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

2018 Local Services Plan Guidelines for Mental Hygiene Services

March 1, 2017

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CHAPTER 1: Introduction

A. Integrated Local Mental Hygiene Planning

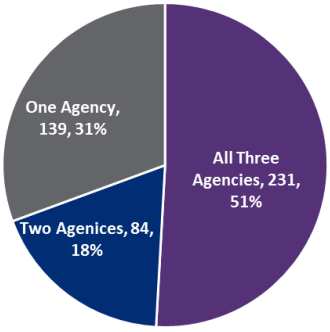
New York State Mental Hygiene Law (§ 41.16) requires the Office of Alcoholism and Substance Abuse Services (OASAS), the Office of Mental Health (OMH) and the Office for People With Developmental Disabilities (OPWDD) to guide and facilitate the local planning process. As part of the local planning process, Local Governmental Units (LGUs) develop and annually submit a combined Local Services Plan (LSP) to all three Mental Hygiene agencies through the Mental Hygiene County Planning System (CPS). There are 57 LGUs in New York, with one LGU representing each county except for a combined LGU for the five counties encompassing New York City and a combined LGU for Warren and Washington counties.

The LSP must establish long-range goals and objectives that are consistent with statewide goals and objectives (§41.16(b) (1)). Mental Hygiene law also requires that each agency's statewide comprehensive plan shall be based upon an analysis of local services plans developed by each LGU.

For many years, each state agency conducted its own local planning process which required LGUs to comply with three different sets of planning requirements. In order to streamline the local planning process and strengthen the state and local partnership, the three state agencies began collaborating with LGUs through the Conference of Local Mental Hygiene Directors (CLMHD) in 2008 on an integrated and uniform local planning process with a single set of plan guidelines. A statewide Mental Hygiene Planning Committee was established which included representation from OASAS, OMH, OPWDD, and LGUs. For the first time, LGUs were able to complete a single integrated local services plan for mental hygiene services that was submitted to all three state agencies.

The 2018 Local Services Plan Cycle is the tenth year that all three mental hygiene agencies have collaborated on an integrated LSP. This integrated approach reflects the reality that mental hygiene needs and initiatives do not affect each population in isolation, but cross between State agencies. The results from the 2017 Priority Outcomes Form, illustrated in Figure 1.1., show that the vast majority (nearly 70 percent) of the 454 priority outcomes identified by LGUs were associated with more than one State agency, including more than half (51 percent) that were associated with all three State agencies.

Figure 1.1: Mental Hygiene Priority Outcomes by Number of Associated State Agencies



B. Mental Hygiene Planning Committee

In 2007 OASAS, OMH, OPWDD, worked with the CLMHD to form the Mental Hygiene Planning Committee (MHPC) in order to explore opportunities for integrated mental hygiene services planning. The MHPC assists in coordinating the integrated local planning process of the three mental hygiene agencies and each LGU. To ensure that the planning process meets the needs of each state agency and is relevant to each county, membership of the MHPC includes planning staff from the three state agencies and several county mental hygiene agencies.

The three State mental hygiene agencies have a fully integrated mental hygiene local services planning process. This facilitates the development of cross-systems priorities and increased collaborations on the local and regional level. As a result of significant reforms in the primary health and mental hygiene services systems, a principal focus of the planning committee is to ensure that the LGUs continue to provide effective oversight of local mental hygiene services for their populations. The MHPC supports LGUs in providing timely and informed input into state, regional and local policy decision-making regarding healthcare delivery and payment reforms.

Functions of the MHPC include:

- reviewing the local services planning process to continually improve the efficiency and utility of plan submissions;
- improving access to and use of relevant state and local data resources to support planning, oversight and system management; and
- fostering and facilitating knowledge sharing to improve local/regional/statewide planning practices.

Members of the MHPC annually review the local services planning process to ensure that it creates value for State agencies, LGUs, and citizens. For the 2018 local services planning cycle, the State agencies, in collaboration with the LGUs through the MHPC, redesigned the primary planning forms. The Local Needs Assessment Form and the Priorities Outcomes Form, used in the 2017 Plan cycle, were integrated in to the 2018 Mental Hygiene Goals and Objectives Form. The new Goals and Objectives Form eliminates redundancy and reduces the administrative burden for LGUs. The Form gives the county planner the opportunity to link need, statewide initiatives or other issues with local goals and objectives.

C. The Mental Hygiene County Planning System (CPS)

https://cps.oasas.ny.gov

The Mental Hygiene County Planning System (CPS) is a web-based application developed by OASAS to enable counties and their service providers to complete and submit required local planning forms to the state electronically. There are nearly 2,000 individuals with a CPS user account. Through CPS counties can:

- access relevant and timely data resources for conducting their needs assessment and planning activities;
- complete required planning forms; and
- submit the entire mental hygiene services plan to all three State agencies.

Several report features were built into CPS that allow state agency and county staff to query all completed plans on selected information and generate specific reports in a quick and efficient manner. These reports result in more timely and accurate summary analyses that inform each state agency's statewide planning process and assists in county dissemination of plan results.

A number of other tools were developed that help counties manage their agency's presence in CPS, including the ability to communicate directly with their addiction service providers and manage the completion and certification of all required planning forms. OASAS prevention and treatment providers also have the ability to manage their presence in CPS by approving user accounts for staff that need to complete planning surveys for OASAS or to access county plans and the data resources available to them in CPS.

Each organization in CPS, LGU, State agency, or OASAS provider, has a tailored landing page listing organizational and individual contact information with instructions on how to update the information in the OASAS Provider Directory System or CPS. Each LGU and OASAS provider also has a designated Planning Coordinator, who is the primary point of contact for that organization on planning related matters. The Planning Coordinator has all of the same entitlements as the Administrator.

Please see **Appendix I** for more information on CPS registration and user roles.

Planning Data Resources added to CPS

Since March 2016, the State mental hygiene agencies have added several data resources to CPS in order assist county planners in their needs assessment and services planning activities. These resources are available by selecting "Planning Resources" from the CPS menu:

- OMH County and Regional Data Books
  This OMH page links to the County Capacity and Utilization Data Book, comprehensive regional needs assessments for mental health and substance use disorders, and county-level cultural group reports.

- OPWDD County Profiles 2016
  This profile contains county-level planning data covering the following five categories: Summary of Enrollments, County of Preference, Fiscal data from FY 15/16, Number of Individuals Requesting an Out-of-Home Residential Service, Autism and Dual Diagnosis by Age Group (Updated July 2016).

- 2012-2014 National Survey on Drug Use and Health (NSDUH) Estimates of Substance Use and Mental Health Disorders
  The data in this file provide regional prevalence estimates of substance use and mental health disorders from the 2012-2014 National Survey on Drug Use and Health (NSDUH) administered by the Substance Abuse and Mental Health Services Administration (SAMHSA). Columns represent the percentage of the civilian, non-institutionalized population (youth ages 12-17, young adults ages 18-25, adults ages 26 and older, and adults ages 18 and older) reporting substance use and mental health disorders by regional groupings of counties (rows). Indicators included are: Alcohol Dependence or Abuse, Alcohol Dependence, Illicit Drug Dependence or Abuse, Illicit Drug Dependence, Dependence or Abuse of Illicit Drugs or Alcohol, Serious Mental Illness, Any Mental Illness, Serious Thoughts of Suicide, and at Least One Major Depressive Episode (Updated February 2017).

- OASAS Trended Medicaid Recipient Summary Profiles (2003-2016)
  These profiles are based upon Medicaid county of fiscal responsibility and show what recipients received what services. Recipient counts, paid claim dollars and claim counts are shown for each type of Medicaid CD service and for a select group of non-CD health and mental health services that are also received by the CD cohort during these periods. Profiles are provided for all eligibility categories combined. Data for these profiles come from the New York State Department of Health, Medicaid Data Warehouse and are trended between SFY 2003 and 2016. (Updated February 2017).

- OASAS Detailed Medicaid Recipient Profiles (2014-2016)
  Similar to the "OASAS Trended Medicaid Recipient Summary Profiles 2003-2016," these profiles contain more detailed rows on Chemical Dependence (CD) claims and non-CD claims incurred by OASAS CD recipients, including general medical inpatient, outpatient and prescription claims as well as mental health inpatient, outpatient and prescription claims. (Updated February 2017).

- 2015 OASAS Primary Substance at Admission by County of Residence and Service Type
  The data in this file show the primary substance at admission to OASAS-Certified chemical dependence treatment programs grouped by the county of residence of the client, during calendar year 2015. This file is based on an extract from OASAS Client Data System (CDS). Included are the total number of admissions for the year in each of five service categories- Crisis, Inpatient Rehabilitation, Residential, Outpatient, and Opioid Treatment Program grouped by six substance categories - Heroin, Other Opioids, Alcohol, Crack/Cocaine, Marijuana, and Other Substance (examples of drugs in the "Other Substance" category include: PCP, Methamphetamine, Benzodiazepine, Ketamine, and Ecstasy) (Updated November 2016).

- Participants in OASAS Funded Prevention Service Approaches, by County and Approach Type 2015-16
  This file displays the number of participants in OASAS funded prevention service approaches for Prevention Year 2015-16. The data are grouped by county and approach type (Updated September

2016). Also available: Prevention Year 2014-15

- 2015 OASAS Admissions by Type and County
  The data in this file show admissions to OASAS-certified chemical dependence treatment during calendar year 2015 based on an extract from OASAS CDS. Included are the total number of admissions for the year and what percentage were in the county of residence of the client. The service types included are Crisis, Opioid Treatment Program, Inpatient Rehabilitation, Residential, and Outpatient (Updated August 2016).

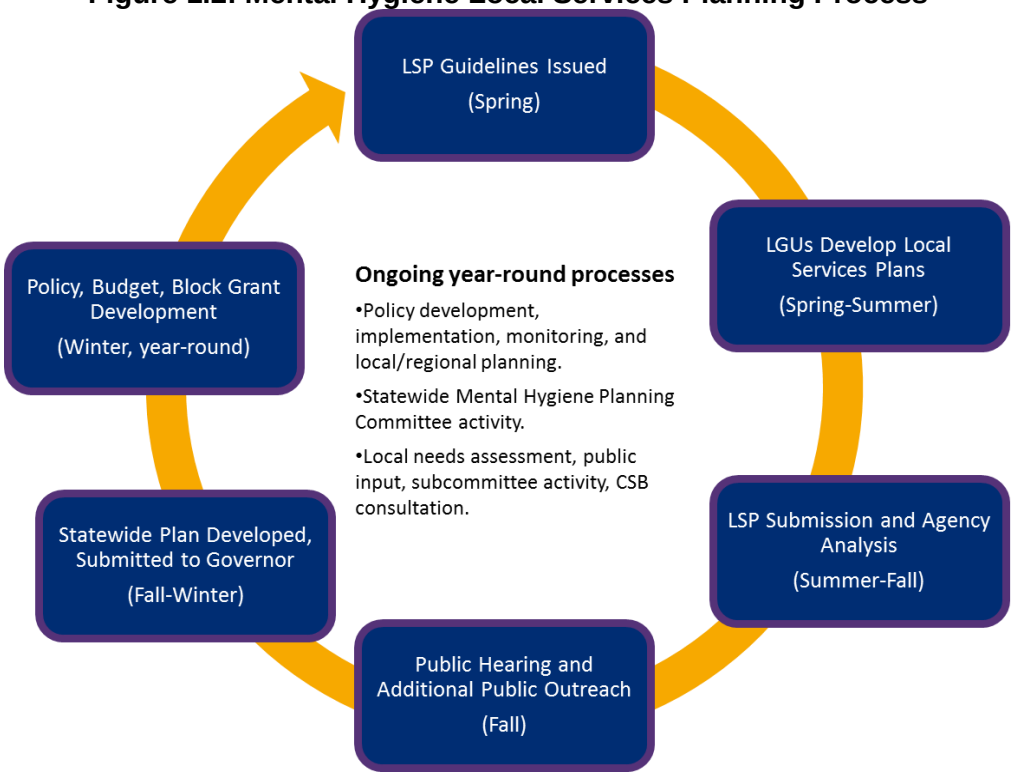
- OASAS 2014-15 Youth Development Survey Reports
  During the 2014-15 school year, OASAS conducted a Youth Development Survey (YDS) of 7th to 12th grade students in public and private schools across New York State. The YDS measured the prevalence of substance use, gambling, and other problem behaviors. The survey also assessed risk and protective factors that predict levels of youth substance use and other problem behaviors such as school drop-out, delinquency, violence, and teen pregnancy (Updated April 2016).

D. The Mental Hygiene Local Services Planning Process

When the mental hygiene local services planning process became integrated, a fixed planning cycle was established so that the local planning process could be conducted in an efficient and predictable manner each year. As Figure 1.2 shows, the annual process begins with the distribution of plan guidelines on March 1. LGUs have 90 days to complete their plan and enter it into CPS. Since planning is an ongoing activity that is carried out throughout the year, completing the plan should reflect the results of that year-long activity. Local Services Plans are analyzed and reports are generated to support the work of various state agency activities, including informing each agency's statewide planning process.

OASAS routinely uses the local planning process to survey Substance Use Disorder (SUD) providers on a variety of topics that help to inform the work of the agency. Surveys are brief and specific, and providers are given 30 days to complete them in CPS. In recent years, this process and the management tools built into CPS have resulted in an average survey response rate of 95 percent, which has dramatically increased the value and reliability of the data collected. Consistent with State Mental Hygiene Law, the statewide plan then serves as an important source of guidance for the subsequent local services planning process, which begins again the following March.

Figure 1.2: Mental Hygiene Local Services Planning Process



Mental Hygiene Local Services Planning Timeline

The timeline shown in Table 1.3 highlights the major dates in the local services planning process and is intended to provide continuity in planning expectations from year to year.

Table 1.3: 2018 Local Services Planning Process Timeline

Process Step	Date
Ongoing planning and needs assessment conducted by counties and the Mental Hygiene Planning Committee	Year round
Local Services Plan (LSP) Guidelines published; CPS updates available	Wednesday, March 1, 2017
LSP Process and CPS Training	Wednesday, March 15, 2017
Due date for completed OASAS provider planning surveys in CPS	**Monday, April 3**
Due date for completed LGU Plans in CPS	**Thursday, June 1**

E. Informing Statewide Planning

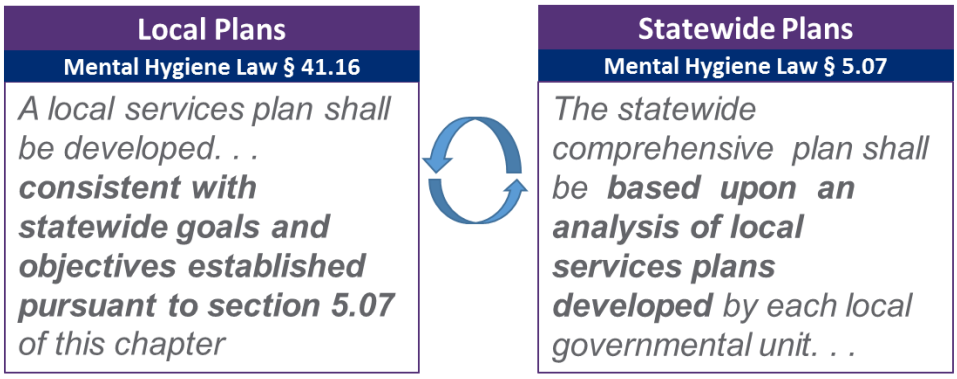
Section 5.07 of Mental Hygiene Law requires OMH, OASAS and OPWDD to develop a Statewide Comprehensive Plan for the provision of State and local services to individuals with mental illness, substance abuse disorders and developmental disabilities. Purposes of the Comprehensive Plan include:

- identifying statewide priorities and measurable goals to achieve those priorities;
- proposing strategies to obtain goals,
- identifying specific services and supports to promote behavioral health wellness;

- analyzing service utilization trends across levels of care; and
- promoting recovery-oriented state-local service development.

Figure 1.4 shows the statutory relationship between local planning and State planning. As Figure 1.4 illustrates, analyses of the Local Services Plans are a key component of the Statewide Comprehensive Plan.

Figure 1.4: Relationship between Statewide and Local Plans



State agencies conduct extensive reviews of information submitted in the LSPs. For the 2017 Plan Cycle OASAS published the following written analyses of Plan forms and surveys (available by selecting "Planning Resources" in CPS and then following the link for "2017 Plan Analyses"):

- 2017 Needs Assessment and Priority Outcome Analysis
- 2017 Human Trafficking Special Population Survey Analysis
- 2017 Talent Management Survey Analysis

The local services planning process and the priorities identified in county plans, particularly the cross-system priorities, inform each State agency's policy, programming and budgeting decisions in a way that is more timely and comprehensive than previously possible. To help ensure that policies supporting people with mental illness, developmental disabilities and/or addictions are planned, developed and implemented comprehensively, OASAS, OMH, and OPWDD will continue to rely on the local services planning process and the annual plan submissions as important sources of input.

CHAPTER 2: Planning for Mental Hygiene Services

A. Behavioral and Physical Health Care Reform

While each mental hygiene system of care continues to provide quality, individualized services, the State Department of Mental Hygiene agencies recognize the transformational changes that are occurring in the health care system. As the public healthcare and the mental hygiene services systems continue to transition and integrate, OASAS, OMH and OPWDD are working with their State and local partners to implement a more coordinated system of care that addresses the needs of all individuals.

While OASAS, OMH and OPWDD face unique challenges in overseeing their respective service systems, several federal and State regulations and policies influence current operating environments and strategic directions across these agencies. Understanding the factors that influence the State's mental hygiene service system empowers LGUs to align their strategic direction with statewide goals and objectives. Included in this chapter is a summary of the federal and statewide initiatives taking place and how local services interact with those initiatives.

Since Governor Cuomo established the Medicaid Redesign Team (MRT) in 2011, several large-scale initiatives have been implemented, however the broader healthcare transformation process continues through this year. The service system redesign across mental hygiene agency settings are advancing care from a fee-for-service

chronic care model to community-based, comprehensively managed, and value-driven delivery systems. Under this churning environment, all systems are realigning to achieve the Triple Aim of better care, population health, and lower costs.

With the many new stakeholders and technologies entering the mental hygiene environment (and vice versa), the role of flexible, goal-oriented local and regional planning is just as important- if not more so than in the past. This Chapter summarizes some of the areas of opportunity that should be considered in the upcoming planning year.

Medicaid Managed Care

The centerpiece of the MRT vision is the expansion and redesign of the State's behavioral health Medicaid program through a broader managed care strategy and "carving in" previously managed care exempt Medicaid services and beneficiaries into a managed, coordinated benefit package.

Adults in Managed Care

For adults aged 21 and older, the integration of all Medicaid behavioral health and physical health benefits under managed care will be delivered through two behavioral health managed care models:

- **Qualified Mainstream Managed Care Organizations (MCOs):** For all adults served in mainstream MCOs throughout the State, the qualified MCO will integrate all Medicaid State Plan covered services for mental illness, substance use disorders and physical health conditions.

- **Health and Recovery Plans (HARPs)**: HARPs will manage care for adults with significant behavioral health needs. These specialized Plans will facilitate the integration of physical health, mental health and substance use disorder services for individuals requiring specialized expertise, tools and protocols which are not consistently found within most medical plans. In addition to the State Plan Medicaid services offered by mainstream MCOs, qualified HARPs will offer access to an enhanced benefit package comprised of Behavioral Health Home and Community Based Services (BH HCBS) designed to provide the individual with a specialized scope of support services not currently covered under the State Plan. BH HCBS will be available to beneficiaries based on their detailed plan of care, which will be informed by a full functional assessment. In order to qualify as HARPs, Plans were required to demonstrate that they have the organizational capacity and culture to ensure the effective management of behavioral health care and facilitate system transformation.

Beginning with adults in New York City, the first phase Health and Recovery Plan (HARP) enrollment letters were distributed between July 2015 and October 2015, followed by staggered enrollments from October 2015 to January 2016. In October 2015, mainstream plans and HARPs implemented non-HCBS behavioral health services for enrolled members, and HCBS service implementation began for the HARP population in January 2016. In the remainder of the State, mainstream plan behavioral health management and phased HARP enrollment began in July 2016, with HCBS service implementation beginning in October. Children's transition to managed care will begin in New York City, Westchester and Long Island in October 2017, followed by the remainder of the State in January 2018. The State agencies are working with plans to ensure that they are ready to implement the requirements included in the request for proposals. Access the full timeline on the New York State Department of Health (DOH) website.

HARP Behavioral Health Home and Community Based Services (Adult BH HCBS)

The Centers for Medicare and Medicaid Services (CMS) authorized various BH HCBS under Medicaid waiver authority. BH HCBS are designed to help adults (21 and over) with serious mental illness and/or substance use disorders remain and recover in the community, and reduce preventable admissions to hospitals, nursing homes, or other institutions.

BH HCBS address isolation and promote integration by providing a means by which individuals may gain the motivation, functional skills, and personal improvement to be fully integrated into the community and achieve life

goals. The goal of integrating BH HCBS into the managed care environment is to promote significant improvements in the behavioral health system of care and move toward a recovery-based managed care delivery model. The recovery model of care, as envisioned in the HARP and HIV Special Needs Plan (SNP) models, emphasizes and supports an individual's recovery by optimizing quality of life and reducing symptoms of mental illness and substance use disorders through empowerment, choice, treatment, education, employment, housing, and health and well-being.

HARPs and HIV SNPs provide BH HCBS as a covered benefit for qualified members. HARPs and HIV SNPs must create an environment where the plan, service providers, plan members, families and other significant supporters, and government partner to assist members in prevention, management, and treatment of physical and behavioral health conditions, including serious mental illness and Substance Use Disorders.

The following BH HCBS are included in the HIV SNP and HARP benefit package:

- Psychosocial Rehabilitation
- Community Psychiatric Support and Treatment
- Habilitation
- Family Support and Training
- Short-term Crisis Respite
- Intensive Crisis Respite
- Education Support Services
- Empowerment Services - Peer Supports
- Pre-vocational Services
- Transitional Employment
- Intensive Supported Employment
- Ongoing Supported Employment
- Non-Medical Transportation[i]

The State has worked with stakeholders to support this transition through several major initiatives including: HARP Behavioral Health Home and Community Based Services (HCBS) and OASAS Residential Redesign. The initial designation process for BH HCBS providers was completed in March 2015 for New York City (NYC) and December 2015 for the rest of State. All agencies wishing to provide BH HCBS must apply to be designated for each service they would like to provide. Applicants may apply at any time for a designation, however the State will only update the designation lists quarterly for each area on a periodic basis. Information on providing BH HCBS can be found in the BH HCBS Manual on the OMH website. As of late 2016, approximately 1,300 Adult BH HCBS programs statewide have been designated and are considered ready to provide services.

Children in Managed Care:

The MRT Children's Health and Behavioral Health Team has designed a separate framework for children's integrated health and behavioral health services under managed care. The separate framework is due to recognition of gaps in the current service system, the complexity of multi-systems involvement by children and families, and the fluidity of children's needs and challenges as they develop.

The Children's BH MRT Subcommittee made a recommendation in 2011 that the children's system needed improvement with respect to service access, funding and earlier intervention for children and families. Since then, the Children's Medicaid Redesign Leadership team, with representation from OMH, the New York State Office of Children and Family Services (OCFS), OASAS, and DOH, has been using the transition of behavioral health services to Medicaid Managed Care to achieve significant reforms in the children's behavioral healthcare system. We recognize that, generally, our system in its current form fails to recognize children soon enough to consistently apply effective intervention. Early identification, accurate diagnosis, and effective intervention of behavioral health problems can help keep children and youth on track developmentally, which in turn prevents expensive, ancillary problems from developing, such as school dropout or involvement in the juvenile justice system. We also recognize that, while we currently offer a continuum of behavioral health services, there are

significant gaps in our children's service delivery system, particularly in the area of home and community-based preventive and step-down services.

The leadership team has put together a proposed benefit package which will address these gaps and weaknesses. This package, once approved and implemented, will enable New York State to serve more children and to prevent the need for more restrictive, more expensive services. The design will also break down some of the systems walls we have historically built up around our services, particularly in the Home and Community Based Services (HCBS) that three State agencies offer through 1915c waivers. We envision building a service delivery system in which children and families can access the services they need, when they need them, and in the right amount, regardless of the door through which they have entered.

We know that today, many opportunities are missed early in a child's trajectory of challenges that could prevent a costly path for the child and their family's future. Children and their families, in many cases, must fail through a variety of programs, services and interventions before being determined eligible for an HCBS Waiver. By that time, they have likely developed a more complex array of challenges which, if addressed earlier, may not have occurred.

The shortcomings of our current systems, combined with the vision of earlier intervention, led to a decision to develop a new set of State Plan Medicaid (SPA) Services. This new set of services will enable our providers to focus on prevention and wellness, will allow for better integration of behavioral health services and early pediatric care, and creates improved opportunity for the delivery of evidence-based practices statewide. The proposed services will be available for all children on Medicaid under the age of 21 who meet medical necessity criteria. Delivery of the new services may take place in natural settings where children live and go to school. The six proposed services are:

- Crisis Intervention,
- Community Psychiatric Support and Treatment,
- Psychosocial Rehabilitation Services,
- Other Licensed Practitioner Services,
- Family Peer Support Services, and
- Youth Peer Training and Support Services.

In addition to adding State Plan services, the State plans to align and transition the existing 1915c Waiver services into one array of HCBS available for children with measurable functional impairment. This includes all existing children's waivers – OMH HCBS Waiver, Office of Children and Family Services (OCFS), Bridges to Health, and Department of Health (DOH) Care At Home.

Unlike the proposed State Plan services, which will be universally available to all children with Medicaid who meet medical necessity, the proposed array of HCBS will be available to children eligible for Medicaid who meet specific target population and functional limitations criteria. The proposed HCBS array was developed by aligning all the services currently offered to children enrolled in the existing 1915c Waivers – services which we know to produce good outcomes, keep children out of long term institutional care, and provide the supports that families need to recover and become more resilient.

New York's vision for the children's system of care integrates physical and behavioral health services within mainstream Medicaid Managed Care Plans. There will be no HARPS for children. When the transition is implemented, services that were previously carved out of managed care and paid on a fee-for-service basis will be included in the Medicaid managed care benefit available to children.

Consistent with the Medicaid Redesign Team's "Care Management for All" goal, every child that receives Medicaid will be enrolled in a high-quality, fully integrated care management program. Care management will be provided by a range of care management models including Plans, Patient Centered Medical Homes and Health Homes. Children with the highest level of need, who meet the criteria, will be enrolled in Health Homes. In an effort to best integrate all care and services, Plans will be required to contract with behavioral health, foster care agencies, and specific community based providers, as well as pediatric health care and specialty health

care providers already in network. We anticipate a designation process for providers similar to the adults, with a two-year government fee schedule requirement.

Children and their families are involved in a variety of systems and in order to ensure that all care is coordinated, we will require Plans to develop and maintain working relationships with school districts, non-Medicaid funded community services and supports, Regional Planning Consortiums, and local government. This entire design and plan has been created, discussed, and moved forward under the collaboration of the four agencies and in partnership with the Children's Health & Behavioral Health MRT Subcommittee.

Delivery System Reform Incentive Payment (DSRIP) Program

The Delivery System Reform Incentive Payment (DSRIP) program is the main mechanism by which New York State will implement the MRT Waiver Amendment. DSRIP´s purpose is to fundamentally restructure the health care delivery system by reinvesting in the Medicaid program, with the primary goal of reducing avoidable hospital use by 25 percent over five years.

Performing Provider Systems (PPS) are providers that form partnerships and collaborate in a DSRIP Project Plan. A DSRIP Project Plan is the overall plan that a Performing Provider System submits to the State. The Project Plan is composed of at least five projects, but no more than eleven projects, based upon projects chosen from a predetermined list. There are four Domains in DSRIP that represent groupings of project milestones and associated metrics. The Domains have strategy sub lists identifying specific strategies. Mental health and substance use disorder (SUD) projects generally fall under one of two Domain sub lists:

- Domain 3: Clinical Improvement Projects: A. Behavioral Health, and
- Domain 4: Population-wide Projects: New York's Prevention Agenda: A. Promote Mental Health and Prevent Substance Abuse.

There are 25 PPSs in the state. Table 2 illustrates the number of PPSs that have chosen a behavioral health project from domains 3.A or 4.A.

Table 2.1: PPS Behavioral Health Project Selections

Domain 3: Clinical Improvement Projects		
A. Behavioral Health	**# of PPSs**	**% of PPSs**
3.a.i Integration of primary care and behavioral health services	**25**	**100%**
3.a.ii Behavioral health community crisis stabilization services	**11**	**44%**
3.a.iii Implementation of evidence-based medication adherence programs (MAP) in community based sites for behavioral health medication compliance	**2**	**8%**
3.a.iv Development of Withdrawal Management (e.g., ambulatory detoxification, ancillary withdrawal services) capabilities and appropriate enhanced abstinence services within community-based addiction treatment programs	**4**	**16%**
3.a.v Behavioral Interventions Paradigm (BIP) in Nursing Homes	**1**	**4%**
Domain 4: Population-wide Projects: New York's Prevention Agenda		
A. Promote Mental Health and Prevent Substance Abuse	**# of PPSs**	**% of PPSs**
4.a.i Promote mental, emotional and behavioral (MEB) well-being in communities	**2**	**8%**
4.a.ii Prevent Substance Abuse and other Mental Emotional Behavioral Disorders	**1**	**4%**
4.a.iii Strengthen Mental Health and Substance Abuse Infrastructure across Systems	**13**	**52%**

Regional Planning Consortiums: Facilitating Oversight and Implementation

In preparation for both the opportunities and challenges the expansion of behavioral health services in Medicaid Managed Care will present at the local level, the State and the counties/New York City collaborated to develop

11 Regional Planning Consortiums throughout the state where key stakeholders can discuss and monitor issues inherent to this type of transition. Each RPC represents natural local patterns of access to care and includes representatives from LGUs, the State, mental health, SUD, and primary care service providers, the child welfare/criminal and or juvenile justice/housing/social service systems, Health Homes, hospitals and MCOs, as well as Medicaid recipients and behavioral health service recipients, peers, families, and advocates.

The RPCs are a necessary mechanism for the State and the MCOs to obtain vital, real-time feedback and recommendations for improving the implementation of behavioral health managed care. In addition, the RPC in each region will help align Medicaid managed behavioral healthcare with other system redesign initiatives aimed at improving the quality and integration of the physical and behavioral healthcare delivery systems, as well as strategize ways to use potential future reinvestment funding. To that end, the RPCs should complement the existing work of their respective and participating LGUs in guiding behavioral health policy as it relates to Medicaid Managed Care in each region.

The following further outlines the specific role and function of all RPCs, in relation to the MCOs, and describes where the New York City RPC (NYC RPC) and the remaining ten New York State RPCs henceforth referred to as the Rest of State RPCs (ROS RPCs), diverge in structure and scope, as relevant to MCO planning and participation.

<u>Scope and Function of RPCs:</u>
The core focus areas within the scope of RPC function are;

1. Service access and capacity: monitoring the timely access to services, including BH HCBS, for Medicaid recipients of behavioral healthcare, as well as service gaps.
2. MCO performance: observing MCO actions with respect to their responsibilities to behavioral health service recipients and providers of Medicaid services.
3. System stability & improvement: facilitate collaboration among any and all regional sectors that touch the Medicaid behavioral health system.
4. Service quality, efficiency, and efficacy: improving care of behavioral health service recipients overall by voicing concerns as they arise and making recommendations to State Partner Agencies (DOH, OMH, and OASAS).

All New York State RPCs share three primary functions

1. To be the early warning system for locally occurring issues which data would not immediately or necessarily show (such as access to needed services, gaps in services, timeliness of eligibility determinations, and engagement or disengagement in care, etc.); and for ongoing monitoring, deliberation, and forming recommendations to the State in response to issues that arise from stakeholders at the table:
    a. Members will be expected to give status updates from the field, especially regarding payment and billing; data needs and Informational Technology (IT); and training and education. Based on issue analyses, the RPC will recommend next steps to the State, which may include:
        i. Identifying systemic and contract related issues, either between the State and the MCOs or the MCOs and service providers, to State partners and recommendations for improvement.
        ii. Convening topic or issue based meetings with MCOs, including HARPs, MMCPs, and HIV SNPs, to address issues at the MCO and local level.
        iii. Establishing and participating in workgroups to address local systems issues in collaboration with the MCOs and State partners.
    b. RPCs will make any request for data related to the MCOs' performance to the State partners. Such data might include payment and billing, data and IT needs, and training and education.

2. To understand and improve the parallel process and intersection of the expansion of behavioral health services under Medicaid Managed Care with other system redesign initiatives, especially the Delivery System Reform Incentive Payment (DSRIP) Program and Population Health Improvement Program (PHIP):

a. All RPCs will include representatives from the DSRIP Performing Provider Systems (PPSs). The RPC, together with the LGU (or in the case of NYC, the NYC RPC), will help create as much continuity and efficiency as possible across multiple MCOs and PPS projects serving the counties and the regions. ROS RPCs will address downsizing and closure of State psychiatric centers.

3. To work with their respective LGUs, which are the points of accountability for MCOs in identifying and addressing local system issues:
   a. In the case of the NYC RPC, the DOHMH will function as both the LGU and RPC convener. DOHMH will systematically analyze problems identified through the RPC, data reviews, and feedback from other stakeholders, and provide appropriate recommendations to the State via the Quality Steering Committee (QSC).
   b. In the ROS RPCs, the LGUs in each region will participate on the RPC. The ROS RPC shall be the primary point of interaction between the LGUs and the MCOs.

The Prevention Agenda, Looking Forward

The New York State Prevention Agenda 2013-2018 is the NYS Department of Health's (DOH) multi-year state health improvement plan. The goal of the Prevention Agenda is for local health departments and hospitals to collaborate with community partners to improve health status and reduce health disparities in five priority areas:

1. Prevent Chronic Diseases;
2. Promote a Healthy and Safe Environment;
3. Promote Healthy Women, Infants and Children;
4. Promote Mental Health and Prevent Substance Abuse; and
5. Prevent HIV, STDs, Vaccine Preventable Diseases and Healthcare Associated Infections.

The Prevention Agenda establishes goals for each priority area and defines indicators to measure progress toward achieving these goals, including reductions in health disparities among racial, ethnic, and socioeconomic groups and persons with disabilities. The Prevention Agenda also identifies interventions and offers guidance on related intermediate measures shown to be effective to reach each goal.

The Prevention Agenda promotes stakeholder collaboration at the community level to assess health status and needs, identify local health priorities and plan and implement strategies for local health improvement, and serves as a guide to local health departments (LHDs) and hospitals as they work together with their community to develop and implement Community Health Assessments, including Community Health Improvement Plans, required of LHDs, and Community Service Plans required of hospitals.

With the current cycle of the Prevention Agenda ending in 2018, a new six-year period is set to begin in January 2019. The New York State and Public Health and Health Planning Council's Public Health Committee will lead the development of the Prevention Agenda 2019-2024 and establishes an Adhoc Committee of key stakeholders. The Public Health and Health Planning Council drives the work of LHDs, hospitals and other partners. In the summer of 2017, DOH will conduct the State health assessment to measure key health indicators and describe health disparities. The assessment will help shape the next Prevention Agenda by addressing the following:

- Identification and description of health status, including social determinants, equity and factors that contribute to health;
- Progress to date on current Prevention Agenda objectives;
- Progress to date on local collaboration and action; and
- Identification of resources that can be mobilized to address health challenges.

LHDs and hospitals submitted their collaborative assessments and plans by December 31, 2016, which are currently being reviewed by DOH and will be returned with feedback by June 2017.

Stakeholder engagement will begin in winter 2017 and continue through summer 2018. The process will ensure diverse participation and address equity health in all policies and social determinants.

The Prevention Agenda 2019-2024 is scheduled to be released in fall 2018.

B. Integrating Care for Earlier Identification and Treatment of Behavioral and Physical Health Conditions

Since the passage of the federal Affordable Care Act, and the creation of the New York State Medicaid Redesign Team (MRT) shortly thereafter, there has been increasing recognition of the value of integrated behavioral and primary/physical healthcare treatment. This section outlines three of the most significant efforts underway in New York State to more build behavioral health capacity for primary care, and to build primary care capacity for behavioral health. They include Integrated Outpatient Clinic services regulations, Collaborative Care, and the State Innovation Model grant initiative for Advanced Primary Care.

Integrated Outpatient Clinic Services

On January 1, 2015, New York witnessed the culmination of a four-year effort to further the integration of physical and behavioral health services in clinic settings across state. The new authorization establishes the licensure category "Integrated Outpatient Services" (IOS) and appears identically within regulations for OMH-licensed providers (14 NYCRR Part 598), OASAS-licensed providers (14 NYCRR Part 825), and DOH-licensed providers (10 NYCRR Part 404).

Over the past four years, the Office of Mental Health, the Office of Alcoholism and Substance Abuse, and the Department of Health have uniquely partnered in the development, implementation and oversight of the "Integrated Licensure Project." This collaboration resulted in the development of clinical and physical plant standards, staffing requirements, and a single application and review process – all with the goal to reduce the administrative burden on providers and to improve the quality of care provided to consumers with multiple needs by improving the overall coordination and accessibility of care.

Participating facilities in the Project have been overseen by a single State ("host") agency, which monitors for compliance with standards at the single site. Therefore, though an agency may have multiple licenses, they are only subject to one survey. Further, the Project has promoted the use of an integrated physical and behavioral health record for recipients.

The now-established IOS regulations further the core principles of the Project, which are:

1. Allowing a provider to deliver the desired range of cross-agency clinic services at a single site under a single license;
2. Requiring the provider to possess licenses within their network from at least 2 of the 3 participating State agencies;
3. Allowing the site's current license to serve as the "host"; and
4. Facilitating the expansion of "add-on" services through a request to the State agency that is principally responsible for oversight of such services.

<u>Applicable Sites for Integrated Outpatient Services</u>
Providers eligible to become IOS providers under the uniform regulations must already possess licenses within their network from at least 2 of the 3 participating State agencies, as indicated above. In addition, the provider must be in "good standing" with the agencies for whom it will be operating integrated services, and must be affiliated with a Health Home (DSRIP Performing Provider System network status is not a sufficient substitute for Health Home affiliation).

Integrated outpatient clinics fall into three main categories that are organized under "host" models. The host model refers to the lead agency which oversees and is the primary point of contact for all of the integrated services:

1. <u>Primary Care Host Model:</u> The State Department of Health is the lead oversight agency, and behavioral health services (substance use disorder (SUD) and/or mental health (MH)) are provided in addition to primary health care.

2. Mental Health Behavioral Care Host Model: The State Office of Mental Health is the lead oversight agency, and primary health care and/or substance use disorder services are provided in addition to mental health care.
3. Substance Use Disorder Behavioral Care Host Model: The State Office of Alcoholism and Substance Abuse Services is the lead oversight agency, and primary health care and/or mental health services are provided in addition to substance use disorder care.

Applications to become an IOS provider are made on a clinic-specific basis, and therefore the agency under which the applicant clinic is originally licensed determines the host site status. For example, an Article 31 mental health clinic applying to become an IOS clinic providing substance use disorder services in addition to those on its original license, will have the State Office of Mental Health as its primary State oversight agency and point of contact.

Services Provided by Integrated Outpatient Clinics

Any clinic that operates as an IOS provider must continue to offer those services required under their host model agency regulations, in addition to those services required under the regulations of the secondary and tertiary licensing agencies.

Any behavioral health care host model must also complete treatment plans for clinic enrollees, which must include physical health, behavioral health, and social service needs. Treatment plans must be completed within 30 days of admission to the clinic. Primary care host models must complete treatment plans for behavioral health services only after a patient has been advanced beyond assessment and pre-admission services. In such cases, a treatment plan is required within 30 days after a decision has been made to begin post-admission behavioral health services.

Adoption of Integrated Outpatient Services by Clinics Statewide

Since the final adoption of the IOS regulations on January 1, 2015, those clinics that were included in the pilot project for integrated outpatient services have continued providing integrated services consistent with the regulations. Additional providers that were not included in the pilot have also since received approval to provide integrated services. The following statistics reflect the number of IOS sites by type, including both grandfathered sites and those approved under the new IOS regulations (as of October 2016):

14 OMH host sites total
- 7 with SUD
- 6 with primary care
- 1 with both

8 OASAS host sites total
- 6 with MH
- 2 with primary care
- 0 with both

5 DOH host sites total
- 4 with MH
- 0 with SUD
- 1 with both

Integration of Primary and Behavioral Health Care under DSRIP: Project 3.a.i.

In addition to the opportunity to provide integrated behavioral health and primary care services under the IOS regulations, the DSRIP Program has provided another avenue for clinics within Performing Provider Systems to integrate care under DSRIP Project 3.a.i.

OMH, OASAS, and DOH collectively agreed to raise the current licensure thresholds associated with clinics in order to allow a greater number of secondary and tertiary services at existing sites, for those clinics that are part of a DSRIP Project 3.a.i. (which was chosen by all 25 PPSs). However, it is important to note that any clinic

providers operating within the existing licensure thresholds or the DSRIP Project 3.a.i. licensure thresholds must also meet certain regulatory requirements outlined by the host model.[ii]

Approved DSRIP 3.a.i. integrated clinic sites (as of October, 2016):
5 OMH host sites total

- 1 with SUD
- 3 with primary care
- 1 with both

4 OASAS host sites total

- 1 with MH
- 2 with primary care
- 1 with both

0 DOH host sites total

- 0 with MH
- 0 with SUD
- 0 with both

Table 2.2 Licensure Threshold Crosswalk for DSRIP Project 3.a.i. Clinics[iii]

Existing Licensure Thresholds	DSRIP Project 3.a.i Licensure Thresholds
A PHL Article 28 provider that has more than 2,000 total visits per year must be licensed by OMH if it has more than 10,000 annual visits for mental health services or more than 30 percent of its total annual visits are for mental health services.	A PHL Article 28 provider that has more than 2,000 total visits per year must be licensed by OMH if more than 49 percent of its total annual visits are for mental health services.
No existing Licensure Threshold. A PHL Article 28 provider may not provide substance use disorder services without being certified by OASAS pursuant to MHL Article 32.	A PHL Article 28 provider must be certified by OASAS if more than 49 percent of its total annual visits are for substance use disorder services.
A MHL Article 31 provider or MHL Article 32 must be licensed by DOH if more than 5 percent of its total annual visits are for primary care services or if any visits are for dental services.	A MHL Article 31 provider or MHL Article 32 must be licensed by DOH if more than 49 percent of its total annual visits are for primary care services or if any visits are for dental services.
No existing Licensure Threshold. A MHL Article 31 provider or MHL Article 32 is able to integrate mental health and substance use disorder services pursuant to a Memorandum of Agreement between OMH and OASAS.	A MHL Article 31 provider must be certified by OASAS if more than 49 percent of its total annual visits are for substance use disorder services. A MHL Article 32 provider must be certified by OMH if more that 49 percent of its total annual visits are for mental health services.

Collaborative Care

Behavioral health disorders such as depression, anxiety, and substance use disorders are major drivers of disability and health care costs, but only 3 in 10 adults living with a mental health or substance use disorder currently receive care from a mental health specialist.[iv] At a time when policymakers and payers are tasked with quickly moving from volume to value-based purchasing of healthcare, there is strong evidence that effectively integrated behavioral health services can help achieve the health care Triple Aim for better care, better outcomes, and lower costs.

