?

INPATIENT (State PC, Article 28/31 Inpatient, Residential Treatment Facilities)	**Decreased**
OUTPATIENT (Clinic, ACT, Day Treatment, PROS, Continuing Day Treatment, Partial Hospitalization)	**Decreased**
RESIDENTIAL (Support, Treatment, Unlicensed Housing)	**No Change**
EMERGENCY (Comprehensive Psychiatric Emergency Programs, Crisis Programs)	**No Change**
SUPPORT (Care Coordination, Education, Forensic, General, Self-Help, Vocational)	**Decreased**

Q13   **Respondent skipped this question**

If you would like to add any detail about your responses
above, please do so in the space below:

Q14

a.   Since March 1, 2020, what number of mental health program sites in your county closed or limited operations due to COVID-19, apart from transition to telehealth?

1

Q15

If you would like to add any detail about your responses above, please do so in the space below:

Glens Falls Hospital furloughed a number of staff in the behavioral health services.

Q16

b.   What number of mental health program sites in your county remain closed or are offering limited services now, apart from transition to telehealth?

0

Q17   **Respondent skipped this question**

If you would like to add any detail about your responses
above, please do so in the space below:

Q18   **N/A**

c. If your county operates services, did you maintain any
level of in-person mental health treatment

Q19

If you would like to add any detail about your responses above, please do so in the space below:

Respondent skipped this question

Q20

d.   As a result of COVID-19, are any mental health programs in your county closing operations permanently? If yes, list program name(s) and type(s).

No

Q21

If you would like to add any detail about your responses above, please do so in the space below:

There are still many unknowns as to how this will impact agencies long term. It is still too soon to gauge in many instances.

Q22

e.   Did any mental health programs in your county close due to workforce issues (e.g. staff infections, recruitment/retention issues)?

No

Q23

If you would like to add any detail about your responses above, please do so in the space below:

Respondent skipped this question

Q24

a.   Apart from telehealth, during COVID-19, did your county or mental health providers within your county develop any innovative services or methods of program delivery that may be continued post-COVID? If yes, please describe.

Yes (please describe):
The use of telehealth became much more normalized and accepted, as it was the primary mode of service delivery. The need for the transition allowed many service providers to see the value in that model and also saw a reduction in the number of 'no show' appointments compared to the traditional model.

Q25

b.   During COVID-19, did any mental health providers within your county form any partnerships with other providers that may be continued post-COVID? If yes, please describe.

Yes (please describe):
I think our community has always partnered well within the service delivery system and do to the needs of the community, the collaboration and integration between providers along with their dedication was truly inspiring.

Q26

a.   During COVID-19, how many mental health providers within your county implemented existing continuity of operations plans?

Respondent skipped this question

Q27

If you would like to add any detail about your responses above, please do so in the space below:

I know most of the agencies did implement the COOP plans, however I do not know an exact number. I would assume that all of the agencies did so, due to the critical nature of the situation and it's wide reaching ramifications.

Q28   **Respondent skipped this question**

b.   During COVID-19, how many mental health providers within your county did not implement existing continuity of operations plans?

Q29   **Respondent skipped this question**

If you would like to add any detail about your responses above, please do so in the space below:

Q30   **Both**

c.   During COVID-19, did your county LGU or Office of Emergency Management (OEM) assist any mental health providers in the development or revision of continuity of operations plans?

Q31   **Respondent skipped this question**

If you would like to add any detail about your responses above, please do so in the space below:

Q32   **Telemental Health Guidance**

During COVID-19, what OMH guidance documents were beneficial to your disaster management process?

Page 3

Q33

1. Please indicate any needs for or issues with SUD and problem gambling prevention, treatment, and recovery providers acquiring Personal Protective Equipment (PPE), face masks, cleaning or disinfectant supplies, or similar materials related to the COVID-19 pandemic:

There was some need for disinfectant supplies and gloves. We did not received many issues around face mask needs.

Q34

a.   How has COVID-19 affected the delivery of and demand for SUD and problem gambling prevention services in your county?

Prevention services basically shut down as their main avenue for service delivery was the school system.

Q35

b.   How has COVID-19 affected the delivery of and demand for SUD and problem gambling recovery services in your county?

The fear and isolation led to an increase in relapse and need for services. While our recovery center did remain open, not all individuals were comfortable attending the space.

Q36

c.   How has COVID-19 affected the delivery of and demand for problem gambling treatment services in your county?

Treatment was limited due to furloughs, clinic closures and telehealth platforms being utilized. The need for inpatient beds increased while availability decreased. While there were some agencies that were available for in person treatment, there were many more limitations that presented.

Q37

d.   Since March 1, 2020, how would you describe DEMAND for SUD Treatment services in each of the following program categories?

INPATIENT	**Increased**
OUTPATIENT	**Increased**
OTP	**No Change**
RESIDENTIAL	**No Change**
CRISIS	**Increased**

Q38   **Respondent skipped this question**

If you would like to add any detail about your responses
above, please do so in the space below:

Q39

e.   Since March 1, 2020, how would you describe ACCESS to SUD Treatment services in each of the following program categories?

INPATIENT	**Decreased**
OUTPATIENT	**Decreased**
OTP	**No Change**
RESIDENTIAL	**No Change**
CRISIS	**Decreased**

Q40   **Respondent skipped this question**

If you would like to add any detail about your responses above, please do so in the space below:

Q41   **No**

a.   Apart from telehealth, during COVID-19, did your county or SUD and problem gambling service providers within your county develop any innovative services or methods of program delivery that may be continued post-COVID? If yes, please describe.

Q42   **No**

b.   During COVID-19, did SUD and problem gambling service providers within your county form any partnerships with other providers that may be continued post-COVID? If yes, please describe.

Page 4

Q43   **No**

1. Has your county conducted analysis on the impact of COVID related to IDD services/OPWDD service system? If yes, please explain.

Q44

2. What are the greatest challenges your county will be facing over the next 12 months related to IDD services?

Financial stability of provider organizations, sustainable workforce based on constraints with staff needs, like daycare, lack of full time school options, reductions in number of individuals that can be served due to social distancing and the inability to provide transportation to services that were already underfunded.

Q45

3. Is there data that would be helpful for OPWDD to provide to better information the local planning process? Please list by order of priority/importance.

Number of individuals in need of each specific service, rate cuts per organization over the past 5 years and recruitment/retention data.

Page 5

Q46   **Respondent skipped this question**

Please use the optional space below to describe anything else related to the effects of COVID-19 on Mental Hygiene service delivery that you were not able to address in the previous questions: