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

# 2020 Local Services Plan Guidelines for Mental Hygiene Services

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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.

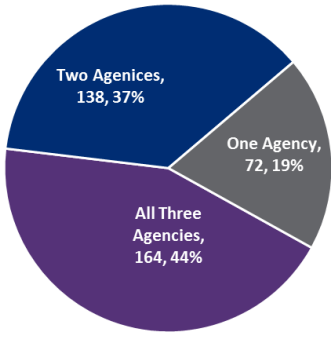
The LSP must establish long-range goals and objectives that are consistent with statewide goals and objectives (§41.16(b) (1)). Mental Hygiene Law also requires that each agency's statewide comprehensive plan shall be based upon an analysis of local services plans developed by each LGU.

For many years, each state agency conducted its own local planning process, which required LGUs to comply with three different sets of planning requirements. 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 could complete a single integrated local services plan for mental hygiene services that was submitted to all three state agencies.

The Goals and Objectives Form is the primary document that LGUs use, as part of local services planning, to communicate and identify their local needs and their goals, objectives, and strategies to address those needs. On the 2019 Goals and Objectives Form, LGUs selected from specific categories to indicate the nature of the unmet mental hygiene needs in their counties. If a need category, such as housing, applied to multiple Mental Hygiene agencies, LGUs had the option of matching it to one, two, or all three agencies. Some need categories are applicable to only one or two agencies.

The results from the 2019 Goals and Objectives Form, illustrated in Figure 1.1, show local mental hygiene needs often occur across agencies and populations. Of the eleven need categories applicable to two or more agencies, LGUs indicated a total of 374 needs. Of these 374 needs identified by LGUs, the vast majority (81 percent) were associated with more than one State agency, including more than 40 percent that were associated with all three State agencies.

**Figure 1.1: Mental Hygiene Local Needs by Number of Associated State Agencies**




The cross-system needs and goals most frequently cited by LGUs include:

- Housing;
- Crisis Services;
- Transportation; and
- Workforce Recruitment and Retention

## B. Mental Hygiene Planning Committee

In 2007, OASAS, OMH, and OPWDD, worked with the CLMHD to form the Mental Hygiene Planning Committee (MHPC) 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.

Because 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.

Members of the MHPC annually review the local services planning process to ensure that it creates value for State agencies, LGUs, and citizens.

## 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.

Other tools were developed to 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 can 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.

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

Planning Data Resources added to CPS

Since March 2018, the State mental hygiene agencies have added or updated several data resources to CPS to assist county planners in their needs assessment and services planning activities. These resources are available by selecting "Planning Resources" from the CPS menu:

- OPWDD County Data 2018 / OPWDD County Data 2018 Supplemental
  This profile contains county-level planning data including enrollment summary of services and supports by selected age groups and demographic information including disability, gender, ethnicity, Individual Service Planning Model (ISPM) score and level of functioning. In addition, the supplemental county level planning data includes enrollments in residential services, a summary of people actively seeking residential placements, and the number of people new to the front door and related service authorization (Updated April 2018).

- 2017 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 2017. 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 September 2018).

- 2017 OASAS Admissions by Type and County
  The data in this file show admissions to OASAS-Certified chemical dependence treatment during calendar year 2017 based on an extract from OASAS Client Data System (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 September 2018).

- 2014-2016 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 2014-2016 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) (Updated September 2018).

- 2013-2014 Expanded Behavioral Risk Factor Surveillance Survey (eBRFSS) Sub-County Binge Drinking and Poor Mental Health
  A New York State Department of Health research team adapted a selected set of core County Health Rankings measures to generate these reports for sub-county level geographies and populations in New York State. The file provides data for the "percentage of adults who report heavy or binge drinking" and "percentage of adults who reported that their mental health was poor or not good" at regional, county, and selected sub-county (city, town, village) levels. (Updated September 2018).