Among models of behavioral health integration, Collaborative Care (also known as the IMPACT model) stands apart through a large evidence base, and a significant potential impact on population health. This model of care brings the individual together with the primary care provider, a care manager, and a consulting psychiatrist to treat depression and other common mental health diagnoses in the primary care environment, and utilizes an electronic registry to track each individual's progress and monitor outcomes on the whole patient population. Collaborative Care helps the practice build in-house capacity to treat behavioral health conditions, as well as enhances the ability to manage co-morbid chronic diseases such as diabetes or hypertension by addressing some of the behavioral factors impacting physical health outcomes. Rigorously evaluated over the last 20 years, there are now more than 80 randomized controlled trials that have shown Collaborative Care to be significantly more effective than the usual process of referring out to specialty behavioral healthcare.

New York State has been a leader in implementing Collaborative Care, beginning with a two year implementation for depression in 2014 through 19 academic medical centers and 32 primary care training clinics as part of the NYS Department of Health Medical Home Demonstration Project. This project provided grant funding and technical assistance to a limited number of sites to build their capacity and implement Collaborative Care, however the lack of a sustainable financing mechanism to support Collaborative Care had initially threatened the infrastructure developed during the grant.

A critical development in advancing Collaborative Care in New York has been the Governor and Legislature's agreement to allocate at least $11 million to support the model for Medicaid recipients. Using this allocation, OMH created the Medicaid Collaborative Care Depression Program. This program has been offered to sites that demonstrated success in the grant project in order to allow them to both continue and expand the work they have done, while new programs that are equipped to implement Collaborative Care, such as Federally Qualified Health Centers (FQHCs), have also been included. The Medicaid Collaborative Care program continues to provide technical assistance and training to participating practices to help them continue to grow their programs. Additionally, practices that meet certain process and outcome standards are able to receive a monthly case rate for each program enrollee. Practices submit quarterly outcomes reports to OMH to demonstrate progress and show the model is functioning as designed. OMH will be evaluating the program to support the case for continued expansion of the Collaborative Care model, as well as the case rate financing method. To date, there are 36 active sites, with an additional 18 expected under DSRIP project technical assistance efforts.

Many other NYS initiatives are encouraging the implementation of Collaborative Care as part of the increasing emphasis on behavioral health integration including the DSRIP project 3.a.i.[v] and Advanced Primary Care. In conjunction with the Medicaid program, these programs will allow more New Yorkers access to integrated and coordinated care so that behavioral health conditions can be recognized earlier and treated more efficiently, thereby reducing the burden of disease statewide. For information on the Collaborative Care model or the Medicaid program, contact nyscollaborativecare@omh.ny.gov.

Advanced Primary Care and the State Innovations Model

In December 2014 New York State DOH, in coordination with Health Research, Inc. was awarded a four-year, $100 million State Innovations Model (SIM) grant by the Centers for Medicare and Medicaid Services. As part of the broader State Health Innovation Plan (NYSHIP), SIM will help New York State integrate care and services by improving access to primary care, and also by integrating primary care into long-term care, behavioral health, specialty care and community supports.

One key strategy and requirement of the SIM grant is the implementation of the Advanced Primary Care (APC) model. The NYS APC model is consistent with principles of NCQA[vi] Patient Centered Medical Home criteria; but seeks to move beyond structural criteria to achieve durable, meaningful changes in processes and outcomes. APC seeks to provide patients with access to high quality, integrated care, delivered by teams of providers with the capacity to manage the care of patients with chronic illnesses. SIM support will enable the State to achieve three core objectives within five years:

1. 80 percent of the state's population will receive primary care within an APC setting, with a systematic focus on population health and integrated behavioral healthcare;

2. 80 percent of the care will be paid for under a value-based financial arrangement; and
3. Consumers will be more engaged in, and able to make more informed choices about their own care, supported by increased cost and quality transparency.

To support practices in the evolution to APC status, NYS will support practice transformation including goal-setting, leadership, practice facilitation, workflow changes, measuring outcomes, and adapting organizational tools and processes to support new team-based models of care delivery over the three year implementation period. Operationally, practice transformation expanded clinical prevention services will be driven in party by SIM-funded Public Health Consultants. These consultants will work closely with regional Population Health Improvement Programs (PHIPs), SIM-funded practice transformation teams and Medicaid DSRIP Performing Provider Systems.

Behavioral health integration will be achieved under APC in part through the broader adoption of depression screening and Collaborative Care, and the addition of screening and interventions for substance use disorders, such as Screening Brief Intervention, and Referral to Treatment (SBIRT).

The hallmark of APC is support from payers, including private insurers, in order to reach all populations. Ultimately, primary care practices will have to negotiate alternative payment models with plans to support value-based payment structured around the APC elements. Two proposed metrics related to behavioral health that will be tracked as well are 1) depression screening and management and 2) initiation and engagement in alcohol or substance use treatment.

In December 2015, DOH submitted the SIM Year Two Operational Report,[vii] with detailed project deliverables and core metrics associated with APC. This report makes it clear that the large scale adoption of APC across settings and payers is a multi-level, long term, and complex endeavor that requires significant and sustained attention by practitioners, planners, and policymakers alike. However, the planning underway places New York on a strong footing to advance the behavioral health competencies in primary practice, and impact thousands more individuals who have not previously been identified or treated for mental health conditions.

C. Planning For Substance Use Disorder (SUD) and Problem Gambling Services

The mission of The New York State Office of Alcohol and Substance Abuse Services (OASAS) is to improve the lives of all New Yorkers by leading a comprehensive premier system of addiction services for prevention, treatment, and recovery. The agency envisions a future where New York State is alcohol safe and free from chemical dependence and compulsive gambling.

OASAS oversees one of the largest chemical dependence service systems in the nation, which includes a full array of services to address prevention, treatment, and recovery. OASAS is also responsible for the prevention and treatment of problem gambling. During 2015, the OASAS chemical dependence treatment system served approximately 233,000 individuals through crisis, inpatient, residential, outpatient, and opioid treatment programs. These individuals were served in 12 State-operated programs and over 900 OASAS-certified community-based programs. Approximately 336,000 youth received a direct prevention service during the 2015-16 school year.

Statewide planning for addiction services is organized around three primary goals:

- Enhancing Access to Treatment and Recovery;
- Increasing SUD Treatment System Efficiency through Healthcare System Transformation; and
- Improving Effectiveness and Quality of Prevention, Treatment, and Recovery Services and Supports.

In addition to the information found in this chapter, more details on OASAS initiatives is found in the Agency's Statewide Comprehensive Plan, available at https://www.oasas.ny.gov/pio/commissioner/5yrplan.cfm.

Enhancing Access to Treatment and Recovery

Heroin and Other Opioid Use

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

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

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

#CombatAddiction Campaign

In October 2016 Governor Cuomo announced the launch of a campaign to urge New Yorkers to join together in the fight against addiction. The statewide #CombatAddiction campaign emphasizes the far-reaching effects of addiction and connects New Yorkers with information and support services through social media, bilingual public service announcements and print ads. The campaign also promotes the message that addiction is a disease that can be can treated and that recovery is possible with support.

The ads direct individuals to a #CombatAddiction webpage, which includes informational sections for individuals, families, friends, medical practitioners, law enforcement, educators, and community organizations. Resources are available to help raise awareness about addiction and provide assistance and guidance on how everyone can help. The site also includes links to helpful websites and videos with real New Yorkers sharing their stories about their progression to addiction, from alcohol to other drugs, along with their path to recovery.

Screening, Brief Intervention and Referral to Treatment

Screening, Brief Intervention and Referral to Treatment (SBIRT) is an evidence-based approach to identifying patients who use alcohol and other drugs at risky levels with the goal of reducing and preventing related health consequences, disease, accidents and injuries. OASAS works closely with DOH and OMH to bring SBIRT to physical and behavioral healthcare settings. Through grants and state initiatives OASAS is supporting the use of SBIRT in various settings. These efforts include: STD clinics in New York City and medical settings in Jefferson County through a Substance Abuse and Mental Health Services Administration (SAMHSA) award (2011–2016), and emergency department and primary care settings within the North Shore-Long Island Jewish Hospital System on Long Island and Staten Island where individuals were affected by Hurricane Sandy (SAMHSA award, 2013-2018 in partnership with CASA Columbia).

Peer Support

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

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

Recovery Community Centers and Youth Clubhouses

In 2016, Governor Cuomo announced funding to support 14 Recovery Community and Outreach Centers in communities across New York State, with one in every state economic development zone and in each of the five boroughs of New York City. The Recovery Community and Outreach Centers provide a community-based, non-clinical setting that is safe, welcoming and alcohol/drug-free for any member of the community. Each Recovery Center responds to the local area's specific needs related to obtaining substance abuse treatment services and addiction recovery supports. The Centers promote long-term recovery through skill building, recreation, wellness education, employment readiness, civic restoration opportunities, and other social activities. Services are accessible not only during the daytime hours, but also during evening and weekends, to meet the needs of individuals and families who may be in need of assistance at varying hours.

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

In addition to the Recovery Community and Outreach Centers, during 2016 Governor Cuomo also announced funding for 11 Youth and Young Adult Clubhouses. These clubhouses are located in Western New York, Finger Lakes, Mohawk Valley, Mid-Hudson, New York City, Long Island, the Capital Region, North Country, Central New York and Southern Tier. The Clubhouses will use evidence-based prevention strategies and help individuals in recovery develop social skills that promote prevention, long-term health, wellness, recovery and an addiction-free lifestyle. A variety of services and activities will be available, including tutoring and help with homework, college and job preparation, community service opportunities, peer mentoring, and sports, fitness and group entertainment activities.

Problem Gambling Services

OASAS supports statewide prevention and treatment services that target problem gambling. Treatment for problem gambling is provided in 19 outpatient programs and six OASAS operated Addiction Treatment Centers. OASAS also partners with the New York Council on Problem Gambling (NYCPG) to integrate problem gambling awareness into its prevention system.

OASAS continues to integrate problem gambling prevention into the statewide prevention services system. Prevention providers are increasing public awareness by integrating problem gambling prevention into their yearly work plan services. OASAS partnered with the New York State Gaming Commission and the New York Council on Problem Gambling (NYCPG) to form the Responsible Play Partnership.

OASAS Treatment Availability Dashboard

The OASAS Treatment Availability Dashboard application allows New Yorkers to access any service in the OASAS continuum of care, including crisis, residential, inpatient, outpatient and opioid treatment programs. By using the online and mobile-friendly platform, any New Yorker, including individuals, families, treatment providers, care coordinators, and health insurance professionals, can easily find a treatment bed or other available services, anywhere in the state and in real time.

Through the newly expanded application, users can find up-to-date information on available treatment beds, outpatient services and opioid treatment programs anywhere in the state, 24 hours a day, seven days a week. The application's search feature includes proximity searches that return reports on available treatment within three to 50 miles of the searcher's location. Queries are simple and customizable allowing for searches by location, gender of the patient, age, city, county or zip code as specified by the user.

Those searching on the system are also given the telephone number of every program that is returned by a search. Individuals are encouraged to call ahead to confirm the availability of a treatment slot. Mobile users can simply click on the treatment provider's phone number to call the provider.

Increasing SUD Treatment System Efficiency through Healthcare System Transformation

New York State's vision for public healthcare reform is to achieve the "Triple Aim" of improved health outcomes, decreased costs, and increased consumer satisfaction. The Medicaid Redesign Team (MRT), convened by Governor Andrew Cuomo in 2011, set forth recommendations for achieving the Triple Aim, including integration of the physical health and behavioral health (mental health and substance use disorder) delivery systems. Healthcare system transformation activities in which OASAS and its providers are involved include:

- Behavioral Health Managed Care,
- Delivery System Reform Incentive Payment (DSRIP) Program; and
- Regional Planning Consortiums (RPCs).

Detailed information on these initiatives is found in Sections A and B of this chapter.

Improving Effectiveness and Quality of Prevention, Treatment, and Recovery Services and Supports

Residential Redesign

Residential Redesign responds to the need for a residential continuum of care that can provide clinical and medical care based on individual needs. It is a direct result of Medicaid Redesign and managed care. Residential Redesign includes OASAS residential treatment options to divert appropriate individuals from higher levels of care to more appropriate community-based options and to allow bedded programs to provide short-term crisis/respite options.

OASAS envisions a residential continuum of care that is able to meet the needs of each individual based on an assessment of individual risks and resources. Residential Redesign incorporates the following three elements of treatment:

- Stabilization - Individuals receive medically-directed care to stabilize acute medical, mental health, and addiction symptoms.
- Rehabilitation - Individuals learn to manage recovery within the safety of the program. (Note: Within the context of the residential redesign initiative "Rehabilitation" refers to the rehabilitative component of a residential treatment modality and is not synonymous with either the type of treatment/services(s), staffing, or level of medical care provided in a Part 818 Chemical Dependence Inpatient Rehabilitation OASAS-certified program).
- Community Reintegration - Individuals further develop recovery skills and begin to reintegrate into the community.

SUD Prevention

OASAS prevention service providers use a proactive planning process to deliver proven evidence-based programs to young people, their families, and communities. Substance abuse prevention services are delivered by over 160 providers operating in schools, community-based organizations, and embedded in the community at large. The providers deliver a wide range of services including: evidence-based education programs, environmental efforts to reduce underage drinking, and early interventions for adolescents who have begun to use alcohol and other drugs.

OASAS promotes the improvement of New York's substance abuse prevention system by using evidence generated by applied scientific prevention services research. Evidence-based programs and strategies (EBPS) are developed using outcome studies to document their effectiveness in preventing substance abuse, violence, delinquency and the risk and protective factors that predict these behaviors. Increasing the delivery of EBPS to prevent substance abuse is an OASAS statewide priority. OASAS maintains a list of EBPS that are approved for providers to use in their delivery of prevention services.

Transferring knowledge of prevention science (e.g., evidence-based programs and practices) is an important element to prevent alcohol, other drug abuse, and problem gambling. One effective way of engaging multiple systems in prevention efforts is through community coalitions. Through its regional Prevention Resource Centers

(PRCs), OASAS supports the implementation of environmental prevention strategies by a network of over 115 registered anti-drug coalitions operating across the state. The regional PRCs are funded to provide training and technical assistance to the community coalitions.

State Epidemiological Workgroup (SEW)

The New York State Epidemiological Workgroup (SEW) is an OASAS-led effort that seeks to understand the social and ecological determinants impacting substance abuse, by integrating data about the nature and distribution of substance use and related consequences into ongoing assessment, planning, and monitoring decisions at the state and local levels. Workgroup members include representatives of State agencies, such as the Department of Health (DOH), Division of Criminal Justice Services (DCJS), and OMH, as well as LGU and prevention provider representatives. Guided by the Strategic Prevention Framework (SPF), the SEW examines, interprets, and applies data to inform prevention planning and decision-making.

Housing

OASAS recognizes that safe and affordable housing for homeless individuals and families suffering from a SUD is a critical recovery support service. Moreover, permanent supportive housing is a major social determinant in the recovery process, as is having opportunities for employment, education, nutritious food, and access to health care services. OASAS provides opportunities for permanent supportive housing to homeless adults and families through rental subsidies and dedicated case managed supportive services.

D. Planning for Mental Health Services

The forces of change in Medicaid Redesign, mental health parity, managed behavioral health and the Olmstead Plan continue to drive the transformation of the public mental health system in New York State, and it is critical that local stakeholders be informed and engaged in ongoing planning. With so many large scale reforms converging, there are numerous opportunities to serve and support the recovery and resiliency of adults, children, and families impacted by mental illness. Below are a number of recent and ongoing initiatives that will drive, and are driven by local and statewide planning efforts in the public mental health system.

The OMH Transformation Plan for State and Community-Operated Services

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

Beginning with the State fiscal year (SFY) 2014-15 State Budget and continuing through SFY 2016-17, the OMH Transformation Plan has "pre-invested" $81 million annualized into priority community services and supports, with the goals of reducing State and community-operated facilities' inpatient psychiatric admissions and lengths of stay. An additional $19 million has been reinvested from Article 28 and 31 inpatient facilities to further support the OMH Transformation Plan.

Early Identification and Intervention Strategies

OMH is focused on supporting increased efforts to identify and provide appropriate treatment for mental health conditions before they become more disabling for individuals, and more expensive to treat. Initiatives focused on early identification and intervention include collaborative efforts with the Department of Health on the Prevention Agenda 2013-2018, and initiatives including:

Project TEACH: TEACH is a collaborative model that is committed to strengthening and supporting the ability of primary care providers (PCPs) to provide mental health services to children, adolescents and their families. This statewide program is comprised of three interrelated services for PCPs: rapid access to child and adolescent

psychiatric consultation, referral and linkage to assist families and primary care providers to access community mental health and support services and educational based training.

In 2015, the Office of Mental Health re-bid contracts for the Regional Provider services with an increase of funding for Project TEACH by $1.4 million to $2.5 million annually through 2020, and instituted other improvements including an increase of child and adolescent psychiatry staffing from 2.0 to 5.25 full time equivalents statewide.

The increased funding will now enable Project TEACH to triple the number of consultations with pediatric primary care providers provided by child and adolescent psychiatrists, increase trainings for primary care providers, and add staff to provide children and families with linkages and referrals to community supports and services. The increased funding will also support a new site for the program—the seventh site statewide. Additionally, other providers who offer ongoing treatment to children, such as general (non-child) psychiatrists, may now request a consultation – further improving the quality of care available to New York children already engaged with psychiatric treatment providers.

In addition to expansion of the Project TEACH Regional Provider services, OMH has established the Project TEACH Statewide Coordination Center (SCC) to oversee the successful expansion of Project TEACH. The SCC will promote Project TEACH, strengthen the coordination of consultation services to ensure that utilization is at full capacity, expand training on a statewide basis, add specialty consultation for identified areas of need, and oversee the evaluation of services provided by Project TEACH. The SCC will work with other prevention and early identification initiatives, such as suicide prevention and first episode psychosis initiatives (described later in this report) to bring training to pediatric PCPs.

Additionally, the SCC will be a New York State leader in advancing prevention science by serving as a clearinghouse and resource for promising and evidence based practices in promoting children's social-emotional health and preventing and treating disorders, and will support the continued integration of pediatric primary care and behavioral health at a systems level.

After expansion of the program is complete, OMH plans to enroll an additional 3,800 providers and conduct an additional 24,500 consultations over the next five years. For more information about Project TEACH, including information on how primary care providers can take advantage of this program, please visit: https://www.omh.ny.gov/omhweb/project_teach/.

OnTrackNY: OMH is seeking to improve early identification and treatment for individuals with psychotic disorders such as schizophrenia through the dissemination of first episode psychosis (FEP) models. The ultimate goal of the FEP initiative is to minimize disability so often associated with schizophrenia and to maximize recovery. New York State's *OnTrackNY* initiative for first episode psychosis interventions has expanded statewide with 18 sites operational as of December 2016, and at least two more in the pipeline for 2017.

Suicide Prevention: Suicide is a significant public health problem in the United States and New York State. The most recent data available indicates that in 2014, 42,773 persons died by suicide in this country. Over the last decade, the nation witnessed the number of annual suicide deaths surpassing deaths by motor vehicle accidents, homicides, and most recently breast cancer. Since 1999 rates of leading causes of death, such as heart disease, stroke, and cancer, have been decreasing, but according to a recent report by the Centers for Disease Control and Prevention (CDC), the suicide death rate in the US increased by 24%.[viii]

New York State itself has one of the lowest suicide rates in the nation, at 8.6 suicide deaths per 100,000 (vs. 13.4 per 100,000 nationally), however this still reflects an increase of 32% over the past decade, amounting to 1,700 deaths by suicide in 2014.[ix]

In consultation with a panel of national and state experts on suicide, public health, and prevention, The New York State Office of Mental Health Suicide Prevention Office (SPO) recently developed a comprehensive suicide prevention plan that addresses the problem at three levels:

1. Implementation of the *Zero Suicide* strategy for preventing suicide for individuals in health and behavioral health care settings;
2. A lifespan prevention approach to foster competent and caring communities; and
3. Suicide surveillance and data-informed suicide prevention.

This chapter provides a brief statistical summary of suicide in New York and nationally, followed by an overview of the Suicide Prevention Office strategic plan to prevent suicide in New York State. The full version of the SPO's Suicide Prevention Plan 2016-17 is available at https://www.omh.ny.gov/omhweb/resources/publications/suicde-prevention-plan.pdf

Early Childhood Initiatives: OMH has developed a number of initiatives that help establish supports for young children's social-emotional development across a wide range of settings. One such initiative is funding for Healthy Steps for Young Children, a program that embeds behavioral health professionals within primary care provider offices to screen children from birth to age five for developmental and behavioral concerns and when necessary, provide support to families and linkages to needed services. There are currently 19 sites statewide, which are estimated to engage 6,650 families across New York State over the next three years.

Additionally, programs such as ParentCorps are also increasing screening services throughout the State. ParentCorps is a culturally-informed, family-centered evidence based, preventive intervention designed to foster healthy development and school success among young children (ages three to six) living in low-income communities.

Through these efforts and others, such as Project TEACH (described above), OMH is better able to align and mobilize resources from various service systems to intervene early and make an important public health impact.

Promotion of Recovery and Resilience in Community Services

An integral component of effective treatment is a recovery-oriented approach to care that supports individuals' capacity to live at home and in their communities with all the needed services and supports. OMH continues to make significant efforts to provide individuals with mental illness the opportunity to participate as complete members of our communities and society as a whole. Efforts underway include:

Peer Workforce Expansion: Given the demand for more information on using peer staff, the OMH Office of Consumer Affairs has provided comprehensive in-person training in all New York State regions for both State and community providers. These trainings help agencies recruit, train, and support peer staff in a variety of program types and roles. They will continue through a series of webinars in 2015 and ongoing technical assistance for LGUs and providers as needed. Local governments, voluntary organizations, and other potential peer employers may also obtain resources on peer workforce development through a free federal resource called the Job Accommodation Network (JAN).

In addition to increasing the size of the peer workforce, New York State has a strong commitment to ensuring a qualified peer workforce that provides evidence-based practices. To ensure continued opportunities for peer services, OMH worked with peer leaders to develop a Peer Specialist Certification process which is currently accepting enrollees. The Academy of Peer Services is a free online training platform for individuals delivering peer support services in New York State. The Academy was developed through the collaboration of peer leaders and the Rutgers University School of Health Related Professions. Enrollment in the Academy can be done on the Academy of Peer Services website.

Family Peer and Youth Support Services: OMH funds and supports a variety of peer-run and peer-oriented services and programs, including peer specialists, family and parent advisors, and youth peer advocates, to help individuals on their journey towards recovery and family members who struggle to access supports and services for children and youth with social and behavioral challenges. In addition, OMH continues to promote the credentialing of Family Peer Advocates (FPAs) and is working with youth peer advocates on the development of

a Youth Peer Advocate credential. The standardization of this credentialing process will help build and sustain the integration of peer services into the future.

New York Employment Services System: OMH has led the efforts designed to support competitive employment opportunities and outcomes for people with disabilities through a comprehensive job matching/employment supports coordination and data system known as the New York Employment Services System (NYESS). NYESS serves as a single point of access for all New Yorkers seeking employment and employment supports, regardless of an individual's abilities/disabilities and regardless of the State agency system from which they receive employment services/supports.

Preparing for and Serving our Aging Population: Based on its work with a recent round of partnership innovation projects, OMH has selected eight mental providers to develop community programs that identify adults age 55 or older whose independence or survival in the community is in jeopardy because of a mental health, substance use, or aging-related concern. In order to effectively serve the aging population, each *Partnership Innovation for Older Adults* program will:

- Create a local "triple partnership" of mental health, substance use disorder, and aging services providers;
- Include the local Office for the Aging as a member of the partnership with partnership responsibilities or as an organization with a key role in carrying out the program;
- Access behavioral health services to meet the needs of older adults in aging services programs who need them;
- Access home and community-based, non-medical, aging support services to meet the needs of older adults in behavioral health services programs who need them;
- Identify at-risk older adults in the community who are not connected to the service delivery system and those who encounter difficulties accessing needed services. Mobile outreach and off-site Services are to be used assess unmet needs for behavioral health and aging services – as well as unmet needs related to areas such as physical health, cognition, social isolation, self-neglect, abuse, housing, financial resources/benefits, and legal issues – and see that needed services are provided; and
- Utilize one or more technological innovations to better serve the target population and help the program and its staff innovatively address the unmet needs of the target population.

This new round of projects will continue to emphasize the necessity for integrated service delivery that has been characteristic of the previous health integration projects. Additional information about the partnership innovation projects can be accessed on the OMH website.

Accountability and Ensuring High Quality of Care

OMH maintains a strong emphasis on continuous quality improvement efforts, from a clinical and a systems perspective, through the use of data and information to measure outcomes and support the implementation of evidence-based treatments.

OMH Data Portals: The OMH data portals are designed to improve accountability and transparency in New York State government by allowing anyone to use OMH data to make more informed choices about services that best meet their needs and to assess the progress the agency is making toward improving public mental health care. An addition to the OMH menu of data reports is the County Capacity and Utilization Data Book, which is updated annually with the most recent Medicaid, licensing, and surveillance data including SPARCS. This tool's purpose is to help users identify the location and utilization patterns for these psychiatric services to further assist in planning improved service delivery.

Health Information Exchange: OMH is working with DOH to connect OMH providers to information hubs in their region of the State. These Regional Health Information Organizations (RHIOs) collect health record data from the healthcare providers in their area, and, with patient consent, allow this information to be shared securely with other providers. Both individuals and their providers, when securely connected to the health exchange will have complete, accurate, and private access to the information carefully gathered by each one of the specialists

the individual has visited. Fewer mistakes will be made, fewer tests repeated, and money and time will be saved on administrative details. Most importantly, the individual and doctor will have more time together to discuss treatment options and recovery.

Center for Practice Innovations: Stemming from OMH's research efforts and the affiliation between OMH's New York State Psychiatric Institute and Columbia University, the Center for Practice Innovations (CPI) assists OMH in promoting the widespread availability of evidence-based practices to improve mental health services, ensuring accountability, and promoting recovery-oriented outcomes.

MyPSYCKES: MyPSYCKES is an innovative Web-based portfolio of reports and tools developed by OMH to promote active participation by consumers in their treatment and recovery. MyPSYCKES includes three major components: the My Treatment Data portal, which allows Medicaid beneficiaries to view and comment on their treatment history; a Learning Center, which provides access to educational materials and recovery tools; and CommonGround, a shared decision-making tool.

E. Planning for Developmental Disability Services

The New York State Office for People With Developmental Disabilities (OPWDD) is undergoing a large scale transformation, reflective of the desires and expectations of individuals with developmental disabilities and parents of children with disabilities. The goals embodied in OPWDD's system transformation are designed to ensure that each person is better understood, better served and ultimately experiences better outcomes and community participation to the greatest extent possible. Achieving such transformational goals will require coordination between local and state planning efforts. The following sections outline a variety of initiatives and partnerships designed to enhance quality and the overall experience for people seeking support and receiving services.

System Transformation

The Office for People With Developmental Disabilities has been engaged in a system-wide transformation, aimed at improving opportunities for individuals with developmental disabilities in the areas of employment, integrated living, and self-direction of services. These goals are captured in the Transformation Agreement between New York State OPWDD and the Centers for Medicare & Medicaid Services. OPWDD has made great strides in accomplishing many of these transformation goals and continues to work towards fully implementing the Transformation Agenda. In 2015 the Transformation Panel was established to bring together experts and stakeholders, including individuals with developmental disabilities, their families and provider agencies. The panel was charged with developing a clear vision and strategy for implementing the transformation agenda.

Transformation Panel: OPWDD established the Transformation Panel to consider the future of OPWDD services and address essential questions facing the agency. The panel brought together a diverse group of stakeholders and involved the public through a series of forums held across New York State to promote meaningful dialogue, discussion and input. Their goal was to find ways to make the benefits of the transformation available to each person served through the OPWDD system by providing greater flexibility, more options, and an increased level of personal choice.

The Transformation Panel issued sixty-one recommendations touching on nearly every aspect of the service system, from expanding residential services to streamlining regulations. The purpose of the recommendations was to help transform OPWDD's system of supports to be more responsive, inclusive, and person-centered while building on the positive aspects of the existing system. The feedback of OPWDD's stakeholders was incorporated in the development of the Transformation Panel's recommendations and with the guidance of the Transformation Panel, OPWDD released a report entitled *Raising Expectations, Changing Lives*. This report was the culmination of the findings of this statewide panel, which worked to identify the challenges OPWDD needed to address, and the opportunities that could be seized upon to help people live the fullest lives possible in the community, as citizens, neighbors and friends.

Enhancing Service Design and Delivery

Coordinated Assessment System: The Coordinated Assessment System (CAS) is a comprehensive needs assessment tool, designed to evaluate the strengths and needs of individuals with developmental disabilities, and inform the development of person-centered support plans. OPWDD began assessing people with the CAS in March 2016. People receiving assessments, their families, and providers will use the information from the CAS to help develop their support plan to match his/her interests, goals and needs. Individual choice, among available options, will continue to be at the heart of service planning. The CAS is an essential part of the changes OPWDD is making to better support people receiving services.

New York Systemic, Therapeutic, Assessment, Respite and Treatment (NY START) Services: OPWDD partnered with leaders at the Center for START Services in July 2012 to develop a START model for New York State. NY START is a community-based program that provides crisis prevention and response services to children and adults who present with complex behavioral and mental health needs. START supports people to live successfully in the community by offering training, consultation, therapeutic services, and technical assistance to enhance the ability of the community to support eligible people, and focuses on establishing integrated services with providers. The START Model has been in operation in the Western/Finger Lakes region and the Capital District/Taconic/Hudson Valley region for approximately two years and has recently expanded to NYC. In October 2016, the NYC START program began to take referrals from OPWDD's regional office. A vendor for a START team in Long Island has been identified and staff hiring and training will be initiated in the first half of 2017. OPWDD plans to have operational START teams across the entire state delivering all of the elements of the national model in each OPWDD region.

Enhancing Self-Direction: Self-direction offers an opportunity for people to have a high level of control over how, when, and by whom their supports are delivered. Individual choice for a self-directed service delivery model has grown considerably over the last several years. In response to stakeholder input, OPWDD has identified areas where improvements can be made to the self-direction model to focus on increased capacity building for the broker and fiscal intermediary (FI) functions, and to increase access and education for a greater understanding of options available within the system.

To increase understanding of self-direction options, OPWDD has focused on the development of enhanced training courses for self-direction support staff, updates and improvement to the website content related to self-direction, development of guidance regarding live-in caregivers, and the initiation of quarterly conferences with agencies who provide self-direction support.

Employment: OPWDD remains committed to helping people with developmental disabilities find work in community-based settings. Increasing integrated employment opportunities for people who receive OPWDD services is a critical strategic goal for the agency identified through the Transformation Panel's recommendations. Five major areas have been identified to reach these employment goals including developing flexible day service models, more volunteer opportunities, improving transportation, workshop transformation, and engaging employers to hire people with disabilities.

For people who are currently employed through sheltered workshops, OPWDD is developing strategies to ensure continuity of employment by assisting workshop providers as they transition to offering other services. OPWDD spent nearly three years engaging individuals, families, and providers regarding the conversion of sheltered workshops to integrated, community-based businesses. OPWDD issued guidance to workshop providers to ensure that person-centered planning is incorporated into this transition from workshops to other services. OPWDD's *Work Settings Report* lays out a comprehensive plan to assist individuals currently working in sheltered workshop programs, as the programs transition to integrated work settings, (consistent with federal requirements). Additionally, the report provides a plan to meet the needs and goals of people who choose not to transition to community-based integrated work settings.

Residential Opportunities: Housing options throughout the OPWDD system range from rental support for an independent apartment, to group homes specialized in around-the-clock supervision. OPWDD is working to advance its housing strategies to better respond to demand and changing models of support that can be more

tailored to the individual. It is OPWDD's priority that individuals are served in the most integrated setting, and are able to live with the highest degree of independence possible.

OPWDD has made major strides in reducing the number of individuals living in institutional settings. These efforts continue through the closure of developmental centers (DCs) and the conversion of Intermediate Care Facilities (ICFs) to community-based models of support. Residents in these institutionally-modeled facilities are offered the opportunity to live in the most community integrated setting possible, and be served in the community with appropriate clinical support to ensure their health and safety.

During 2017, OPWDD will continue to define how its largest ICFs will be supported to downsize and close, so that all residents of ICFs can be supported in individualized ways in community settings. To help support this transition, OPWDD established a funding policy and guidance to assist nonprofit providers to convert ICFs into residential models which offer greater community access and integration. This plan does not apply to Children's Residential Projects which serve to prevent children from out of state placements and other less suitable institutional placements.

Home and Community Based Services (HCBS) Settings Transition Plan

OPWDD's Home and Community Based Services (HCBS) Settings Transition Plan is part of the broader NYS transition plan, required by CMS, that reinforces the values of integration, personal choice, and independence throughout OPWDD's waiver supports and services.

The plan focuses on how OPWDD assesses the quality of our service system and ensures that each person is afforded full rights and options for community life. This plan must be implemented no later than October 1, 2018. To ensure proper implementation, OPWDD is taking the following actions:

- Working with stakeholders, including people who receive services, to capture their perspectives and insights;
- Reviewing regulations and policies to identify where changes are needed;
- Changing regulations, such as adopting person-centered planning requirements;
- Creating assessment tools to determine gaps and monitor our standards in certified settings; and
- Designing communication and training tools including a web-based HCBS Settings Toolkit and quality improvement tools for providers.

The OPWDD HCBS Settings Transition Plan activities will help to ensure that all people enjoy the highest quality of life possible based on their personal needs, goals and preferences. The Plan will help to sustain and improve the entire system of community-based services and supports.

Enhancements to service design and delivery will:

- Help people thrive in communities and live the fullest life possible;
- Increase independence, self-determination, and choice for all people supported;
- Provide more flexibility in supports to people in the community to do the things they want to do, in the places they want to do them, and live and work where they want to;
- Enable service providers to better respond to changing needs and preferences;
- Support goal achievement and personal outcomes; and
- Instill a greater level of quality and accountability.

Strengthening the Direct Support Workforce

The stability of the Direct Support Professionals (DSP) in the OPWDD workforce is critical to the success of the system transformation. Support for DSPs and the important role they play in supporting people is an essential

element in quality outcomes. OPWDD is investing in the workforce to ensure staff have the tools and support they need to excel at the important work they do supporting individuals with developmental disabilities.

Positive Relationships Offer More Opportunities to Everyone (PROMOTE): OPWDD developed a new curriculum called PROMOTE (Positive Relationships Offer More Opportunities to Everyone) which trains DSP staff to emphasize positive relationships and strategies to support people with developmental disabilities; and offers the opportunity for increasing skills needed for success through this training for employees and supervisors.

Direct Support Professional Core Competencies: To advance the skills and abilities of direct support professionals, the New York State Direct Support Professional (DSP) Core Competencies were created. The core competencies are areas of focus for delivering high quality services, are based on nationally validated community support skill standards, and center on the belief that knowledge, skills and ethics are the foundation of quality. Staff supervisors are being provided training and other tools to ensure all DSPs are proficient in the core competency areas.

Direct Support Professional (DSP) credentialing program: In January 2016, OPWDD presented a study of service providers and a model for a DSP Credential to the NYS Legislature. The report explained how a DSP credential would help stabilize the workforce, professionalize the work, close the wage gap, and improve the skills and abilities of the workforce. In August 2016, the NYS Credential Stakeholder Advisory Group was reconvened to strategize on how to advance a credential program in New York the full report and its findings are available: Direct Support Professional Credentialing Report

CHAPTER 3: County Plan Guidance and Forms

The mental hygiene local services planning process is an ongoing, data-driven process that engages providers, individuals with disabilities, and other stakeholders in identifying local needs and developing strategies to address those needs. As noted in Chapter 1 of these guidelines, Mental Hygiene Law requires each LGU to annually develop a local services plan that establishes long-range goals and objectives consistent with statewide goals and objectives. The law also requires that each agency's statewide comprehensive plan be formulated from the LGU comprehensive plans. In addition to meeting statutory mandates, LGUs are required to comply with other requirements that support statewide planning efforts. This chapter provides guidance to assist counties in meeting those requirements.

The Needs Assessment Form and Priority Outcomes Form have been integrated this year into the 2018 Goals and Objectives Form to better reflect the sweeping transformational changes toward integrated care in the physical and behavioral health care sectors. It will also give local planners the opportunity to streamline and link their needs and initiatives with their goals and objectives. The form addresses changes in overall needs and in planning goals and objectives to address those needs.

Data from the 2017 Needs Assessment Form and Priority Outcomes Form will **not** be bought forward in the Goals and Objectives Form but there will be the capability to attach documents and insert narrative. We encourage counties to also take advantage of the Executive Summary Form for added narrative and description of local demographics and need assessments. This year, there is an OMH Agency Planning Form which includes questions regarding Criminal Procedure Law 730 and Local Administration of Assisted Outpatient Treatment. OASAS continues to collect the LGU's Emergency Manager Contact Information and the Multiple Disabilities Considerations Form is discontinued. For 2018, we are requesting that LGUs maintain the Alcohol and Substance Abuse (ASA), Mental Health (MH), and Developmental Disabilities (DD) Sub-Committee Rosters in CPS. The New York City and LGU Community Service Board Rosters will continue to be maintained and data will be bought forward from plan year 2017 in these forms.

All plans must be completed, certified, and submitted in CPS by Thursday June 1, 2017.
Questions, problems or concerns regarding planning forms or the County Planning System (CPS) may be directed to Marialice Ryan at 518-485-0506 or Marialice.Ryan@oasas.ny.gov.

A. Mental Hygiene Goals and Objectives Form

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 Goals and Objectives Form is being introduced in plan year 2018 to better streamline and integrate local needs and priorities. The 2018 plan cycle is the tenth year of a fully integrated mental hygiene services planning process and the Goals and Objectives Form continues to facilitate a more person-centered planning process that focuses on cross-system collaboration. The form is designed to provide counties with the opportunity to base their goals and objectives in three categories; needs assessment, state initiatives and other.

Developed goals can be aligned with relevant statewide and regional health planning initiatives or based on high need for services. Goals can also be developed in other areas that do not fall into the first two categories. There will be opportunity to insert background information on each goal and change or progress recorded over the last 12 months.

Instructions for completing the Goals and Objectives Form

The first section of the Goals and Objectives Form asks LGUs to identify if their overall local needs for each disability have changed over the last year. Local needs generally do not change significantly from one year to the next. Years of planning, policy change and action are required for real change. In an effort to assess what changes may be happening more rapidly across the state, these questions were included in the 2017 Needs Assessment Form. 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.

1. Overall Needs Assessment by Population (Required)
Please explain why or how the overall needs have changed and the results from those changes.

a. Indicate how the level of unmet **mental health service needs**, in general, has changed over the past year:
○ Improved ○ Stayed the Same ○ Worsened
Please Explain: [ ]

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

c. Indicate how the level of unmet needs of the **developmentally disabled** population, in general, has changed in the past year:
○ Improved ○ Stayed the Same ○ Worsened
Please Explain: [ ]

The 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. <u>Goals Based On Local Needs</u>-

Please select any of the categories below for which there is a **high level of unmet need** for the 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 Adult Services			☐
t) Developmental Disability Student/Transition Services			☐
u) Developmental Disability Respite Services			☐
v) Developmental Disability Family Supports			☐
w) Developmental Disability Self-Directed Services			☐
x) Autism Services			☐
y) Developmental Disability Person Centered Planning			☐
z) Developmental Disability Residential Services			☐

aa) Developmental Disability Front Door			☐
ab) Developmental Disability Service Coordination			☐
ac) Other Need (Specify in Background Information)	☐	☐	☐

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

Background Information – (Required) 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), and
- 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.

BACKGROUND INFORMATION: ☐

[FOR EACH ISSUE CATEGORY CHECKED ABOVE] Do you have a Goal related to addressing this need?
○Yes ○No

Goal Statement – The following section will prompt for a goal statement for each Issue Category indicated as high need. (*If you do NOT have a goal statement for the selected need category: Indicate No when prompted and enter MANDATORY explanation of challenges).* 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. The following are examples of possible Goal Statements:

Example #1: Increase access to affordable housing with support services for people with behavioral health disorders.

Example #2: Build and strengthen connections between children's primary care and mental health provider systems.

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

If "Yes", state Goal: ☐

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.

CHANGE OVER PAST 12 MONTHS: ☐ Optional

Priority Goal? - Not all goals are of equal value. When the state agencies analyze individual county goals, or objectives on a regional or statewide basis, there has to be a way to provide relative weight to them. After all goals and objectives have been entered onto the form and you are ready to certify the form for submission, you will need to indicate five priority goals. You do not have to rank priorities by disability. If the plan contains fewer than six goals, all goals will be priority. You will not be able to certify this form until you have indicated your five

priority goals. Please identify five goals from all goals listed in questions 2, 3, and 4 as "Priority Goals"- those goals which are the most significant in your county.

PRIORITY GOAL? Only can select "Yes" for five goals ○Yes ○No

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?"

Example #1: Reduce the number of people waiting for acceptance to supported housing by 25 percent in 2018

Example #2: School-based clinic satellites will be established in the three largest districts in the county.

OBJECTIVE: [ ] At least one is required for each goal; add more as necessary

+ Add an additional objective

Applicable State Agency – You will already have selected the applicable state agency when you select the need category for the linked goal. For *each objective* please indicate the state mental hygiene agency to which the objective pertains.

☐ OASAS
☐ OMH
☐ OPWDD

3. Goals Based On State Initiatives –

The next section includes goals that are based on behavioral health state initiatives. Please select any of the State Initiatives below for which your LGU has a related goal. For each State Initiative identified you will be asked if you have a goal. If you DO have a goal, you will be asked to state your related goals and objectives. *If you DO NOT have a goal, you will be REQUIRED to explain.* **You will be limited to one goal for each state initiative category but will have the option for multiple objectives.**

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

(After state initiative category is selected background information, goal text box, change over last 12 months and priority goal? will display)

BACKGROUND INFORMATION: [ ] REQUIRED
GOAL: [ ]
No? Explain REQUIRED
CHANGE OVER PAST 12 MONTHS: [ ] Optional
PRIORITY GOAL: Only can select "Yes" for five goals ○Yes ○No

OBJECTIVE: [ ]

APPLICABLE STATE AGENCY:
☐ OASAS
☐ OMH
☐ OPWDD

+ Add an additional objective

4. Other Goals –

This section should include any additional Mental Hygiene goals for your LGU not addressed in questions 2 or 3 above. Optional

+ Add a Goal
GOAL: ☐
BACKGROUND INFORMATION: ☐ REQUIRED
CHANGE OVER PAST 12 MONTHS: ☐ Optional
PRIORITY GOAL: Only can select "Yes" for five goals ○ Yes ○ No

OBJECTIVE: ☐
+ Add an additional objective

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

(end of survey)

Glossary of Terms Used on this Form

Cross-Systems Need Definitions by Disability
For some definitions please refer directly to the linked content for explanations.

Housing:

OASAS: OASAS-funded permanent supportive housing services that include one and two-bedroom apartments with support services necessary to assist families in gaining stability, daily life skills and marketable work skills, with supportive services to help families maintain physical and emotional health, assist with educational and employment opportunities, and sustain healthy relationships and quality of life. May also include non-OASAS funded short-term transitional housing options for individuals leaving substance use disorder treatment.

OMH: Residential services are provided to maximize access to housing opportunities, particularly for persons with histories of repeated psychiatric hospitalizations, homelessness, involvement with the criminal justice system, and co-occurring substance abuse. They are also provided to persons leaving adult homes and to persons receiving court-ordered Assisted Outpatient Treatment. Residential services are also offered to children to provide short-term residential assessment, treatment, and aftercare planning.

Residential services include support programs (community residence single room occupancy (CR-SRO), support apartment, support congregate), treatment programs (community residence for children and youth, treatment apartment, treatment congregate) and unlicensed housing (supported housing, supported/single room occupancy (SP-SRO)). Visit OMH's Mental Health Program Directory for a full description of each housing type.