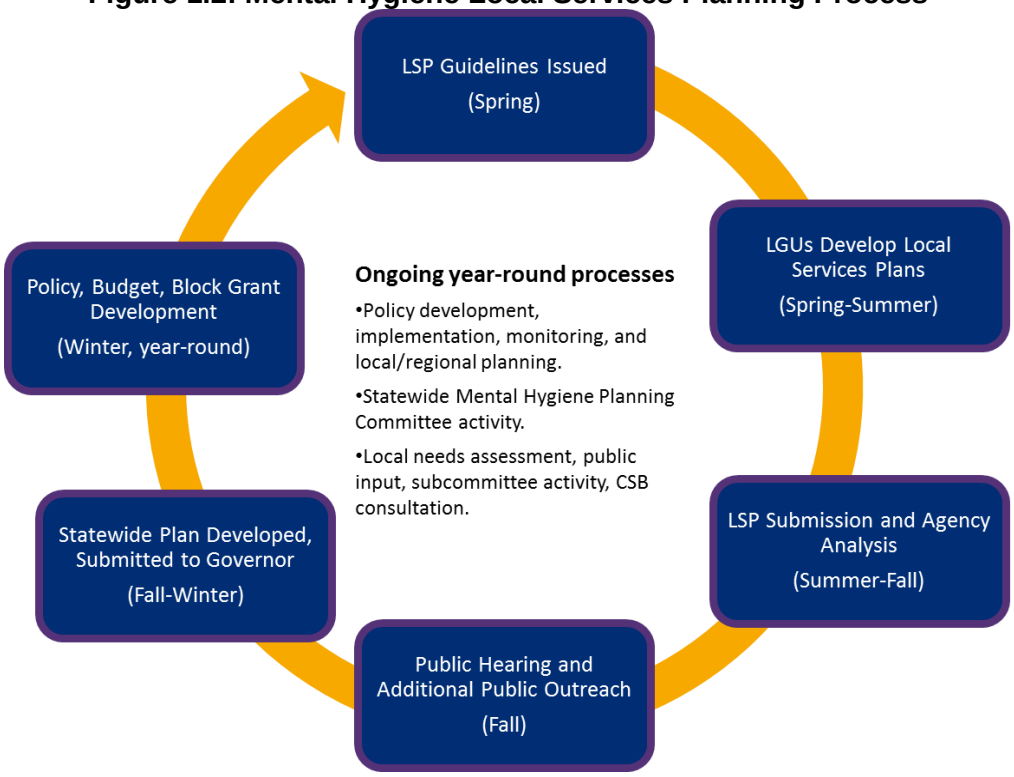
- OMH Statistics and Reports
  The publicly available data resources that OMH publishes for community providers, local governmental units, and other stakeholders to support planning and understanding of mental health services statewide. These data portals and books are described in more detail within the OMH Data Portal section of this document.

### D. 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 in March. 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. State agencies analyze Local Services Plans and reports 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 90 percent, which has dramatically increased the value and reliability of the data collected.

**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: 2020 Local Services Planning Process Timeline**

| Process Step | Date |
|---|---|
| Ongoing planning and needs assessment conducted by counties and the Mental Hygiene Planning Committee | Year round |
| LGU LSP Forms and OASAS Provider and Program Surveys available on CPS | March 2019 |
| **Due date for completed OASAS provider planning surveys in CPS** | **Monday, April 1, 2019** |
| **Due date for completed LGU Plans in CPS** | **Monday, June 3, 2019** |

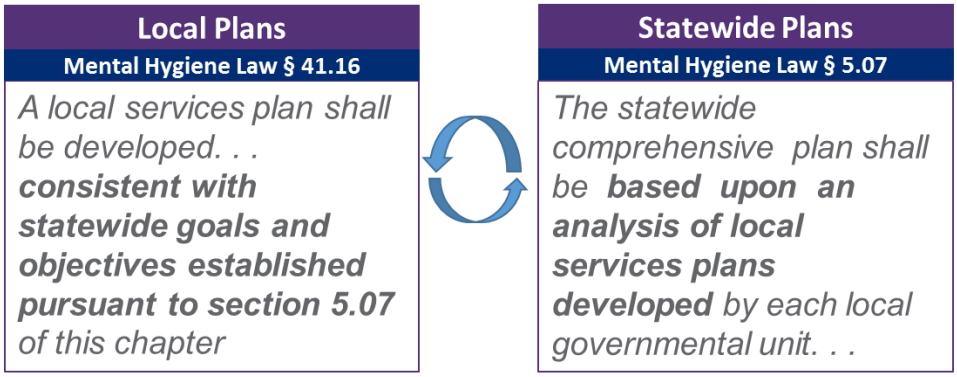
## E. Informing Statewide Planning

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 achieve 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 2019 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 "2019 Plan Analyses"):

- 2019 Prevention Provider Staffing Survey Results
- 2019 Treatment Staffing Survey Results
- 2019 Goals and Objectives Form 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. To help ensure that policies supporting people with mental illness, developmental disabilities and/or substance use disorder 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.