Transportation:

OASAS: The ability of individuals involved in the substance use disorder service system to get to SUD treatment services, as well as other needed health care services, school, work, training, or other destinations necessary to support their treatment and recovery.

OPWDD: The ability of individuals involved in the OPWDD service system to get to supports and services, as well as other needed health care services, school, work, training, or other destinations necessary to enjoying a full life.

Crisis Services:

OASAS: OASAS-certified chemical dependence withdrawal and stabilization services (Part 816), including medically managed withdrawal, medically supervised withdrawal (inpatient or outpatient), and medically monitored withdrawal services. May also include non-OASAS certified hospital-based detoxification services.

OMH: Residential and non-residential services to reduce acute symptoms and restore individuals to pre-crisis levels of functioning. These services include crisis intervention, crisis residence, crisis/respite beds, and Home-Based Crisis Intervention (HBCI). Visit OMH's Mental Health Program Directory for a full description of each crisis service type.

OPWDD: http://www.opwdd.ny.gov/ny-start/home

Workforce Recruitment and Retention (service system):

OASAS: The ability of OASAS-certified and funded prevention and treatment programs to effectively provide high quality, qualified, trained, and culturally competent services to individuals suffering from a substance use disorder and their families. This does not refer to recruiting and retaining LGU staff or vocational services for clients.

OMH: The ability of mental health program programs to staff appropriately to offer high quality, culturally competent services that comply with regulatory and payment requirements.

OPWDD: The ability of OPWDD and provider agencies to offer high quality, qualified, trained, and culturally competent services to individuals with developmental disabilities and their families.

Employment/ Job Opportunities (clients):

OASAS: Vocational services and assistance available and accessible for substance use disorder treatment clients.

OMH: Vocational services and integrated, competitive employment opportunities for individuals with mental illness.

OPWDD: http://www.opwdd.ny.gov/opwdd_services_supports/employment_for_people_with_disabilities

Prevention Services:

OASAS: Can be either:

a) OASAS-funded primary prevention services, which may include service approaches such as: prevention education, environmental strategies, community capacity building, positive alternatives, and information awareness; or other prevention services such as prevention counseling and early intervention services; or

b) A public health approach to preventing and reducing substance use and related consequences, as well as Mental, Emotional and Behavioral (MEB) disorders, which focuses on population-wide prevention of health problems and promotion of healthy living.

OMH: Primary, secondary, or tertiary prevention strategies; including but not limited to the interventions and strategies identified under the NYS Department of Health Prevention Agenda: https://www.health.ny.gov/prevention/prevention_agenda/2013-2017/plan/mhsa/ebi/

Inpatient Treatment Services:

OASAS: OASAS-certified chemical dependence inpatient rehabilitation services (Part 818) and chemical dependence residential rehabilitation services for youth (Part 817).

OMH: Inpatient services provide stabilization and intensive treatment and rehabilitation with 24-hour care in a controlled environment. They are the programs of choice only when the required services and supports cannot be delivered in community settings. Inpatient service settings include State Psychiatric Centers (PCs), psychiatric unit(s) of general hospitals (Article 28 hospitals), private psychiatric hospitals (Article 31 hospitals), or residential treatment facilities (RTFs) for children and youth. Visit OMH's Mental Health Program Directory for a full description of each inpatient service setting.

Recovery and Support Services:

OASAS Services that help to support recovery from a substance use disorder that are not tied to housing and that are in addition to transportation. May include educational and vocational services, peer support services, and services provided by OASAS Recovery Centers or clubhouses

OMH: This category refers to recovery, recreation, self-help, advocacy, outreach, and general support services. This may include adult and children's behavioral health home and community based services.

Reducing Stigma:

OASAS: Stigma refers to a cluster of negative attitudes and beliefs that motivate the general public to fear, reject, avoid, and discriminate against people with substance use disorders. Needs in this category include efforts to educate and raise awareness about addiction and to reduce the stigma associated with this disease.

OMH: OMH recognizes that stigma has no place in our society today that presenting the facts about mental illness can change attitudes. Needs in this category include conducting educational programs and services dedicated to eliminating the stigma attached to mental illness and reducing the fear and cultural obstructions that lead some people to hide their mental illness or avoid seeking help all together.

Other: Any need not mentioned in the above categories.

SUD-Specific Need Definitions

SUD Outpatient Treatment Services: OASAS-certified treatment programs that provide outpatient services that assist individuals suffering from a substance use disorder and their family members and/or significant others (Part 822). May also provide outpatient rehabilitation services designed to assist individuals with more chronic conditions. May also include outpatient chemical dependency services for youth (Part 823).

SUD Residential Treatment Services: OASAS-certified treatment programs that provide 24/7 structured treatment/recovery services in a residential setting. Programs may provide residential stabilization, rehabilitation, and/or reintegration services in congregate or scatter-site settings (Part 820). May also include intensive residential rehabilitation, community residential, and supportive living services (Part 819).

Heroin and Opioid Programs and Services: Can refer specifically to a) OASAS-certified treatment programs that are approved to administer methadone or other approved medications to treat opioid dependency (OTP programs), including opioid detoxification, opioid medical maintenance, and opioid taper services; or more

generally to b) any other needs related to the heroin and opioid crisis besides OTP services such as overdose prevention or community opioid abuse coalitions.

Coordination/Integration with Other Systems for SUD clients: The need to coordinate services with other systems that individuals with a substance use disorder may be involved with, including mental health, developmental disabilities, public health, social services, criminal justice, education, etc. Also refers to engagement in regional and statewide initiatives such as DSRIP, PPS, PHIP, Prevention Agenda, RPC, etc. In addition, can refer to coordination between SUD service providers.

Mental Health Services:

Mental Health Clinic: Clinic treatment programs provide treatment designed to minimize the symptoms and adverse effects of illness, maximize wellness, and promote recovery. Clinic treatment programs for adults provide the following services: outreach, initial assessment (including health screening), psychiatric assessment, crisis intervention, injectable psychotropic medication administration, psychotropic medication treatment, psychotherapy services, family/collateral psychotherapy, group psychotherapy, and complex care management. The following optional services may also be provided: developmental testing, psychological testing, health physicals, health monitoring, and psychiatric consultation.

Clinic treatment programs for children provide the following services: outreach, initial assessment (including health screening), psychiatric assessment, crisis intervention, psychotropic medication treatment, psychotherapy services, family/collateral psychotherapy, group psychotherapy, and complex care management. The following optional services may also be provided: developmental testing, psychological testing, health physicals, health monitoring, psychiatric consultation, and injectable psychotropic medication administration.

Other Mental Health Outpatient Services (non-clinic): Non-clinic outpatient services provide treatment and rehabilitation in settings such as partial hospital programs, day treatment, Assertive Community Treatment (ACT), and Personalized Recovery-Oriented Services (PROS). Visit OMH's Mental Health Program Directory for a full description of each outpatient service type.

Mental Health Care Coordination: Services include Health Home Care Management, Health Home Non-Medicaid Care Management and Non-Medicaid Care Coordination. Visit OMH's Mental Health Program Directory for a full description of each care coordination type.

Developmental Disability Services:

For some definitions please refer directly to the linked content for explanations.

Developmental Disability Clinical Services:
http://www.opwdd.ny.gov/opwdd_resources/information_for_clinicians

Developmental Disability Children Services: http://www.opwdd.ny.gov/opwdd_services_supports/children

Developmental Disability Adult Services: Refers to the supports and services available to adults with developmental disabilities. This includes OPWDD's ability to support aging adults live a high quality life.

Developmental Disability Student/Transition Services:
http://www.opwdd.ny.gov/opwdd_services_supports/children/transition-students-developmental-disabilities

Developmental Disability Respite Services:
http://www.opwdd.ny.gov/opwdd_services_supports/supports_for_independent_and_family_living/respite_services

Developmental Disability Family Supports:
http://www.opwdd.ny.gov/opwdd_services_supports/supports_for_independent_and_family_living

Developmental Disability Self-Directed Services: http://www.opwdd.ny.gov/selfdirection

Autism Services: http://www.opwdd.ny.gov/opwdd_community_connections/autism_platform

Developmental Disability Person Centered Planning:
http://www.opwdd.ny.gov/opwdd_services_supports/person_centered_planning

Developmental Disability Residential Services:
http://www.opwdd.ny.gov/opwdd_services_supports/residential_opportunities

Developmental Disability Service Coordination:
http://www.opwdd.ny.gov/opwdd_services_supports/service_coordination

B. 2018 Office of Mental Health Agency Planning Survey

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

   ☐ a) Mental hygiene/community services

   ☐ b) Sheriff/county law enforcement

   ☐ c) Other

   If "other" please indicate how these charges are budgeted

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

2. **For Local Administration of the Assisted Outpatient Treatment Program (AOT):**

   a) Please describe the system used in your locality to ensure that petitions are filed for individuals requiring Assisted Outpatient Treatment and,

   b) Please describe the system used in your locality to ensure that such individuals requiring Assisted Outpatient Treatment receive the services included in the AOT treatment plan.

   c) Please list the Care Management Programs your Single Point of Access (SPOA) uses to assign AOT referrals.

   Questions regarding this survey item should be directed to Rebecca Briney at Rebecca.Briney@omh.ny.gov or 518-402-4233.

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(end of survey)

C. Community Services Board Roster (New York City)

Community Services Board Chair:

Name: _____ Name: _____

☐ Physician ☐ Psychologist ☐ Physician ☐ Psychologist

Represents: _____ Represents: _____

NYC Borough: _____ NYC Borough: _____

Term Expires: Month _____ Year _____ Term Expires: Month _____ Year _____

Email Address: _____ Email Address: _____

Name: _____ Name: _____

☐ Physician ☐ Psychologist ☐ Physician ☐ Psychologist

Represents: _____ Represents: _____

NYC Borough: _____ NYC Borough: _____

Term Expires: Month _____ Year _____ Term Expires: Month _____ Year _____

Email Address: _____ Email Address: _____

• • •

• • •

Note: There must be 15 board members including at least two residents from each borough. Indicate if member is a licensed physician or certified psychologist. Under item labeled "Represents", enter the name of the member's organization or enter "Consumer", "Family", "Public Representative", etc. to indicate the particular community interest being represented. Members shall serve four-year staggered terms.

(End of survey)

D. Community Services Board Roster (Counties Outside NYC)

LGU: _____

Community Services Board Chair

Name: _____ Name: _____

☐ Physician ☐ Psychologist ☐ Physician ☐ Psychologist

Represents: _____ Represents: _____

Term Expires: Month _____ Year _____ Term Expires: Month _____ Year _____

Email Address: _____ Email Address: _____

Name: _____ Name: _____

☐ Physician ☐ Psychologist ☐ Physician ☐ Psychologist

Represents: _____ Represents: _____

Term Expires: Month _____ Year _____ Term Expires: Month _____ Year _____

Email Address: _____ Email Address: _____

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

(End of survey)

E. Alcoholism and Substance Abuse Subcommittee Roster

Subcommittee Chair

Name: ____________________ Name: ____________________

CSB Member: ☐ Yes ☐ No CSB Member: ☐ Yes ☐ No

Represents: ____________________ Represents: ____________________

Email Address: ____________________ Email Address: ____________________

Name: ____________________ Name: ____________________

CSB Member: ☐ Yes ☐ No CSB Member: ☐ Yes ☐ No

Represents: ____________________ Represents: ____________________

Email Address: ____________________ Email Address: ____________________

Name: ____________________ Name: ____________________

CSB Member: ☐ Yes ☐ No CSB Member: ☐ Yes ☐ No

Represents: ____________________ Represents: ____________________

Email Address: ____________________ Email Address: ____________________

Name: ____________________ Name: ____________________

CSB Member: ☐ Yes ☐ No CSB Member: ☐ Yes ☐ No

Represents: ____________________ Represents: ____________________

Email Address: ____________________ Email Address: ____________________

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

F. Mental Health Subcommittee Roster

Subcommittee Chair

Name: ______________________

CSB Member: ☐ Yes ☐ No

Represents: ______________________

Email Address: ______________________

Name: ______________________

CSB Member: ☐ Yes ☐ No

Represents: ______________________

Email Address: ______________________

Name: ______________________

CSB Member: ☐ Yes ☐ No

Represents: ______________________

Email Address: ______________________

Name: ______________________

CSB Member: ☐ Yes ☐ No

Represents: ______________________

Email Address: ______________________

Name: ______________________

CSB Member: ☐ Yes ☐ No

Represents: ______________________

Email Address: ______________________

Name: ______________________

CSB Member: ☐ Yes ☐ No

Represents: ______________________

Email Address: ______________________

Name: ______________________

CSB Member: ☐ Yes ☐ No

Represents: ______________________

Email Address: ______________________

Name: ______________________

CSB Member: ☐ Yes ☐ No

Represents: ______________________

Email Address: ______________________

Name: ______________________

CSB Member: ☐ Yes ☐ No

Represents: ______________________

Email Address: ______________________

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

G. Developmental Disabilities Subcommittee Roster

Subcommittee Chair

Name: ____________________

CSB Member: ☐ Yes ☐ No

Represents: ____________________

Email Address: ____________________

Name: ____________________

CSB Member: ☐ Yes ☐ No

Represents: ____________________

Email Address: ____________________

Name: ____________________

CSB Member: ☐ Yes ☐ No

Represents: ____________________

Email Address: ____________________

Name: ____________________

CSB Member: ☐ Yes ☐ No

Represents: ____________________

Email Address: ____________________

Name: ____________________

CSB Member: ☐ Yes ☐ No

Represents: ____________________

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Name: ____________________

CSB Member: ☐ Yes ☐ No

Represents: ____________________

Email Address: ____________________

Name: ____________________

CSB Member: ☐ Yes ☐ No

Represents: ____________________

Email Address: ____________________

Name: ____________________

CSB Member: ☐ Yes ☐ No

Represents: ____________________

Email Address: ____________________

Name: ____________________

CSB Member: ☐ Yes ☐ No

Represents: ____________________

Email Address: ____________________

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

H. LGU Emergency Manager Contact Information

Emergency Manager Contact information is necessary in order for OASAS to communicate directly with each LGU and OASAS-certified treatment programs to ensure proper planning and preparedness during emergency situations. A rapid and coordinated response to an emergency is necessary to ensure the safety of staff and patients and continuity of care. The information entered here will be maintained in CPS until it can be incorporated into the OASAS Provider Directory System (PDS) where other program contact information is maintained.

We are asking this survey to be completed by **Thursday, June 1, 2017**. All questions regarding this survey should be directed to Kevin Doherty, OASAS Emergency Manager, at (518) 485-1983, or at Kevin.Doherty@oasas.ny.gov.

First Name:

Last Name:

Job Title:

Email Address:

Main Work Phone:

Desk Work Phone:

Home Phone:

Mobile Phone:

NOTE: To ensure privacy, home and mobile phone numbers will not be displayed in CPS output reports.

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

(End of survey)

I. Local Services Planning Assurance Form

LGU: _____

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

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

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

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

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

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

CHAPTER 4: OASAS Provider Plan Guidance and Forms

The local services planning process for addiction services relies on the partnership between OASAS, the LGUs, and OASAS-funded and certified providers. The involvement of providers and other stakeholders in the local planning process is necessary to ensure that community needs are adequately identified, prioritized, and addressed in the most effective and efficient way.

Providers are expected to participate in the local services planning process and to comply with these plan guidelines. Each provider must have at least one person with access to the OASAS online County Planning System (CPS) in order to complete the required planning forms that help to support various OASAS initiatives. Please refer to Chapter One of these guidelines for additional information about CPS and the appropriate user roles for provider staff.

This year, providers are once again being asked to complete a limited number of planning surveys that provide OASAS with important information in support of a variety of programming, planning, and administrative projects. Some surveys are repeated in order to show changes over time, while other surveys are new. In every case, the information being requested is not collected through existing data reporting systems. Some surveys are to be completed at the provider level on behalf of the entire agency, while other surveys are to be completed at the program level. In all cases, the provider should make sure that the surveys are completed by staff in a position to provide accurate and reliable information, or who can coordinate with appropriate staff within the agency to obtain the information.

All provider surveys must be completed in CPS no later than **Monday, April 3, 2017**. Each survey includes the name and contact information of the OASAS staff person responsible for that survey and who can answer any questions you have about it. Each survey in CPS also contains a link back to the relevant section of the plan guidelines associated with that survey.

Each of the following surveys includes a brief description of its purpose and the intended use of the data collected. All questions included in the survey (including skip patterns and follow-up questions built into the CPS version) and definitions of certain terms used in the survey are shown.

A. Health Coordination Survey (Treatment Providers)

Under New York State regulations, providers certified under the following parts are required to "have a qualified individual designated as the Health Coordinator who will ensure the provision of education, risk reduction, counseling and referral services to all patients regarding HIV and AIDS, tuberculosis, hepatitis, sexually transmitted diseases, and other communicable diseases":

- Chemical Dependence Residential Rehabilitation Services for Youth (Part 817)
- Chemical Dependence Inpatient Rehabilitation Services (Part 818)
- Chemical Dependence Residential Services (Part 819)
- Residential Services (Part 820)
- Non-Medically Supervised Chemical Dependence Outpatient Services (Part 821)
- Chemical Dependence Outpatient and Opioid Treatment Programs (Part 822)

Regulatory requirements regarding Health Coordinators and comprehensive treatment plans are defined for each chemical dependence treatment service category in the Official Compilation of the Codes, Rules and Regulations of the State of New York. For additional information, please refer to the applicable regulations located on the OASAS Website.

The **Health Coordination Survey** documents compliance with OASAS regulations and, for those programs that are funded by OASAS, additionally documents requirements of the Federal Substance Abuse Prevention and Treatment (SAPT) Block Grant. Early HIV Intervention Services (EIS), which under the SAPT Block Grant must be provided on site of chemical dependence treatment, are defined as: pre- and post-test counseling for HIV,

the actual testing of individuals for the presence of HIV and testing to determine the extent of the deficiency in the immune system, and the provision of therapeutic measures to address an individual's HIV status. OASAS has determined that Health Coordinators and OTP comprehensive treatment planning provide EIS.

All questions on this form should be answered as they pertain to each program operated by this agency. The responses to this survey should be coordinated to ensure accuracy of responses across all programs within the agency. We are asking that the survey be completed by **Monday, April 3, 2017**. Any questions related to this survey should be directed to Matt Kawola by phone at 518-457-6129, or by e-mail at Matt.Kawola@oasas.ny.gov.

1. What is the overall average fringe benefit rate paid to employees by this agency? This number must be entered in number format as a percentage of salary, without the percent sign (example: 20.0).

   ☐

2. How are **health coordination** services provided to patients in each program operated by your agency? (check all that apply)

	PRU	Program Name	Paid Staff	In-kind Services	Contracted Services
a)	PRU #1	Program Name #1	☐	☐	☐
b)	PRU #2	Program Name #2	☐	☐	☐
c)	PRU #3	Program Name #3	☐	☐	☐
d)	PRU #4	Program Name #4	☐	☐	☐

3. Please provide the following information for each PRU where those paid staff and in-kind services are provided. If multiple individuals provide these services at a single program, provide the total hours worked and the hourly pay rate for each individual. For hourly pay rate, use number format without a dollar sign (example: 35.00).

			Health Coordinator #1				Health Coordinator #2			
			Services Provided		Hours/Week Worked as a Health	Hourly Rate	Services Provided		Hours/Week Worked as a Health	Hourly Rate
	PRU	Program Name	On-site	Off-site	Coordinator	(dollars)	On-site	Off-site	Coordinator	(dollars)
a)	PRU #1	Program Name #1	☐	☐			☐	☐		
b)	PRU #2	Program Name #1	☐	☐			☐	☐		
c)	PRU #3	Program Name #1	☐	☐			☐	☐		
d)	PRU #4	Program Name #1	☐	☐			☐	☐		

4. Please provide the following information for each PRU where those contracted services are provided. If multiple contracted individuals provide these services at a single program, provide the total hours worked per week and the average hourly rate paid. For dollars paid, use number format without a dollar sign (example: 35.00).

			Service Provided		Hours per Week Worked as a Health	Hourly Rate
	PRU	Program Name	On-site	Off-site	Coordinator	(dollars)
a)	PRU #1	Program Name #1	☐	☐		
b)	PRU #2	Program Name #2	☐	☐		
c)	PRU #3	Program Name #3	☐	☐		
d)	PRU #4	Program Name #4	☐	☐		

(End of survey)

B. 2018 Talent Management Survey (Treatment Providers)

It is important for OASAS to identify which licenses and certifications staff hold who perform clinical functions that are protected in statute by the Social Work and Mental Health Practitioner Scopes of Practice. Currently, all SUD treatment services operated, funded and/or certified by OASAS are exempt from the Social Work and Mental Health Practitioner scopes of practice, but since this is a temporary exemption, it is necessary for OASAS to understand how many staff are benefiting from this exemption. OASAS is also implementing a SUD Counselor Scope of Practice to mitigate the effects of the potential sunset of the exemption but it is still important to understand the number and types of Qualified Health Professionals (QHPs) in our system.

It is important to note that CASACs and CASAC-Trainees are permanently exempt from the restricted scopes of practice for the work they do in OASAS certified programs, but other certifications and certain supervisory functions may be impacted if the more general exemption were to sunset, and this data will assist OASAS in identifying these impacts. More information on these Scopes of Practice and the exemptions can be found at:

Social Workers: http://www.op.nysed.gov/prof/sw/
Mental Health Practitioners: http://www.op.nysed.gov/prof/mhp/

We are asking that the survey be completed by **Monday, April 3, 2017**. All inquiries regarding Questions 1 and 2 should be directed to Julia Fesko at 518-457-6511 or at Julia.Fesko@oasas.ny.gov. Questions 3-5 ask for Medical Personnel information and questions 6-8 address adolescent services and cultural competency. The appropriate OASAS staff contact information for each section is included.

1. **How many total clinical staff (part-time and full-time) are currently employed in all of this agency's OASAS-certified treatment programs?**

Staff Category

Clinical Staff:	**Number:**
a) Qualified Health Professional (QHP)	
b) CASAC Trainee	
c) Other Non-Qualified Health Professional	

Non-Clinical Peer Workers: (Only those solely working in this capacity)

d) Certified Recovery Peer Advocate (CRPA)	
e) Certified Addiction Recovery Coach (CARC)	
f) Other Peer Worker	

2. **The following QHPs may be impacted if and when the exemption was to sunset. Please indicate how many staff in each category your agency currently employs.**

	a) Licensed Master Social Worker (LMSW)
	b) Certified Rehabilitation Counselor
	c) Certified Therapeutic Recreation Therapist
	d) NBCC Certified Counselor

Medical Personnel

OASAS regulations require certain programs to employ a Medical Director who has a waiver to prescribe Buprenorphine and also an OASAS approved addiction specific certification. Additionally, programs may also employ other Physicians, Physician Assistants and/or Nurse Practitioners to assist Medical Directors. Please

provide information about the qualifications of your Medical Personnel so that OASAS may determine what resources and opportunities are needed for providers to attract and retain medical personnel with addiction specific competencies. Please contact Belinda Greenfield with any questions regarding survey questions 3, 4 and 5 at Belinda.Greenfield@oasas.ny.gov or 646-728-4581.

3. Please list the number of each type of Medical Personnel and their capacity to prescribe Buprenorphine.

Medical Personnel	Number		Data 2000 Waiver		Buprenorphine Capacity (30, 100, 275)	
	Part-time	Full-time	No.PT	No.FT	Current	Planned
Medical Director	☐	☐	☐	☐	☐	☐
Physician- not Medical Director	☐	☐	☐	☐	☐	☐
Physician Assistant	☐	☐	☐	☐	☐	☐
Nurse Practitioner	☐	☐	☐	☐	☐	☐

4. For each type of Medical Personnel please list their certifications and/or specialties. NOTE: If someone possesses multiple licenses or certifications, include that individual in the count under each category.

Medical Personnel	Total No.	Certification/Specialty	Total No.
Medical Director	☐	American Society of Addiction Medicine (ASAM)	☐
		American Board of Addiction Medicine (ABAM)	☐
		Board Certified in Psychiatry	☐
		Subspecialty in Addiction Psychiatry	☐
		Addiction Specialist, American Osteopathic Assoc	☐
		Other – Please list	☐
Physician not Medical Director	☐	American Society of Addiction Medicine (ASAM)	☐
		American Board of Addiction Medicine (ABAM)	☐
		Board Certified in Psychiatry	☐
		Subspecialty in Addiction Psychiatry	☐
		Addiction Specialist, American Osteopathic Assoc	☐
		Other- Please list	☐
Physician Assistant	☐	Specialties- Please list (Repeat)	☐
Nurse Practitioner	☐	Specialties- Please list (Repeat)	☐

5. Please indicate how many of your Medical Personnel plan on securing the new American Board of Preventative Medicine Addiction Medicine Certificate? (your best approximation)

Medical Personnel	Number
Medical Director	

Physician-not Medical Director ☐

Any questions regarding Numbers 6, 7 and 8 should be directed to Maria Morris-Groves at Maria.Morris@oasas.ny.gov or 518 402-2844.

6. Please select below if your agency provides the following services: Check all that apply.

Services	Yes	No
a) Gender Specific Programming	☐	☐
b) Services for Pregnant Women	☐	☐
c) Services for Individuals Aged 21 and Under?	☐	☐
d) If Yes to C, do you Offer Age Specific Groups?	☐	☐
e) Services for Youth Aged 18 and Under?	☐	☐
f) If Yes to E, do you Offer Age Specific Groups?	☐	☐
g) Services in a Language Other Than English?	☐	☐

7. How many clinical staff serving adolescents 18 and under have the following credentials, licenses, or certifications? If someone possesses multiples licenses or certifications, include the individual in the count under each category:

Professional License/Certification	No. Staff Serving 18 & U
a) Registered Professional Nurse (RN)	
b) Nurse Practitioner	
c) Psychiatrist	
d) Physician (MD or DO)	
e) Physician Assistant	
f) Clinical Nurse Specialist	
g) Licensed Master Social Worker (LMSW)	
h) Licensed Clinical Social Worker (LCSW)	
i) Licensed Psychologist	
j) Licensed Psychoanalyst	
k) Licensed Mental Health Counselor (LMHC)	
l) Licensed Marriage and Family Therapist (LMFT)	
m) Licensed Occupational Therapist	
n) Licensed Creative Arts Therapist (LCAT)	
o) Certified Rehabilitation Counselor	
p) Certified Therapeutic Recreation Therapist	
q) NBCC Certified Counselor	
r) Credentialed Alcoholism and Substance Abuse Counselor (CASAC)	
s) Credentialed Alcoholism and Substance Abuse Counselor- Trainee (CASAC-T)	
t) Certified Recovery Peer Advocate (CRPA)	
u) Certified Addiction Recovery Coach (CARC)	
v) Certified Rehabilitation Counselor	
w) Community Psychiatric Supportive Treatment Specialist	
x) Other: Please Specify:	

8. How many clinical staff serving individuals 21 and under have the following credentials, licenses, or certifications? If someone possesses multiples licenses or certifications, include the individual in the count under each category:

Professional License/Certification	No. Staff Serving 21 & U
y) Registered Professional Nurse (RN)	
z) Nurse Practitioner	
aa) Psychiatrist	
bb) Physician (MD or DO)	
cc) Physician Assistant	
dd) Clinical Nurse Specialist	
ee) Licensed Master Social Worker (LMSW)	
ff) Licensed Clinical Social Worker (LCSW)	
gg) Licensed Psychologist	
hh) Licensed Psychoanalyst	
ii) Licensed Mental Health Counselor (LMHC)	
jj) Licensed Marriage and Family Therapist (LMFT)	
kk) Licensed Occupational Therapist	
nn) Licensed Creative Arts Therapist (LCAT)	
oo) Certified Rehabilitation Counselor	
pp) Certified Therapeutic Recreation Therapist	
qq) NBCC Certified Counselor	
rr) Credentialed Alcoholism and Substance Abuse Counselor (CASAC)	
ss) Credentialed Alcoholism and Substance Abuse Counselor- Trainee (CASAC-T)	
tt) Certified Recovery Peer Advocate (CRPA)	
uu) Certified Addiction Recovery Coach (CARC)	
ww) Certified Rehabilitation Counselor	
xx) Community Psychiatric Supportive Treatment Specialist	
yy) Other:	
Please Specify:	

The Bureau of Adolescent, Women and Children's Services is interested in looking further into staff qualifications and training as it relates to the Adolescent Workforce. We are specifically, interested in learning about the educational background, skills and qualifications, and demographics of clinical staff, along with identifying training gaps and needs and other related domains. This follow-up survey will assist us in planning for future activities related to developing the Adolescent Workforce as well as assist us with a requirement of our Federal Grant from SAMHSA/CSAT - The State Youth Infrastructure Grant – T1026007-01. If you are interested, please provide us with the name and contact information with whom we can follow up.

Thank you for participating in the 2018 Mental Hygiene Local Services Planning Process by completing this survey. We appreciate and value your input on the licenses and certifications staff hold who perform clinical functions in your treatment provider agency.

Any technical questions regarding the online County Planning System Please contact the OASAS Planning Unit at 518-457-5989 or by email at oasasplanning@oasas.ny.gov.

Glossary of Terms Used on this Form

Qualified Health Professional (QHP): Any of the professionals listed in OASAS Chemical Dependence Regulations (Part 800) who are in good standing with the appropriate licensing or certifying authority, with a minimum of one year of experience or satisfactory completion of a training program in the treatment of substance use disorders.

Non-Qualified Health Professional: A member of the **clinical staff** who **does not** hold a license or certification as listed in the OASAS Chemical Dependence Regulations (Part 800). (e.g., social work intern, BSW or MSW without license, or anyone else that is not a QHP).

Credentialed Alcoholism and Substance Abuse Counselor- Trainee (CASAC-T): An individual who has a current valid CASAC-Trainee certificate issued by NYS OASAS.

Certified Recovery Peer Advocate (CRPA): A non-clinical individual certified by one of the OASAS approved CRPA Certification Boards.

Certified Addiction Recovery Coach (CARC): A non-clinical individual certified by the New York Certification Board, an entity of the Alcoholism and Substance Abuse Providers of New York State (ASAP).

Other Peer Worker: The peer support worker offers help, based on the shared understanding, respect, and mutual empowerment between people in similar situations. Peer support is a system of giving and receiving help based on key principles that include shared responsibility, and mutual agreement of what is helpful. Peer support workers engage in a wide range of activities, including advocacy, linkage to resources, sharing of their experience, community and relationship building, group facilitation, skill building, mentoring, goal setting, and more. They may also plan and develop groups, services or activities, supervise other peer workers, provide training, gather information on resources, administer programs or agencies, educate the public and policymakers, and work to raise awareness.

Licensed Master Social Worker (LMSW): An individual licensed and registered as a LMSW by the New York State Education Department.

Certified Rehabilitation Counselor: An individual certified as a rehabilitation counselor by the Commission of Rehabilitation Counselor Certification.

Certified Therapeutic Recreation Therapist: An individual certified by the National Council on Therapeutic Recreation or the American Therapeutic Recreation Association; or a person who holds a baccalaureate degree in a field allied to therapeutic recreation and, either before or after receiving such degree, has five years of full-time, paid work experience in an activities program in a health care setting.

NBCC Certified Counselor: A Counselor certified and registered as such with the National Board for Certified Counselors.

Medical Director: Each program must have a physician designated by the program sponsor to be the medical director. The medical director shall be a physician licensed and registered as such by the New York State Education Department and shall have at least one year of education, training, and/or experience in substance use disorder services. They must have a Data 2000 waiver and be certified in one of the approved addiction medicine specialties within the timeframes indicated in the OASAS Chemical Dependence Regulations (Part 800).

Data 2000 Waiver: The Drug Addiction Treatment Act of 2000 (DATA 2000) expands the clinical context of medication-assisted opioid dependency treatment. Qualified physicians are permitted to dispense or prescribe specifically approved Schedule III, IV, and V narcotic medications (medications that have a lower risk for abuse, like buprenorphine) in settings other than an opioid treatment program (OTP) such as a methadone

clinic. OTPs provide medication-assisted treatment (MAT) for people diagnosed with an opioid use disorder. Learn more about OTPs. Find information on drug scheduling from the Drug Enforcement Administration (DEA). In addition, DATA 2000 reduces the regulatory burden on physicians who choose to practice opioid dependency treatment by permitting qualified physicians to apply for and receive waivers of the special registration requirements defined in the Controlled Substances Act.

Physician (MD or DO): An individual licensed as an MD or DO by the New York State Education Department.

Physician Assistant: An individual licensed as a PA by the New York State Education Department.

Nurse Practitioner: An individual licensed as a Nurse Practitioner by the New York State Education Department.

American Society of Addiction Medicine: ASAM, founded in 1954, is a professional society representing over 4,000 physicians, clinicians and associated professionals in the field of addiction medicine. ASAM is dedicated to increasing access and improving the quality of addiction treatment, educating physicians and the public, supporting research and prevention, and promoting the appropriate role of physicians in the care of patients with addiction.

American Board of Addiction Medicine: ABAM is the nation's first medical specialty board that certifies addiction medicine physicians across a range of medical specialties. The board sets standards for physician education, assesses physicians' knowledge and requires and tracks life-long education. It is an independent specialty board established in 2007.

Board Certified in Psychiatry: The American Board of Psychiatry and Neurology, Inc. (ABPN) is a not-for-profit corporation dedicated to serving the public interest and the professions of psychiatry and neurology by promoting excellence in practice through certification and maintenance of certification processes.

Subspecialty in Addiction Psychiatry: Candidates in the subspecialty of addiction psychiatry are those in the field of psychiatry, who are seeking ABPN Board Certification. Addiction psychiatry is a subspecialty that involves focusing on evaluation and treatment of individuals with alcohol, drug, or other substance-related disorders, and of individuals with dual diagnosis of substance-related and other psychiatric disorders.

The American Osteopathic Academy of Addiction Medicine: provides osteopathic education, leadership and expertise in the field of addiction medicine. It educates the profession and the public with the highest level of prevention, early identification, treatment and recovery for individuals and families living with the disease of addiction.

American Board of Preventative Medicine Addiction Medicine Subspecialty: In March 2016, the American Board of Medical Specialties (ABMS) announced the recognition of Addiction Medicine (ADM) as a new subspecialty under the American Board of Preventive Medicine. ABPM applied to ABMS for recognition of the new subspecialty and will be the administering board for ADM. An updated **FAQ** with information on the first examination, specific eligibility criteria, and details of the application process is provided for your information.

Gender Specific Programming: Gender-specific programming is treatment such as groups or individual services that are specific to either male or female clients. Gender specific programming is important to address issues that are unique to those populations and may be easier for clients to discuss in a single gender environment.

Services for Pregnant Women: Substance abuse services for pregnant women are offered in a safe and empowering environment. Women have unique needs due to the high correlation between addiction, trauma, and domestic violence. Additionally, women face unique barriers in seeking recovery related to pregnancy, health and medical needs, safety, parenting, child welfare, treatment accessibility, family and relationships.

Services for Individuals Aged 21 and Under: Services of all levels provided to any clients who have not yet turned 22.

Services for Individuals Aged 18 and Under: Services of all levels provided to any clients who have not yet turned 19.

Registered Professional Nurse (RN): An individual licensed and registered as a Registered Professional Nurse by the New York State Education Department.

Psychiatrist: An individual licensed as an MD by the New York State Education Department and holds a current and valid board certification in Psychiatry.

Clinical Nurse Specialist: Clinical nurse specialists are advanced practice registered **nurses** who hold a master's or doctoral degree in a specialized area of **nursing** practice. Their area of **clinical** expertise may be in a: Population (e.g., pediatrics, geriatrics, women's health) Setting (e.g., critical care, emergency room

Licensed Psychologist: The practice of psychology or use of the title "psychologist" or terms "psychologist, psychology, or psychological" or any derivative thereof within New York State requires licensure as a psychologist, unless otherwise exempt under the law. To be licensed as a psychologist in New York State you must: be of good moral character; be at least 21 years of age; meet education, examination, and experience requirements. The specific requirements for licensure are contained in Title 8, Article 153, Sections 7603 and 7604 of New York's Education Law and Part 72 of the Commissioner's Regulations.

Licensed Psychoanalyst: An individual licensed as a Nurse Practitioner by the New York State Department of Education.

Licensed Mental Health Counselor (LMHC): An individual licensed and registered as a Licensed Mental Health Counselor by the New York State Education Department, including individuals with a Limited Permit Licensed Mental Health Counselor (LP-LMHC).

Licensed Marriage and Family Therapist (LMFT): An individual licensed and registered as a Licensed Marriage and Family Therapist by the New York State Education Department.

Licensed Occupational Therapist: Any use of the titles occupational therapist or occupational therapy assistant within New York State requires licensure as an occupational therapist or authorization as an occupational therapy assistant. To be licensed as an occupational therapist in New York State you must: be of good moral character; be at least 21 years of age; meet education and examination requirements

Licensed Creative Arts Therapist (LCAT): An individual licensed and registered as a Licensed Creative Arts Therapist by the New York State Education Department

Credentialed Alcoholism and Substance Abuse Counselor (CASAC): An individual who has a current valid credential issued by OASAS.

Community Psychiatric Supportive Treatment Specialist: CPST is a case management program for Medicaid-eligible children and adults. CPST provides services in the home, community and school. CPST serves as an extra support to outpatient counseling and medication management services. We strive to assist our clients in becoming as independent as possible.

Mental Hygiene Local Services Planning Process: As part of the local planning process, Local Governmental Units (LGUs) develop and annually submit a combined Local Services Plan (LSP) to all three Mental Hygiene agencies through the Mental Hygiene County Planning System (CPS). OASAS also routinely uses the local

planning process to survey Substance Use Disorder (SUD) providers on a variety of topics that help to inform the work of the agency.

C. 2018 Talent Management Survey (Treatment Programs)

It is important for OASAS to identify which licenses and certifications staff hold who perform clinical functions that are protected in statute by the Social Work and Mental Health Practitioner Scopes of Practice. Currently, all SUD treatment services operated, funded and/or certified by OASAS are exempt from the Social Work and Mental Health Practitioner scopes of practice, but since this is a temporary exemption, it is necessary for OASAS to understand how many staff are benefiting from this exemption. OASAS is also implementing a SUD Counselor Scope of Practice to mitigate the effects of the potential sunset of the exemption but it is still important to understand the number and types of Qualified Health Professionals (QHPs) in our system.

It is important to note that CASACs and CASAC-Trainees are permanently exempt from the restricted scopes of practice for the work they do in OASAS certified programs, but other certifications and certain supervisory functions may be impacted if the more general exemption were to sunset, and this data will assist OASAS in identifying these impacts. More information on the Scopes of Practice and the exemptions can be found at:

Social Workers: http://www.op.nysed.gov/prof/sw/
Mental Health Practitioners: http://www.op.nysed.gov/prof/mhp/

We are asking that the survey be completed by **Monday, April 3, 2017**. All inquiries regarding Questions 1 and 2 should be directed to Julia Fesko at 518-457-6511 or at Julia.Fesko@oasas.ny.gov. Questions 3-5 ask for Medical Personnel information and questions 6-8 address adolescent services and cultural competency. The appropriate OASAS staff contact information for each section is included.

1 How many total clinical staff (part-time and full-time) are currently employed in this OASAS-certified treatment program?

Staff Category

Clinical Staff:	**Number:**
a) Qualified Health Professional (QHP)	
b) CASAC Trainee	
c) Other Non-Qualified Health Professional	

Non-Clinical Peer Workers: (Only those solely working in this capacity)	
d) Certified Recovery Peer Advocate (CRPA)	
e) Certified Addiction Recovery Coach (CARC)	
f) Other Peer Worker	

2. The following QHPs may be impacted if and when the exemption was to sunset. Please indicate how many staff in each category your agency currently employs.

	a) Licensed Master Social Worker (LMSW)
	b) Certified Rehabilitation Counselor
	c) Certified Therapeutic Recreation Therapist
	d) NBCC Certified Counselor

3. **Each category of professional license or certification listed below is included in the list of Qualified Health Professionals (QHPs) as defined in the OASAS Part 800 Regulations. For all the part-time and full-time clinical staff/QHPs indicated in #1a above, how many possess each of the following professional licenses or certifications? NOTE: If someone possesses multiple licenses or certifications, include that individual in the count under each category.**

Professional License/Certification	No. of Staff
Clinical Staff/QHP	
a) Registered Professional Nurse (RN)	
b) Licensed Master Social Worker (LMSW)	
c) Licensed Clinical Social Worker (LCSW)	
d) Limited Permit – Licensed Master Social Worker (LP-LMSW)	
e) Licensed Psychologist	
f) Licensed Mental Health Counselor (LMHC)	
g) Licensed Marriage and Family Therapist (LMFT)	
h) Licensed Occupational Therapist	
i) Licensed Creative Arts Therapist (LCAT)	
j) Certified Rehabilitation Counselor	
k) Certified Therapeutic Recreation Therapist	
l) NBCC Certified Counselor	
m) CASAC	

Medical Personnel

OASAS regulations require certain programs to employ a Medical Director who has a waiver to prescribe Buprenorphine and also an OASAS approved addiction specific certification. Additionally, programs may also employ other Physicians, Physician Assistants and/or Nurse Practitioners to assist Medical Directors. Please provide information about the qualifications of your Medical Personnel so that OASAS may determine what resources and opportunities are needed for providers to attract and retain medical personnel with addiction specific competencies. Please contact Belinda Greenfield with any questions regarding survey questions 3, 4 and 5 at Belinda.Greenfield@oasas.ny.gov or 646-728-4581.

4. **Please list the number of each type of Medical Personnel and their capacity to prescribe Buprenorphine.**

Medical Personnel	Number		Data 2000 Waiver		Buprenorphine Capacity (30, 100, 275)	
	Part-time	Full-time	No.PT	No.FT	Current	Planned
Medical Director						
Physician-not Medical Director						
Physician Assistant						
Nurse Practitioner						

5. **For each type of Medical Personnel please list their certifications and/or specialties.**
NOTE: If someone possesses multiple licenses or certifications, include that individual in the count under each category.

Medical Personnel	Total No.	Certification/Specialty	Total No.
Medical Director		American Society of Addiction Medicine (ASAM)	
		American Board of Addiction Medicine (ABAM)	
		Board Certified in Psychiatry	
		Subspecialty in Addiction Psychiatry	
		Addiction Specialist, American Osteopathic Assoc	
		Other- Please list	
Physician- not Medical Director		American Society of Addiction Medicine (ASAM)	
		American Board of Addiction Medicine (ABAM)	
		Board Certified in Psychiatry	
		Subspecialty in Addiction Psychiatry	
		Addiction Specialist, American Osteopathic Assoc	
Other – Please list			
Physician Assistant		Specialties- Please list (Repeat)	
Nurse Practitioner		Specialties- Please list (Repeat)	

6. Please indicate how many of your Physicians plan on securing the new American Board of Preventative Medicine Addiction Medicine Certificate? (your best approximation)

Medical Personnel	Number
Medical Director	
Physician-not Medical Director	

The Bureau of Adolescent, Women and Children's Services is interested in staff qualifications and training as it relates to the Adolescent Workforce. We are specifically, interested in learning about the educational background, skills and qualifications, and demographics of clinical staff, along with identifying training gaps and needs and other related domains. Any questions regarding Numbers 7, 8 and 9 should be directed to Maria Morris-Groves at Maria.Morris@oasas.ny.gov or 518 402-2844.