This Chapter summarizes some of the areas of opportunity that should be considered in the upcoming planning year.

#### Medicaid Managed Care

Overview

Governor Cuomo's Medicaid Redesign Team (MRT) provided New York State with a blueprint and action plan for reforming Medicaid services and optimizing health-system performance through alignment with what the Institute of Healthcare Improvement calls the "Triple Aim": improving the patient's experience of care, improving the health of populations, and reducing the per-person cost of healthcare. Overall, the design and operational components of the newly configured behavioral health system for Medicaid beneficiaries address the MRT vision and goals through:

- Improved access to appropriate behavioral and physical healthcare services for individuals with mental illnesses and/or substance use disorders;
- Better management of total medical costs for individuals diagnosed with co-occurring behavioral and physical health conditions;
- Improved health outcomes and increased satisfaction among individuals engaged in care;
- Transformation of the behavioral health system from one dominated by inpatient care to one based more strongly in ambulatory and community care; and
- Enhanced service delivery system that supports employment, success in school, housing stability and social integration.

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" Medicaid services and beneficiaries that had previously been exempt from managed care, into a coordinated benefit package. Some of the key requirements for successful behavioral health care delivery system transformation through an integrated managed care benefit include:

- Ensuring that Medicaid Managed Care plans have the organizational capacity and culture to manage

behavioral health benefits, serve specialized populations, and develop specialty Health and Recovery Plans (HARPs) for people with serious mental health conditions and substance use disorders. This includes implementing a new recovery-oriented suite of services to support people in their communities and homes.
- Preserving the behavioral health safety net through contractual provisions that promote access to care, maintain provider financial stability, and preserve patient-provider treatment relationships without disruption.
- Maintaining a strong behavioral health managed care oversight and monitoring infrastructure that not only ensures a smooth transition to this new system, but also positions New York State to remain anchored in the vision of the MRT.
- Improving community engagement and developing strategies to strengthen partnerships among stakeholders through training, technical assistance, start-up funding, and the creation of Regional Planning Consortiums to discuss, identify, and address issues related to implementation.

Values Guiding the Transition

New York State has aimed to seamlessly transition the behavioral health service system into Medicaid managed care in a manner that will increase recovery outcomes, stabilize the behavioral health care system, and maintain access to care. New York is working to create an environment in which managed care plans, service providers, peers, families, and governmental entities partner to help enrollees prevent chronic health conditions and recover from serious mental illness and substance use disorders. This partnership shares the following core values:

- Person-Centered: Care should be self-directed whenever possible and emphasize shared decision-making approaches that empower enrollees, provide choice, and minimize stigma. Services should be designed to optimally treat illness and emphasize wellness and attention to the entirety of the person.
- Recovery-Oriented: The system should include a broad range of services that support recovery from mental illness and/or substance use disorders. These services support the acquisition of living, vocational, and social skills, and are offered in settings that promote hope and encourage each enrollee to establish an individual path towards recovery.
- Integrated: Service providers should attend to both physical and behavioral health needs of enrollees, and actively communicate with care coordinators and other providers to ensure health and wellness goals are met. Care coordination activities should be the foundation for care plans, along with efforts to foster individual responsibility for health awareness.
- Data-Driven: Providers and plans should use data to define outcomes, monitor performance, and promote health and well-being. Plans should use service data to identify high-risk/high-need enrollees in need of focused care management. Performance metrics should reflect a broad range of health and recovery indicators beyond those related to acute care.
- Evidence-Based: The system should incentivize provider use of evidence-based practices (EBPs) and provide or enable continuing education activities to promote uptake of these practices. NYS has partnered with plans to educate and incentivize network providers to deliver EBPs. The NYS Office of Mental Health provides technical assistance through entities such as the Center for Practice Innovations at Columbia University/New York State Psychiatric Institute, and the Managed Care Technical Assistance Center (a partnership between the McSilver Center at NYU and the National Center on Addiction and Substance Abuse at Columbia University). Additionally, the Northeast Addiction Technology Transfer Center provides technical assistance with EBPs for substance use disorder programs.

The Infrastructure to Administer Adult Behavioral Health Services

New York is taking a two-pronged approach to incorporate adult behavioral health services into Medicaid managed care:

1. Qualified Mainstream Medicaid Managed Care Organizations (MCOs): For all adults served in mainstream MCOs throughout the State, qualified MCOs now integrate all Medicaid State Plan covered services and new demonstration services for mental illness, substance use disorders (SUDs), and physical health conditions. Plans are required to meet strict criteria set by the State before administering the behavioral health benefit. Premiums for mainstream plans have been adjusted to reflect the additional behavioral health benefits of mainstream enrollees.

2. Health and Recovery Plans (HARPs): In order to address the unique needs of adults with serious mental health conditions and serious substance use disorders, the State developed a new managed care product called a Health and Recovery Plan. HARPs administer the full continuum of physical health, mental health, and substance use disorder services covered under the Medicaid State Plan, as well as additional rehabilitative services, called Behavioral Health Home and Community Based Services. HARPs also provide enhanced care management for enrollees to help them coordinate all their physical health, behavioral health and non-Medicaid support needs. HARPs have an integrated premium established for this behavioral health population. They have specialized staffing requirements and qualifications along with focused behavioral health performance metrics and incentives to achieve health, wellness, recovery, and community inclusion for their enrollees.

Transitioning Children's Services to Medicaid Managed Care

The Children's Health and Behavioral Health MRT Subcommittee, comprised of stakeholders including providers, family members, youth, advocacy groups, State and local government representatives, and MCOs, offered a specific set of Medicaid managed care recommendations designed to improve service access and provide earlier intervention for children/ youth and families. These recommendations envision an integrated children's healthcare system where there is "no wrong door" for children with complex needs, including those with serious comorbid medical conditions. Similar to the adult system, the children's public healthcare system includes a wide range of providers and services that are often disjointed and inefficient, with few incentives for effective care coordination and person-centered care. A comprehensive cross-system approach is needed to diminish silos of care and improve health outcomes for children well into adulthood to further the MRT goals.

Key principles of children's Medicaid redesign include:

- Early identification and intervention
- Family-driven and youth-guided care planning
- Focus on resiliency for children and recovery for young adults building resilience
- Culturally and linguistically competent services and providers
- Limit progression into high intensity and acute service individualized and flexible care
- Availability of evidence-based, evidence-informed, and promising practices
- Establish Trauma Informed Care principles across the entire service delivery system
- Maintaining children at home with support and services or in the least restrictive community-based settings Integrate the delivery of behavioral health and health benefits

The Adverse Childhood Events (ACEs) study showed powerful associations between childhood trauma and the onset of chronic conditions and associated functional deficits which persist into adulthood. Importantly, the study also showed that often, the impact of childhood adverse events is not evident until well into adulthood.

Individuals with childhood trauma have a much higher risk of developing chronic medical and behavioral health conditions that are primary drivers of morbidity and mortality as well as high healthcare costs. These findings underscore the critical need for a redesigned system of care that emphasizes early identification and integrated service delivery. These children deserve to grow into healthy adults and live full and satisfying lives.

Today, two million children in New York State receive their physical health services through Medicaid managed care which emphasizes coordination, health outcomes, and quality of care. While much progress has been made, children and youth mental health and substance use disorder services are still delivered through a fee-for-service model that reimburses based upon volume of services delivered and offers limited incentives for quality of care. New York State plans to leverage the Medicaid managed care program to transform the children's system of care. An effective partnership between Medicaid managed care and providers will support delivery system transformation promoting early identification, prevention, and treatment and, in turn, will reduce the need for intensive services, acute levels of care, and out-of-home placements. A well-functioning children's health system of care will not only benefit children and families but will also provide important opportunities for improved quality and cost savings in the adult healthcare system. Managed care plans should view efforts to support and intervene with children and

their families as a key element of value-based initiatives aimed to limit the prevalence of negative physical, emotional, and social outcomes associated with chronic conditions in adults.