7. Please select below if your program provides the following services: Check all that apply.

Services	Yes	No
a) Gender Specific Programming		
b) Services for Pregnant Women		
c) Services for Individuals Aged 21 and Under?		
d) If Yes to C, Do you Offer Age Specific Groups?		
e) Services for Youth Aged 18 and Under?		
f) If Yes to E, Do you Offer Age Specific Groups?		
g) Services in a Language Other Than English?		

8. How many clinical staff serving adolescents 18 and under have the following credentials, licenses, or certifications? If someone possesses multiples licenses or certifications, include the individual in the count under each category:

Professional License/Certification	No. Staff Serving 18 & U
a) Registered Professional Nurse (RN)	
b) Nurse Practitioner	
c) Psychiatrist	
d) Physician (MD or DO)	
e) Physician Assistant	
f) Clinical Nurse Specialist	
g) Licensed Master Social Worker (LMSW)	
h) Licensed Clinical Social Worker (LCSW)	
i) Licensed Psychologist	
j) Licensed Psychoanalyst	
k) Licensed Mental Health Counselor (LMHC)	
l) Licensed Marriage and Family Therapist (LMFT)	
m) Licensed Occupational Therapist	
n) Licensed Creative Arts Therapist (LCAT)	
o) Certified Rehabilitation Counselor	
p) Certified Therapeutic Recreation Therapist	
q) NBCC Certified Counselor	
r) Credentialed Alcoholism and Substance Abuse Counselor (CASAC)	
s) Credentialed Alcoholism and Substance Abuse Counselor- Trainee (CASAC-T)	
t) Certified Recovery Peer Advocate (CRPA)	
u) Certified Addiction Recovery Coach (CARC)	
v) Certified Rehabilitation Counselor	
w) Community Psychiatric Supportive Treatment Specialist	
x) Other:	
Please Specify:	

9. How many clinical staff serving individuals 21 and under have the following credentials, licenses, or certifications? If someone possesses multiples licenses or certifications, include the individual in the count under each category:

Professional License/Certification	No. Staff Serving 21 & U
a) Registered Professional Nurse (RN)	
b) Nurse Practitioner	
c) Psychiatrist	
d) Physician (MD or DO)	
e) Physician Assistant	
f) Clinical Nurse Specialist	
g) Licensed Master Social Worker (LMSW)	
h) Licensed Clinical Social Worker (LCSW)	
i) Licensed Psychologist	
j) Licensed Psychoanalyst	
k) Licensed Mental Health Counselor (LMHC)	
l) Licensed Marriage and Family Therapist (LMFT)	
m) Licensed Occupational Therapist	
n) Licensed Creative Arts Therapist (LCAT)	

o) Certified Rehabilitation Counselor ☐
p) Certified Therapeutic Recreation Therapist ☐
q) NBCC Certified Counselor ☐
r) Credentialed Alcoholism and Substance Abuse Counselor (CASAC) ☐
s) Credentialed Alcoholism and Substance Abuse Counselor- Trainee (CASAC-T) ☐
t) Certified Recovery Peer Advocate (CRPA) ☐
u) Certified Addiction Recovery Coach (CARC) ☐
w) Certified Rehabilitation Counselor ☐
x) Community Psychiatric Supportive Treatment Specialist ☐
y) Other: ☐
Please Specify: ☐

The Bureau of Adolescent, Women and Children's Services is interested in a follow-up survey to assist us in planning for future activities related to developing the Adolescent Workforce as well as to assist us with a requirement of our Federal Grant from SAMHSA/CSAT - The State Youth Infrastructure Grant – T1026007-01. If you are interested, please provide us with the name and contact information with whom we can follow up.

Thank you for participating in the 2018 Mental Hygiene Local Services Planning Process by completing this survey. We appreciate and value your input on the licenses and certifications staff hold who perform clinical functions in your treatment program.

Any technical questions regarding the online County Planning System Please contact the OASAS Planning Unit at 518-457-5989 or by email at oasasplanning@oasas.ny.gov.

(end of survey)

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Non-Qualified Health Professional: A member of the **clinical staff** who **does not** hold a license or certification as listed in the OASAS Chemical Dependence Regulations (Part 800). (e.g., social work intern, BSW or MSW without license, or anyone else that is not a QHP).

Credentialed Alcoholism and Substance Abuse Counselor-Trainee (CASAC-T): An individual who has a current valid CASAC-Trainee certificate issued by NYS OASAS.

Certified Recovery Peer Advocate (CRPA): A non-clinical individual certified by one of the OASAS approved CRPA Certification Boards.

Certified Addiction Recovery Coach (CARC): A non-clinical individual certified by the New York Certification Board, an entity of the Alcoholism and Substance Abuse Providers of New York State (ASAP).

Other Peer Worker: The peer support worker offers help, based on the shared understanding, respect, and mutual empowerment between people in similar situations. Peer support is a system of giving and receiving help based on key principles that include shared responsibility, and mutual agreement of what is helpful. Peer support

workers engage in a wide range of activities, including advocacy, linkage to resources, sharing of their experience, community and relationship building, group facilitation, skill building, mentoring, goal setting, and more. They may also plan and develop groups, services or activities, supervise other peer workers, provide training, gather information on resources, administer programs or agencies, educate the public and policymakers, and work to raise awareness.

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Licensed Psychologist: The practice of psychology or use of the title "psychologist" or terms "psychologist, psychology, or psychological" or any derivative thereof within New York State requires licensure as a psychologist, unless otherwise exempt under the law. To be licensed as a psychologist in New York State you must: be of good moral character; be at least 21 years of age; meet education, examination, and experience requirements. The specific requirements for licensure are contained in Title 8, Article 153, Sections 7603 and 7604 of New York's Education Law and Part 72 of the Commissioner's Regulations

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medicine specialties within the timeframes indicated in the OASAS Chemical Dependence Regulations (Part 800).

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Gender Specific Programming: Gender-specific programming is treatment such as groups or individual services that are specific to either male or female clients. Gender specific programming is important to address

issues that are unique to those populations and may be easier for clients to discuss in a single gender environment.

Services for Pregnant Women: Substance abuse services for pregnant women are offered in a safe and empowering environment. Women have unique needs due to the high correlation between addiction, trauma, and domestic violence. Additionally, women face unique barriers in seeking recovery related to pregnancy, health and medical needs, safety, parenting, child welfare, treatment accessibility, family and relationships.

Services for Individuals Aged 21 and Under: Services of all levels provided to any clients who have not yet turned 22.

Services for Individuals Aged 18 and Under: Services of all levels provided to any clients who have not yet turned 19.

Psychiatrist: An individual licensed as an MD by the New York State Education Department and holds a current and valid board certification in Psychiatry.

Clinical Nurse Specialist: Clinical nurse specialists are advanced practice registered **nurses** who hold a master's or doctoral degree in a specialized area of **nursing** practice. Their area of **clinical** expertise may be in a: Population (e.g., pediatrics, geriatrics, women's health) Setting (e.g., critical care, emergency room

Licensed Psychoanalyst: An individual licensed as a Nurse Practitioner by the New York State Department of Education.

Community Psychiatric Supportive Treatment Specialist: CPST is a case management program for Medicaid-eligible children and adults. CPST provides services in the home, community and school. CPST serves as an extra support to outpatient counseling and medication management services. We strive to assist our clients in becoming as independent as possible.

Mental Hygiene Local Services Planning Process: As part of the local planning process, Local Governmental Units (LGUs) develop and annually submit a combined Local Services Plan (LSP) to all three Mental Hygiene agencies through the Mental Hygiene County Planning System (CPS). OASAS also routinely uses the local planning process to survey Substance Use Disorder (SUD) providers on a variety of topics that help to inform the work of the agency.

D. Clinical Supervision Contact Information Form (All Treatment Programs)

The OASAS Clinical Supervision Survey should be completed by all OASAS-certified treatment programs. The goal of clinical supervision is to continuously improve client care, support ongoing staff development and, ultimately, improve client outcomes. The implementation of a strong Clinical Supervision program results in enhanced staff understanding of clinical situations, prevention of escalating clinical crises, better assessment, stronger case conceptualization, treatment strategies and discharge planning. It also provides a vehicle by which directives are followed and helps facilitate the implementation of evidence-based practices and institutional awareness.

OASAS is developing a type of “Community of Learning” for its constituency of clinical supervisors with the intention that this initiative will result in the development of a “culture” based clinical supervision practice. It will also enable OASAS to hear and respond to areas of concern, interest and ongoing assessment, collect data through ongoing survey responses, and establish clinical supervision as a fundamental and foundational element of “best practice.” Clinical supervisors will be contacted in the near future with more information on how they can become involved in the important development of this new community and how OASAS can offer technical assistance and support for this endeavor.

To ensure that the agency has the most up-to-date information, all OASAS-certified and funded treatment programs are being asked to complete the following brief survey and provide contact information for each clinical supervisor in the program. In addition to developing a culture based practice, this information will facilitate communication on relevant topics and resources to clinicians and provide clinical guidance issued by OASAS. Accordingly, clinical supervisors will have additional tools to better perform their essential role in assuring quality treatment to clients.

We are asking that the survey be completed by **Monday, April 3, 2017**. If you have any questions about this survey, please contact Brenda Harris-Collins at Brenda.Harris-Collins@oasas.ny.gov or 646-728-4673.

Thank you for taking the time to complete this survey and for your agency's role in helping us to update our information.

For each clinical supervisor employed by this program, please enter his/her name and email address. If you need to enter contact information for additional clinical supervisors, click on the **+** sign next to the first supervisor's name and a new row will open for you to enter the additional information.

	Name	Email Address	Phone Number
+			

Thank you for participating in the 2018 Mental Hygiene Local Services Planning Process by completing this survey.

Any technical questions regarding the online County Planning System Please contact the OASAS Planning Unit at 518-457-5989 or by email at oasasplanning@oasas.ny.gov

(end of survey)

E. Program Emergency Manager Contact Information Form (All Treatment Programs)

Emergency Manager Contact information is necessary in order for OASAS to communicate directly with each OASAS-certified treatment program to ensure proper planning and preparedness during emergency situations. A rapid and coordinated response to an emergency is necessary to ensure the safety of staff and patients and continuity of care. An Emergency Manager must be designated for each program site, so we are asking that contact information be provided for each PRU. The information entered here will be incorporated into the OASAS Provider Directory System (PDS) where other program contact information is maintained.

We are asking that the survey be completed by **Monday, April 3, 2017**. All questions regarding this survey should be directed to Kevin Doherty, OASAS Emergency Manager, at (518) 485-1983, or at KevinDoherty@oasas.ny.gov.

First Name:

Last Name:

Job Title:

Email Address:

Main Work Phone:

Desk Work Phone:

Home Phone:

Mobile Phone:

NOTE: To ensure privacy, home and mobile phone numbers will not be displayed in CPS output reports.

Thank you for participating in the 2018 Mental Hygiene Local Services Planning Process by completing this survey.

Any technical questions regarding the online County Planning System Please contact the OASAS Planning Unit at 518-457-5989 or by email at oasasplanning@oasas.ny.gov

(End of survey)

F. Impaired Driving Outpatient Treatment Program Survey

(Please complete survey if you are approved by OASAS to provide clinical services to Impaired Driving Offenders.)

OASAS is charged with the responsibility of compiling and maintaining an authorized listing of agencies and professionals who are determined to be capable of providing screening, assessment, and treatment of alcohol and substance use disorders for individuals charged with or convicted of an impaired driving offense in accordance with changes in the State's Vehicle and Traffic law (VTL) of 2006 and 2007 (§1198-a). The Learning and Development Unit at OASAS is distributing the Impaired Driving Outpatient Treatment Survey to gather information to be utilized in evaluating the overall implementation and processes of impaired driver services provided by OASAS certified 822 programs.

OASAS is committed to keeping roadways safe by assuring high quality service to individuals charged with or convicted of an impaired driving offense. Providers approved by OASAS to provide clinical services to impaired driving offenders are held to the "*Standards for Clinical Services Provided to Individuals Arrested for an Impaired Driving Offense"* consistent with the best practices in prevention, treatment, and recovery: https://www.oasas.ny.gov/dwi/clinicalstds.cfm. Accordingly, all clinicians treating impaired driving offenders must attend training before this service is provided. Information about the training protocol can be found on OASAS' website: https://www.oasas.ny.gov/dwi/stdstraining.cfm.

The Impaired Driving System (IDS) was developed with grant funding from the New York State Governor's Traffic Safety Committee (GTSC) through the National Highway Traffic Safety Administration (NHTSA). IDS is a web-based tracking and reporting application that significantly improves the quality of information and efficiency of transfer of information related to impaired driving offenders in New York State (NYS). The IDS facilitates information sharing and automates processes that were previously handled manually via DMV's DS-449, MV-2025 and MV-2026 paper forms. Impaired Driver Program (IDP) Directors and clinical providers have immediate electronic access to clients' records regarding IDP enrollment and clinical screening, assessment, and treatment. In addition, the system also allows electronic access to a client's Abstract of Driving Record in real time.

Full implementation of IDS began in spring 2012 with a regional rollout throughout the state. Once registered for the system, all IDS users are required to electronically report pertinent details of their work. *Providers of clinical services to impaired driving clients are required to document the start date, completion date and completion status for each impaired driving screening, assessment, and treatment service that is provided*. Information regarding a motorist's status that is reported in IDS is electronically transferred to DMV where it is posted to the motorist's internal license file for view by DMV staff authorized to process the motorist's application for relicensing. **It is required that all IDS entries take place within three business days of the service provided.**

We are asking that this survey be completed by **Monday, April 3, 2017**. All questions regarding this survey should be directed to Brigette Hartman-DeCenzo at 518-485-2071 or Brigette.Hartman-DeCenzo@oasas.ny.gov.

1. What is the total number of clinical treatment staff in your program?

2. Of this number of total clinical program staff, how many are providing services to impaired driving offenders?

3. How many staff providing clinical services to impaired driving offenders have a certificate of completion verifying that they viewed or attended the mandatory OASAS training? (please refer to this link for more information) https://www.oasas.ny.gov/dwi/stdstraining.cfm

   If any clinical staff treating impaired driving offenders do NOT have a training certificate please explain why:

4. How many program staff retain a log in to the Impaired Driver System (IDS)?
   a) Support Staff
   b) Clinical Staff
   c) Administrative Staff

5. Are there any problems in obtaining an IDS log-in?
   - a) Yes, please explain
   - b) No

6. Is all assessment and treatment information entered into IDS within three business days as required?
   - a) Yes, please explain
   - b) No

7. Do you enter information into IDS for all impaired driving offenders regardless of referral source or status of prosecution?
   - a) Yes, please explain
   - b) No

8. Does your program have a standardized treatment "track" for impaired driving offenders?
   - a) Yes, how long does it take to complete?
   - b) No

9. It is understood by OASAS that not all impaired driving offenders meet DSM-5 diagnostic criteria. In these cases, do you select "no treatment recommended" in IDS?
   - a) Yes
   - b) No, please explain

10. Does your screening or assessment protocol of impaired driving offenders include the following at all times? (check all that apply) If No, please explain.
    - a) Yes, OASAS endorsed screening tool (if applicable)
    - b) No, please explain
    - Yes, Bio psychosocial

- ○ b) No, please explain [ ]
- ○ Yes, Urine Drug Screen to include EtG
  - ○ b) No, please explain [ ]
- ○ Yes, Review of Abstract of Driving Record
  - ○ b) No, please explain [ ]
- ○ Yes, Review of arrest documentation
  - ○ b) No, please explain [ ]
- ○ Yes, Collateral contacts
  - ○ b) No, please explain [ ]

Thank you for participating in the 2018 Mental Hygiene Local Services Planning Process by completing this survey. We appreciate and value your input on the screening, assessment, and treatment procedures of alcohol and substance use disorders for individuals charged with or convicted of an impaired driving offense.

Any technical questions regarding the online County Planning System Please contact the OASAS Planning Unit at 518-457-5989 or by email at oasasplanning@oasas.ny.gov.

Glossary:

Impaired Driving: Impaired driving is one of America's most often committed and deadliest crimes. Driving while impaired can refer to operating a motor vehicle while under the influence of alcohol, drugs, or both. All states have laws to address impaired driving.

Impaired Driving Offense: Driving under the influence (DUI), or driving while intoxicated (DWI), is the crime of driving a motor vehicle while impaired by alcohol or other drugs (including recreational drugs and those prescribed by physicians), to a level that renders the driver incapable of operating a motor vehicle safely. People who receive multiple DUI offenses are often people struggling with a substance use disorder.

Impaired Driver Program: The Impaired Driver Program (IDP) (previously known as Drinking Driving Program (DDP)) is part of New York State's effort to lessen the incidence of injury, disability, and fatality that results from alcohol and other drug related motor vehicle crashes, thereby reducing the risk of re-offense for an impaired driving offense.

New York State Governor's Traffic Safety Committee (GTSC): The **New York State Governor's Traffic Safety Committee (GTSC)** coordinates traffic safety activities in the state. Through this website, the GTSC seeks to share timely, accurate and useful news, information and other resources about traffic safety and the state's highway safety grant program. Grant program applications, program management forms and local and state crash and ticket data are posted. These resources are available for both the professional partners and the citizens of New York State.

National Highway Traffic Safety Administration (NHTSA): NHTSA was established by the Highway Safety Act of 1970 and is dedicated to achieving the highest standards of excellence in motor vehicle and highway safety. It works daily to help prevent crashes and their attendant costs, both human and financial.

The Impaired Driving System (IDS): IDS is a web-based tracking and reporting application that significantly improves the quality of information and efficiency of transfer of information related to impaired driving offenders in New York State.

DSM-5: The ***Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition** (***DSM-5***) is the 2013 update to the American Psychiatric Association's (APA's) classification and diagnostic tool. In the United States the DSM serves as a universal authority for psychiatric diagnoses. Treatment recommendations, as well as payment by health care providers, are often determined by DSM classifications, so the appearance of a new version has significant practical importance.

Mental Hygiene Local Services Planning Process: As part of the local planning process, Local Governmental Units (LGUs) develop and annually submit a combined Local Services Plan (LSP) to all three Mental Hygiene agencies through the Mental Hygiene County Planning System (CPS). OASAS also routinely uses the local planning process to survey Substance Use Disorder (SUD) providers on a variety of topics that help to inform the work of the agency.

G. Capital Funding Request Form - Schedule C (All treatment programs-optional)

OASAS Bonded Capital Funding

Capital costs are defined as the acquisition of real property, design, construction, reconstruction, rehabilitation and improvement, original furnishings and equipment, site development, and appurtenances of the local facility. Capital costs do not include operating costs; payments of principal, interest, or other charges on obligations; or costs for which State Aid is claimed or paid under provisions of law other than the Mental Hygiene Law. For the 2018 planning cycle, capacity expansions, new programs or existing programs that would require additional State Aid will NOT be considered for capital funding.

Capital projects will be reviewed by OASAS staff to determine the priority that should be given to Schedule C requests and if they meet OASAS criteria for project development. For the 2018 planning cycle, any new capital funding will be used primarily for preservation, relocation or purchase of existing sites. Preservation is not limited to projects which specifically address structural repairs, but rather any project that is necessary or advisable to allow the site to continue to serve as an acceptable space for the provision of services of the particular kind and to the particular populations served (i.e., capital funds may be requested for improvements in space layout, un-grandfather programs to meet current space regulations, improvement in the service environment, improved amenities, upgraded electrical, plumbing or HVAC systems, rearranged space and facilities to adapt to changing service requirements, etc.) OASAS recognizes that some facilities are in premises which cannot be economically preserved. In these circumstances, funding may be made available for program relocation or reconstruction.

Mental Health Facilities Improvement Bond Program (MHFIBP), a bond-backed financing program, permits voluntary providers to borrow 100 percent of their capital project costs at fixed interest rates for 20-30 year periods. The loans made to providers for capital construction and acquisition of property secured by a mortgage on the property necessitates a first lien on the entire site. Debt service (payments for principal and interest on the borrowing) is repaid through the OASAS local assistance account.

To take advantage of the MHFIBP financing program, voluntary providers must be in good standing with the New York State Department of State, possess the powers to enter into the mortgage agreement in accordance with incorporation documents, and receive appropriate boards of directors' approvals. In addition, providers must have an effective notification from the Internal Revenue Service that qualifies the provider as a tax-exempt organization under Section 501(c) (3) of the Internal Revenue Code.

Providers will be expected to sign a waiver or assignment agreement authorizing OASAS to intercept local assistance payments otherwise due to providers for the purposes of paying debt service on the mortgage. OASAS will make debt service payments directly to the Dormitory Authority (DA) on a semi-annual or other agreed upon basis.

To be eligible for tax-exempt bond financing on leased property, the lease term must exceed the economic life of the building, must constitute the equivalent of tax ownership, and must be at least five years longer than the

term of the bond. Projects under $500,000 are generally considered too small to warrant the cost of bond issuance.

Other OASAS Capital Funding Available

Minor Maintenance

OASAS also has funding available to address capital needs for rehabilitation of existing facilities that do not qualify for the bond-backed mortgage program. If the estimated cost of a project is less than $100,000, a PAS-34 Minor Rehabilitation Request form should be completed and submitted directly to the Field Office. It should not be submitted in the local services plan. Minor maintenance project requests will be reviewed and approved on a continuous basis. The PAS-34 form is available on the OASAS Website.

Capital Projects Costing $100,000 or More

For all other projects (i.e., those projects costing at least $100,000), **a completed Schedule C form must be submitted via the Online County Planning System**. Projects that will be considered for funding include:

- Program relocation
- Purchase of existing leased space
- Regulatory compliance
- Health and safety improvements
- Access for physically disabled
- General preservation

OASAS will review all projects proposed on a Schedule C form and submitted through the local services planning process based solely on the information provided. All project proposals that have a strong justification in relation to program, physical plant and community need, OASAS capital plans, their cost, the provider's ability to provide or arrange interim financing, and OASAS' anticipated capital funding authority will be considered. Staff will be assigned to arrange performance of feasibility studies and appraisals. The provider will have to complete an application for approval in accordance with Part 810 of OASAS regulations. OASAS will provide advice and assistance in completing the Schedule C form. After a capital request is approved and all detailed information about the project is submitted, a decision will be made by OASAS on whether the project will be funded or not. If OASAS approves the project, it will seek Division of the Budget (DOB) approval. After DOB approval, a capital contract will be executed with the provider. Upon obtaining a fully executed capital contract approval, project obligations and expenditures can commence. Only approved expenditures made during the capital contract period will be eligible for reimbursement.