To support this integration, create better health outcomes for children and youth, and lay the groundwork for better health outcomes for adults, New York State is taking 3 key policy steps to stimulate the transformation:

1. NYS will make available via a State Plan Amendment, new services that were either not available in NYS previously or only available to children who met narrow eligibility criteria.
2. NYS is establishing "Level of Care" and "Level of Need" criteria to identify subpopulations of children who are likely to benefit from an array of home and community-based services. The Level of Need subpopulation will identify children prior to needing institutional care or as a step down from Level of Care. This population is at risk by virtue of exposure to adverse events or symptoms leading to functional impairment in their home, school, or community.
3. NYS is simplifying the five existing children's 1915(c) waivers into one integrated array of home and community-based services for an expanded number of Medicaid-eligible children, allowing more children to stay in their home communities and avoid residential and inpatient care

An estimated 65,000 children and youth will be eligible for Medicaid Home and Community Based Services (HCBS) benefits at full implementation across the State. Approximately 10% of the more than two million children and youth eligible for Medicaid will likely need the new State Plan services at some point in time. Further, the addition of approximately 18,000 foster care children to managed care greatly enhances the availability of services and the use of managed care tools to efficiently serve children and youth.

New York State remains strongly committed to expanding Medicaid behavioral health services for children, and the Office of Mental Health is working closely with advocates, stakeholders and our partner agencies to ensure adequate service capacity among not-for-profit providers. The State is prioritizing and expediting the most critical components of this expansion and is moving as quickly as possible towards full implementation.

Value Based Payment (VBP)

The New York State Medicaid managed care system is transforming from one that pays for service volume to one that rewards value, as defined by the intersection of cost and quality. To ensure the long-term sustainability of the improvements made possible by the DSRIP investments, the State is required to submit a multiyear roadmap for comprehensive Medicaid payment reform, including how the State will amend its contracts with managed care organizations.

To support the transition to VBP, the State is tasking each DSRIP Preforming Provider System (PPS) with the development of a local PPS sustainability plan which must include how the PPS intends to support its assigned catchment area with the successful implementation of VBP, even after the expiration of the Delivery System Reform Incentive Payment (DSRIP) waiver in 2020. In that sustainability plan the PPS must indicate how they plan to help the State advance value-based services design.

NYS Behavioral Health Value Based Payment Readiness Program:

A Behavioral Health Care Collaborative (BHCC) is a network of providers delivering the entire spectrum of behavioral health services available in a natural service area. BHCCs may include but are not limited to licensed/certified/designated OMH/OASAS/Adult BH HCBS programs. The Readiness Program is designed to achieve two overarching goals:

1. Prepare behavioral health providers to engage in VBP arrangements by facilitating shared infrastructure and administrative capacity, collective quality management, and increased cost-effectiveness; and
2. Encourage VBP payors, including but not limited to MCOs, hospitals, and primary care practices, to work with BH providers who demonstrate their value as part of an integrated care system.

As BHCCs mature they will begin to collaborate with primary care and hospitals to better manage population health under VBP arrangements. BHCCs will enhance quality care through clinical and financial integration and community-based recovery supports. They will promote integrated care (physical and behavioral) and attention to

social determinants of health and prevention through community partnerships. As part of the population health management ecosystem in a given region, BHCCs must work with the PPSs and MCOs to advance this physical and behavioral health collaboration and integration. It is very important that BHCCs not duplicate existing infrastructure (especially IT capability) already built by PPSs. Funding will assist BHCCs in building infrastructure necessary to collect, analyze, and respond to data to efficiently improve Behavioral Health (BH) and physical health (PH) outcomes. BHCCs will use the resulting data collection, analytics, quality oversight and reporting, and clinical quality standards to improve care quality and enhance their value in VBP arrangements. The expectation is that BHCCs will leverage their shared expertise to be in a better position to enter VBP contracts.

For additional information, please review the following webpages regarding New York State's VBP initiatives:
VBP Roadmap Update Year 3:
https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_library/docs/2017-11_final_vbp_roadmap.pdf

NYS DOH DSRIP VBP Home Page:
https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_reform.htm

NYS DOH VBP for Providers:
https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_providers/index.htm

NYS OMH VBP Provider Readiness: https://www.omh.ny.gov/omhweb/bho/bh-vbp.html

NYS OMH BHCC Readiness Program: https://omh.ny.gov/omhweb/bho/bh_vbp_readiness_overview_9152017.pdf

**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 build more behavioral health capacity for primary care, and to build primary care capacity for behavioral health. They include Integrated Outpatient Services regulations, DSRIP integration projects, and Collaborative 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-certified programs (14 NYCRR Part 825), and DOH-licensed providers (10 NYCRR Part 404).

Over the past eight years, OMH, OASAS, and DOH have 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.

Applicable Sites for Integrated Outpatient Services

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. Primary Care Host Model: 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 March 2019):

60 Approved OMH Host Sites (7 applications currently under review/pending final approval, as of March 2019)

- 47 with SUD
- 9 with primary care
- 4 with both SUD and primary care

27 Approved OASAS Host Sites (2 applications currently under review/pending final approval, as of March 2019)

- 24 with mental health
- 2 with primary care
- 1 with both mental health and primary care

7 Approved DOH Host Sites (4 additional applications currently under review/pending final approval, as of March 2019)

- 6 with mental health
- 0 with SUD
- 1 with both mental health and SUD

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 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.

Approved DSRIP 3.a.i. integrated clinic sites (as of January 2019):

27 OMH host sites total

- 16 with SUD
- 9 with primary care
- 2 with both

11 OASAS host sites total

- 2 with MH
- 3 with primary care
- 6 with both

5 DOH host sites total (with 17 additional under review as of January 2019)

- 0 with MH
- 3 with SUD
- 1 with both

**Table 2.2 Licensure Threshold Crosswalk for DSRIP Project 3.a.i. Clinics**

| 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 provider is able to integrate mental health and substance** | 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. |

| | |
|---|---|
| **use disorder services pursuant to a Memorandum of Agreement between OMH and OASAS.** | 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 Medicaid Program**

Behavioral health disorders such as depression, anxiety, and substance use disorders are major drivers of disability and health care costs, but only three in 10 adults living with a mental health or substance use disorder currently receive care from a mental health specialist.[1] At a time when policy makers 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. An electronic registry is used to track each individual's progress and to monitor outcomes on the whole patient population. Collaborative Care helps a practice build the capacity in-house to treat behavioral health conditions, and 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.

New York has continued to be a leader in the promotion of the Collaborative Care model for integration of behavioral health into primary care. The model is supported by more than 80 randomized controlled trials that demonstrate that patients achieve better outcomes when their behavioral health needs are addressed in their primary care practice with Collaborative Care.

With a legislative allocation of at least $10 million annually to support the New York State Collaborative Care Medicaid Program (CCMP), more than 6,000 Medicaid patients have benefited from receiving treatment for their depression and anxiety in primary care since the program began in 2015. There are now more than 185 primary care practices that have been approved by OMH to be providing evidence-based Collaborative Care across the State, including hospital-affiliated clinics, federally qualified health centers and independent provider practices. CCMP continues to provide technical assistance and training to participating practices to help them continue to grow and sustain their programs. Medicare and many commercial plans are now reimbursing providers for Collaborative Care, giving even greater access for patients and increased sustainability for providers.

In addition to the training and support practices receive, New York State has designed an innovative payment model to advance sustainability for practices in CCMP. Reimbursement is one of the principal barriers to adoption of the Collaborative Care model, since it does not fit in a typical fee-for-service structure. New York State has developed a value-based formula that uses a monthly case-rate payment. This allows practices to provide necessary services flexibly, without being limited by fee-for-service billing. The monthly payment also helps to support crucial infrastructure, such as the addition of behavioral health care management staff to provide counseling and care coordination as well as maintenance of a population-health registry system that allows for tracking of patient progress.