Considering the routine state budget process, the Part 810 review process, and the time it takes to get DOB approval, major capital projects must be considered multi-year efforts. Even after a contract is executed, project design, other approvals, construction bidding, and construction will take two to three years or longer for very large projects. Thus, as OASAS reviews and approves projects for development, the agency will schedule the projects over a number of years. Therefore, funding will come from appropriations made over a number of years as well. Providers submitting proposals for major projects should be aware that regardless of the speed of the initial decision, the conduct of the approved project is a long-term effort.

Instructions for the Capital Project Funding Request Form - Schedule C

A Schedule C "OASAS Capital Project Funding Request Form" should be completed by any provider that wants to request capital funds as described above. The completed form must be completed and submitted in CPS. Each Schedule C will be reviewed and considered by OASAS on a case-by-case basis. Further information may be requested, as needed.

For the **2018 Local Services Plan,** a Schedule C should be completed for each project that meets the criteria for fundable capital projects. The focus of all capital funding will be on preservation of existing sites, with the highest priority being given to correction of code and regulatory violations, health and safety matters and maintenance of service delivery space. All provider and project site information at the top of the form must be completed. Specific instructions follow:

Question #1 - Project Purpose: Place an "X" in the box next to each purpose, which applies to the project proposed.

a. **Relocation:** Check this box if the project is intended to physically relocate an existing program or site to a new location.
b. **Purchase of Existing Leased Space:** Check this box if the project involves the possible purchase of an existing program that is in leased space. For example: with skyrocketing lease costs, it may be more financially feasible to pay debt service on a mortgage as opposed to a lease with large escalator clauses.
c. **Regulatory Compliance:** Check this box if the project is intended to bring the program and/or its space into compliance with building, health or safety codes or OASAS regulatory requirements. These violations may be ones you have identified by outside inspectors including, but not limited to, OASAS inspectors.
d. **Health and Safety Improvements:** Check this box if the project is intended to improve health and safety of the space in ways not required by code or regulation. Examples might include rehabilitation of bathroom fixtures and plumbing, upgrading smoke detection and alarm systems, replacing kitchen floors and finishes, etc.
e. **Access for Physically Disabled**: Check this box if the project is to improve access to or use of all or part of the site by physically challenged persons. Examples include construction of wheelchair ramps at entrances, installations of lifts, handrails and grab bars, installation of special bathroom equipment, and acquisition and installation of calling devices for summoning assistance.
f. **General Preservation**: Check this box if the project is to preserve an existing facility. Projects in this category are intended to maintain or protect the use of an existing facility and do not materially extend the useful life or provide enhancement of the environment or program, for example, replacement of a deteriorated bathroom, replacement of heating system, roof, kitchen, driveway, etc.

Question #2: Estimated Project Cost: If the estimated cost is less than $100,000, a PAS-34 Minor Rehabilitation Request should be submitted separately to the Field Office.

Question #3: Briefly Describe the Physical Plant Problem and Corrective Work Required:

Question #4: Indicate Approximate Square Footage of Space to be Added or Affected by the Proposed Capital Project:

Question #5: Briefly Describe the Proposed Scope of Work in the Project:

Question #6: Provide a Detailed Statement of the Need for the Project and a Justification for it. Describe the need/benefit to the program's operation, to the improvement of the physical plant and the need/benefit to the financial operation of the facility.

- ***Program need/benefit*** refers to correction/improvement of client safety, access, privacy, space layout and traffic flow, or number and types of spaces for patient services and staff activity, etc.
- ***Physical need/benefit*** refers to correction/improvement of inadequate functioning of building or mechanical systems (plumbing, electric, HVAC etc.), structural safety and adequacy, energy efficiency, building integrity (leaky roof windows etc.), building security or internal security of property, supplies, personnel, etc.
- ***Financial need/benefit*** refers to improved financial circumstances resulting from projects which increase energy efficiency, reduce property costs, allow more efficient use of space allowing reduced space use, or reduction of space and cost due to program reorganization or contraction, etc.

Expiration of Schedule C Application: The Schedule C application will expire 24 months from the OASAS Field Office approval date unless the project has moved to the funding stage. If the application expires prior to satisfying the need and the project has not moved to the funding stage a new Schedule C application must be submitted for approval by OASAS Field Office in order for the application to remain active.

A sample of the Schedule C form appears on the following pages.

Schedule C – OASAS Capital Project Funding Request Form (Page 1)

Corporate Headquarters			Date:
Provider Name (full legal name):			Provider Number:
LGU this Schedule C Form Submitted to:			
Street/P.O. Box:	City:	State:	Zip:
Project Site			
Street/P.O. Box:	City:	State:	Zip:
Service Category:	PRU:	County:	
Contact Person:	Title:		
Telephone:	E-mail:	Certified Capacity:	Funded Capacity:

1. Project Purpose:
   - ☐ a) Program Relocation
   - ☐ b) Purchase of Existing Leased Space
   - ☐ c) Regulatory Compliance
   - ☐ d) Health and Safety Improvements
   - ☐ e) Access for Physically Disabled
   - ☐ f) General Preservation

2. Estimated Project Cost: _____ If the estimated cost is less than $100,000, a PAS-34 Minor Rehabilitation Request should be submitted separately to the Field Office.

3. Briefly describe the physical plant problem and corrective work required:

4. Indicate approximate square footage of space to be added or affected by the proposed capital project: _____ ft^2

5. Briefly describe the proposed scope of work in the project:

New York State Office of Alcoholism and Substance Abuse Services, SCHEDC2009

Schedule C – OASAS Capital Project Funding Request Form (Page 2)

Project Site

Provider Name:	Provider Number:	PRU:

6. Provide a detailed statement of need for the proposed project that addresses programmatic, physical plant and financial need, as appropriate: (provide attachment, if necessary)

7. Complete if the project is for an EXISTING certified site:

a) The site is: ☐ Leased ☐ Owned ☐ Provided as a gift

b) If leased, is the lease an arms-length lease? ☐ Yes ☐ No

c) If leased, what is the annual rent? $____

d) If owned, are there any liens on the site? ☐ Yes ☐ No

e) If YES, what is the current market value of the site? $____

f) If YES, what is the total balance of all liens on the site? $____

g) Are you the sole occupant of the site? ☐ Yes ☐ No

8. Complete if the project is for a NEW site:

a) Has a probable site been identified? ☐ Yes ☐ No

b) How do you expect to acquire the site? ☐ Lease ☐ Purchase ☐ Other (attach explanation)

c) Have you obtained an option on the site? ☐ Yes ☐ No

d) If an appraisal or fair market rental study of the proposed site has been completed, forward a copy to the field office.

9. If a feasibility study has been completed for the project, forward a copy to the field office.

10. Planned project financing:

a) Provider funds: $____

b) Commercial loans/debt: $____

c) Grants (other than OASAS): $____

d) OASAS: $____

11. Has this financing plan been adopted by the governing authority? ☐ Yes ☐ No

NOTE: The Schedule C application will expire 24 months from the OASAS Field Office approval date unless the project has moved to the funding stage. If the application expires prior to satisfying the need and the project has not moved to the funding stage a new Schedule C application must be submitted for approval by OASAS Field Office in order for the application to remain active.

Provider Official

Name: _____ Title: _____ Date: _____

FOR OASAS USE ONLY

OASAS Field Office Approval of Need **(Funding is to be determined)**	Signature (Statewide Field Office Director or Designee)	Date Approved

New York State Office of Alcoholism and Substance Abuse Services, SC

H. Prevention Provider Professional Workforce Survey (Prevention Programs)

All OASAS funded prevention providers are required to implement ***Primary* Prevention Services**, which include: prevention education; environmental strategies; community capacity building; positive alternatives; and information awareness. In addition, providers may choose to implement ***Other* Prevention Services**, which are: Prevention Counseling; Prevention Counseling-Project Success; and Early Intervention Services (Teen Intervene and BASICS). See the 2014 Prevention Guidelines for details.

OASAS is conducting this survey of prevention providers to obtain an increased understanding of the current workforce. Your answers to questions below will assist us in developing strategies to promote the professional development and skills of our prevention workforce.

We are asking that this survey be completed by **Monday, April 3, 2017**. All questions regarding this survey should be directed to Patricia Talaba at 518-485-2875 or Patricia.Talaba@oasas.ny.gov.

1. Please indicate if you are a Prevention Provider of the following services approaches:
   - ○ a) *Primary* Prevention Only
   - ○ b) *Other* Prevention Only
   - ○ c) Both Primary and Other Prevention

2. Are you a certified provider of prevention counseling?
   - ○ a) Yes
   - ○ b) No

3. How many staff provide *Primary* Prevention services at your agency?
   - ○ a) Not applicable
   - ○ b) Less than 1 FTE
   - ○ c) 1
   - ○ d) 2
   - ○ e) 3-5
   - ○ f) 6-10
   - ○ g) 11-20
   - ○ h) 20 or more

4. How many staff provide *Other* Prevention services at your agency?
   - ○ a) Not applicable
   - ○ b) Less than 1 FTE
   - ○ c) 1
   - ○ d) 2
   - ○ e) 3-5
   - ○ f) 6-10
   - ○ g) 11-20
   - ○ h) 20 or more

5. Please indicate the minimum educational requirement for staff hired to provide *Primary* Prevention Services as defined above (Check only one)

- ○ a) GED or High School
- ○ b) Some College, no degree
- ○ c) Associates Degree
- ○ d) Bachelor's Degree
- ○ e) Master's Degree
- ○ f) Ph.D.

6. Please indicate the minimum educational requirement for staff hired to provide *Other* Prevention Services as defined above (Check only one):

- ○ a) GED or High School
- ○ b) Some College, no degree
- ○ c) Associates Degree
- ○ d) Bachelor's Degree
- ○ e) Master's Degree
- ○ f) Ph.D.

7. How many prevention **staff** have the following credentials, licenses, or certifications?

a) Certified Prevention Professional (CPP)? ☐

b) Of the staff that have the CPP credential, how many are supervisors? ☐

8. How many prevention **staff** have the following credentials, licenses, or certifications?

a) Certified Prevention Specialist (CPS)? ☐

b) Of the staff that have the CPS credential, how many are supervisors? ☐

c) Of the supervisory staff that have the CPS credential how many have the required additional years' experience and 150 hours of OASAS approved training and education? ☐

9. How many prevention **staff (excluding supervisors)** have the following credentials, licenses, or certifications? **If someone possesses multiples licenses or certifications, include the individual in the count under each category:** Also indicate if they meet BOTH the two years of experience and 60 hours of prevention specific training and education. **See page 31 in the** Prevention Guidelines.

Professional License/Certification	No. Staff	No. w 2 yrs. Exp & 60 hrs. Training & Ed.
☐ a) Credentialed Alcoholism and Substance Abuse Counselor (CASAC)		
☐ b) Credentialed Problem Gambling Counselor (CPGC)		
☐ c) Certified Teacher:		
☐ d) Certified Health Educator		
☐ e) Certified School Counselor		
☐ f) Certified Rehabilitation Counselor		

☐ g) Licensed Master Social Worker (LMSW)		
☐ h) Licensed Clinical Social Worker (LCSW)		
☐ i) Licensed Mental Health Counselor (LMHC)		
☐ j) Licensed Marriage and Family Therapist (LMFT)		
☐ k) Registered Professional Nurse (RN)		
☐ l) Licensed Physician		
☐ m) Licensed Creative Arts Therapist (LCAT)		
☐ n) National Board Certified Counselor		

10. How many prevention **staff that are supervisors** have the following credentials, licenses, or certifications? **If someone possesses multiples licenses or certifications, include the individual in the count under each category:** Also indicate if they meet BOTH the two years of experience and 60 hours of prevention specific training and education. **See page 31 in the** Prevention Guidelines.

Professional License/Certification	No. Staff	No. w 2 yrs. Exp & 60 hrs. Training & Ed.
☐ a) Credentialed Alcoholism and Substance Abuse Counselor (CASAC)		
☐ b) Credentialed Problem Gambling Counselor (CPGC)		
☐ c) Certified Teacher:		
☐ d) Certified Health Educator		
☐ e) Certified School Counselor		
☐ f) Certified Rehabilitation Counselor		
☐ g) Licensed Master Social Worker (LMSW)		
☐ h) Licensed Clinical Social Worker (LCSW)		
☐ i) Licensed Mental Health Counselor (LMHC)		
☐ j) Licensed Marriage and Family Therapist (LMFT)		
☐ k) Registered Professional Nurse (RN)		
☐ l) Licensed Physician		
☐ m) Licensed Creative Arts Therapist (LCAT)		
☐ n) National Board Certified Counselor		

11. How many OASAS approved Evidence Based Programs (EBPs) are being implemented by agency staff? https://www.oasas.ny.gov/prevention/evidence/EBPSList.cfm:

- ○ a) None
- ○ b) 1
- ○ c) 2
- ○ d) 3-5
- ○ e) 6--10
- ○ f) 10 or more

12. Do you require staff to be trained in OASAS approved Evidence-Based Programs prior to implementing them?

- ○ a) Yes
- ○ b) No, please explain why ☐

13. Does your agency do succession planning for the prevention program?

- ○ a) Yes
- ○ b) No, please explain why [ ]

14. Is there any information you would like to add about how you are strengthening the prevention workforce in your agency?

[ ]

Thank you for participating in the 2018 Mental Hygiene Local Services Planning Process by completing this survey. We appreciate and value your input on the licenses and certifications staff hold who perform prevention functions in your program.

Any technical questions regarding the online County Planning System Please contact the OASAS Planning Unit at 518-457-5989 or by email at oasasplanning@oasas.ny.gov**Glossary:**

***Primary* Prevention Services:** All OASAS funded prevention provider s are required to implement Primary Prevention services, which include the following service approaches: prevention education; environmental strategies; community capacity building; positive alternatives; and information awareness.

***Other* Prevention Services** are prevention counseling and early intervention services.

Certified Prevention Professional (CPP): In order to become a Credentialed Prevention Professional (CPP) or Credentialed Prevention Specialist (CPS) in New York State, you must: (1) meet specific competency and ethical conduct requirements; (2) meet specific work experience requirements; (3) meet minimum education and training requirements; and (4) pass the International Certification and Reciprocity Consortium (IC&RC) Prevention examination. All the stated requirements are overseen and/or coordinated by OASAS.

Certified Prevention Specialist (CPS): If you hold a CPS certificate, you may obtain a CPP certificate without being required to pass another IC&RC Prevention examination. You will be required to submit a credential upgrade packet which verifies that all CPP requirements have been satisfied, along with a credential upgrade.

Credentialed Alcoholism and Substance Abuse Counselor (CASAC): An individual who has a current valid credential issued by OASAS, or a comparable credential, certificate or license from another recognized certifying body as determined by OASAS.

Credentialed Problem Gambling Counselor (CPGC): An individual who has a current valid credential issued by OASAS, or a comparable credential, certificate or license from another recognized certifying body as determined by OASAS.

Certified Teacher: A certified teacher is a teacher who has earned credentials from an authoritative source, such as the government, a higher education institution or a private source

Certified Health Educator: The CHES (pronounced chez) designation signifies that an individual who has met required academic preparation qualifications, has successfully passed a competency-based examination and who satisfies the continuing education requirement to maintain the national credential.

Certified School Counselor: Most public school systems require advanced-degree courses that include the following topics: Human growth and development, Theories, Individual counseling, Group counseling, Social and cultural foundations, Testing/appraisal, Research and program evaluation, Professional orientation, Career development, Supervised practicum, and Supervised internship.

Certified Rehabilitation Counselor: An individual certified as a rehabilitation counselor by the Commission of Rehabilitation Counselor Certification.

Licensed Master Social Worker (LMSW): An individual licensed and registered as a LMSW by the New York State Education Department.

Licensed Clinical Social Worker (LCSW): An individual licensed and registered as a LCSW by the New York State Education Department.

Licensed Mental Health Counselor (LMHC): An individual licensed and registered as a Licensed Mental Health Counselor by the New York State Education Department, including individuals with a Limited Permit Licensed Mental Health Counselor (LP-LMHC).

Licensed Marriage and Family Therapist (LMFT): An individual licensed and registered as a Licensed Marriage and Family Therapist by the New York State Education Department.

Registered Professional Nurse (RN): An individual licensed and registered as a Registered Professional Nurse by the New York State Education Department.

Physician (MD or DO): A **physician** or **medical doctor,** or simply **doctor,** is a professional who practices medicine, which is concerned with promoting, maintaining, or restoring health through the study, diagnosis, and treatment of disease, injury, and other physical and mental impairments. Physicians may focus their practice on certain disease categories, types of patients, or methods of treatment—known as specialist medical practitioners—or assume responsibility for the provision of continuing and comprehensive medical care to individuals, families, and communities—known as general practitioners.[2] Medical practice properly requires both a detailed knowledge of the academic disciplines (such as anatomy and physiology) underlying diseases and their treatment—the *science* of medicine—and also a decent competence in its applied practice—the art or *craft* of medicine.**Licensed Creative Arts Therapist (LCAT):** An individual currently licensed and registered as a Licensed Creative Arts Therapist by the New York State Education Department.

National Board Certified Counselor: A Counselor certified by and registered as such with the National Board for Certified Counselors.

Evidence Based Programs: Those programs that have been found to be effective based on the results of rigorous evaluations are often called “evidence-based.” An important element of EBPs is that they have been evaluated rigorously in experimental or quasi-experimental studies.

Mental Hygiene Local Services Planning Process: As part of the local planning process, Local Governmental Units (LGUs) develop and annually submit a combined Local Services Plan (LSP) to all three Mental Hygiene agencies through the Mental Hygiene County Planning System (CPS). OASAS also routinely uses the local planning process to survey Substance Use Disorder (SUD) providers on a variety of topics that help to inform the work of the agency.

Appendix I: CPS Registration and User Roles

To register an account with CPS:

1. Obtain an OASAS Applications user account, by completing an OASAS External Access Request Form, an IRM-15, available on the OASAS website and submitting the form to the NYS OASAS PROVIDER HELP DESK as instructed. Please indicate on the form that it is a request access to the County Planning System.
2. Once an OASAS Applications user account is created, go to the CPS website to register a CPS user account.

The table for CPS User roles shows the primary user roles, with each providing the user with specific entitlements depending on their organization and the features and resources they need to access or use. Each role provides the user with specific entitlements depending on their organization and the features and resources they need to access. While the system was designed primarily for county and OASAS provider use, it has expanded significantly over the years. Additional roles have been added for anyone not employed by the three state agencies, the county mental hygiene agencies, or OASAS provider agencies.

Primary CPS User Roles and Entitlements

User Role	Entitlements
Planning Coordinator	This role is identical to the Administrator role and was developed so that state agency staff can communicate with a single individual within a LGU or OASAS provider organization on planning related matters. This will helps to eliminate confusion when action is requested, allowing a single point of contact to coordinate an organization's response.
Administrator	This role is appropriate for individuals responsible for managing their organization's presence in CPS. They have the ability to approve and delete staff accounts within their organization and can use the broadcast email feature and other system management features. LGU and provider administrators can also complete and submit required planning forms. All administrator accounts are approved by OASAS.
Staff	This role is appropriate for individuals in LGU and provider organizations that need to complete planning forms but do not need to perform system management functions. Completed forms can be submitted to the CPS administrator within the organization for approval. State agency staff roles have read-only access to the entire system. LGU and provider staff roles can be approved by any administrator from the same organization. State agency staff roles are approved by the appropriate state agency administrators.
Guest Viewer	This role has read-only access to completed plans and most available data resources. These are typically individuals not employed by one of the three state agencies, an LGU, or an OASAS provider agency but have a need to access resources in CPS. They may include researchers, students, consultants, or staff from another state or county agency. The Guest Viewer role is approved by OASAS.
All Roles	All user roles can view and print forms, run special reports, and access most county planning data resources.

NOTES

[i] Non-Medical Transportation will be carved out of the MCO benefit, managed by a Medicaid Transportation Manager based on the Plan of Care, and paid FFS directly to the transportation provider. In addition to Non-Medical Transportation, transportation to BH HCBS included in an individual's Plan of Care will be treated the same way as medically necessary Medicaid Transportation. Please see Managed Care Transition Manual for additional plan requirements for this service.

[ii]The host model can be found on the Department of Health website at http://www.health.ny.gov/health_care/medicaid/redesign/dsrip/regulatory_waivers/licensure_thresholds.htm

[iii] Table from link in note above.

[iv]Wang, P.S., Lane, M., Olfson, M., et al. (2005). Twelve-month use of mental health services in the United States: Results from the National Comorbidity Survey Replication. *Arch Gen Psychiatry, 62* (6) 629-40.

[v]Attachment J- NY DSRIP Strategies Menu Metrics (2014, April 14). DSRIP Project 3.a.i is the integration of primary care services and behavioral health. This is a behavioral health, Domain 3, clinical improvement project selected by all Performing Provider Systems (PPS). For more information on DSRIP Projects visit http://www.health.ny.gov/health_care/medicaid/redesign/docs/strategies_and_metrics_menu.pdf

[vi] NCQA is the name commonly used by The National Committee for Quality Assurance.

[vii] The current Operational Report can be accessed at https://www.health.ny.gov/technology/innovation_plan_initiative/docs/nys_sim_year2_operational_plan.pdf

[viii] Curtin, S., Warner, M., Hedegaard, H. (2016). Increase in suicide in the United States, 1999–2014. NCHS data brief, no 241. Hyattsville, MD: *National Center for Health Statistics.*

[ix] Centers for Disease Control and Prevention. Injury prevention and control: Data and statistics (WISQARS). http://www.cdc.gov/injury/wisqars/fatal_injury_reports.html