The value-based payment model emphasizes frequent telephonic contacts with the patient, recurring in-person sessions, and virtual consultation with an off-site psychiatrist for caseload support focused on patients who are not improving. In order to receive the monthly payment, the practice needs to have had contact with patients and completed a PHQ-9 depression screening to track patients' depression symptoms.[2] 25 percent of the payment is withheld each month, and can be paid retroactively after six months if the practice can attest that the patient has

[1]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. *Archives of General Psychiatry, 62* (6) 629-40.

[2] The Patient Health Questionnaire, or PHQ-9 is a widely-used nine-question depression screening tool.

improved, or that they have intervened and made adjustments to the patient's treatment plan to address the lack of improvement. Participating sites report process and outcomes data on a quarterly basis. These measures hold providers accountable so that patients do not remain in ineffective treatment for too long.

The combination of financial and training support has resulted in positive outcomes for participating sites. As of September 2018, an average of 50 percent of patients being treated for depression or anxiety in CCMP sites have shown improvement after 10 weeks or more of treatment. CCMP sites are screening an average of 80 percent of their patients for depression. Sites have also seen an increase in the number of patients who are not improving that have had changes made to their treatment plan and/or their case reviewed by the psychiatric consultant -- which indicates practices are intervening earlier to improve outcomes.

In addition to CCMP, other major NYS initiatives support the implementation of Collaborative Care as part of the increasing emphasis on behavioral health integration, including the Delivery System Reform Incentive Payment (DSRIP) Program project 3.a.i. and Advanced Primary Care. In concert with the Medicaid program, these programs stand to materially improve access to integrated and coordinated behavior healthcare for New Yorkers. In doing so, NYS seeks to reduce the burden of disease for common, disabling behavioral health conditions, such depression, anxiety and substance use disorders. For information on the Collaborative Care model or its role in the Medicaid program, contact nyscollaborativecare@omh.ny.gov.

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

The mission of the New York State Office of Alcoholism 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.

OASAS oversees an SUD and problem gambling service system that provides a full array of services to a large and culturally diverse population. OASAS funds, certifies and regulates the State's system of SUD and problem gambling treatment and prevention services, including the direct operation of 12 Addiction Treatment Centers (ATCs) statewide. The OASAS treatment provider system serves about 234,000 people each year, with an average daily enrollment of 99,100 across more than 900 certified programs. During the 2017-18 school year, approximately 3,717,000 residents were reached by a one-time, population-based prevention service and 454,000 youth received a direct prevention service.

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

- Enhancing Access to Prevention, Treatment, and Recovery;
- Improving Effectiveness and Quality of Prevention, Treatment, and Recovery Services and Supports; and
- Strengthening the SUD Clinical Workforce to Meet the Evolving Needs of the Services System

#### Enhancing Access to Prevention, Treatment, and Recovery

2018-2019 Enacted Budget Opioid Treatment Initiatives

The 2018-2019 Enacted Budget included several initiatives that build on existing efforts to combat the heroin and opioid crisis affecting communities throughout the state, including:

- *Creating the Office of the Independent Substance Use Disorder and Mental Health Ombudsman*
  The Office is operated, and the Ombudsman was selected by OASAS, in consultation with OMH. The Ombudsman identifies, investigates, refers and resolves complaints relating to health insurance coverage, network adequacy, and access to initial and continuing substance use disorder care and mental health care.
- *Eliminating Prior Authorization for Outpatient Substance Use Disorder Services*
  The Enacted Budget amended NYS Insurance Law to eliminate prior authorization for outpatient SUD services. Coverage cannot be subject to a concurrent review during the first two weeks of continuous treatment.
- *Establishing the Children and Recovering Mothers Program*
  This program is aimed at providing health care providers, hospitals and midwifery birth centers with

guidance, education and assistance when providing care to expectant mothers with a substance use disorder

- *Setting Up New Infant Recovery Centers*
  The 2018-2019 Budget authorized the creation of up to four new Infant Recovery Centers to care for infants with prenatal substance exposure and to provide services and supports to parents for bringing these infants home.
- *Funding County Correctional Facility-based Substance Use Disorder Treatment and Transition Services*
  The State supported County Correctional Facility-based substance use disorder treatment and transition services with a $3.75 million appropriation in the 2018-2019 Budget.

Hospital Detoxification Services Waiver

New York State Mental Hygiene Law §32.05 specifically requires OASAS certification for the operation of a discrete residential or non-residential chemical dependence services unit in a hospital. When an individual presents at a hospital Emergency Department (ED) having had an overdose reversed with Narcan, or seeking detoxification services, hospitals have been reluctant to admit such an individual for detoxification services to a general medical/surgical bed because they do not hold a separate certification issued by OASAS. OASAS recognizes that this is a missed opportunity that could potentially have fatal consequences.

In March 2018, OASAS exercised its power to provide Article 28 hospitals with a time limited waiver to provide detoxification services above the threshold of 5 beds or greater than 10% of overall patient days, upon notification to OASAS and DOH of their intent to provide such services. This waiver will permit the admission and treatment of appropriate patients above the regulatory limits for detoxification without the need for an OASAS operating certificate.

Opioid State Targeted Response Grant Program Treatment System Enhancements

In April 2017, the Substance Abuse and Mental Health Services Administration (SAMHSA) awarded OASAS $25.2 million in federal funding through the Opioid State Targeted Response (STR) grant program. For Year 1 of the grant, OASAS identified 16 upstate counties, including tribal territories, with the highest need, and divided them into seven Centers of Treatment Innovation (COTIs). The 16 counties receiving the bulk of funding are designated as having high needs, based on the number of opioid overdose deaths, emergency room visits involving opioids, and residents leaving the county to access treatment for Opioid Use Disorder (OUD). The counties are Oswego, Yates, Cayuga, Greene, Tioga, Tompkins, Jefferson, Ulster, Sullivan, Madison, Erie, Onondaga, Ontario, Saratoga, Niagara, and Montgomery.

In April 2018, SAMHSA awarded OASAS an additional approximately $25.3 million in a second round of Opioid STR funding. OASAS identified 19 additional counties and tribal areas based on the same need criteria as year one. An additional 12 COTIs were established serving an additional three Empire State Development (ESD) regions. All ten of the State's ESD regions are now being served by these COTIs.

Each COTI is overseen by a provider that is an expert in its respective region and has demonstrated success in the field of SUD treatment. COTIs identified specific gaps in services and developed plans to address the gaps within their area using:

- telehealth practices;
- treatment technologies, including mobile apps that support recovery efforts;
- phone contacts with clinical staff;
- family support; and
- in-community peer and counseling services that will be delivered at an individual's residence.

State Opioid Response (SOR) Grant Treatment Expansion

In September 2018, OASAS received a $36.8 million State Opioid Response (SOR) grant from SAMHSA. Projects funded through SOR are aimed at increasing access to MAT for OUD; reducing unmet treatment needs; and reducing opioid overdose related deaths through prevention, treatment and recovery. OASAS allocated

approximately $12.5 million for Prevention efforts and MAT education and training, and approximately $21.6 million for Treatment and Recovery efforts with the balance used for grant administration.

Additional OUD Treatment Expansion Through Federal Grants

In addition to the Opioid STR funding, in the fall of 2017 SAMHSA awarded OASAS three additional, competitive multi-year grants to increase OUD treatment:

- *Medication-Assisted Treatment Prescription Drug and Opioid Addiction (MAT-PDOA)*-
  The $5.7 million provided through the MAT-PDOA grant will expand access to MAT to underserved individuals in Bronx, Chautauqua, and Dutchess counties.
- *Promoting Integration of Primary and Behavioral Health Care (PIPBHC)*-
  SAMHSA awarded OASAS $10 million over five years to integrate primary health, mental health, and SUD treatment for individuals with OUD receiving services through partnership arrangements between Opioid Treatment Programs (OTPs), primary health clinics, and mental health clinics in Bronx and Albany counties.
- *State Pilot Grant Program for Treatment for Pregnant and Postpartum Women (PPW-PLT)*-
  The PPW-PLT grant provides $1.1 million to enhance treatment access and services for pregnant and postpartum women and their substance exposed newborns.

Innovative New Services

OASAS is rapidly implementing innovative services throughout the State. These new services include:

- 24/7 Open Access Centers
- Peer Engagement Specialists;
- Family Support Navigators;
- Youth Clubhouses;
- Recovery Centers;
- Recovery High Schools
- Certified Recovery Peer Advocates (CRPAs); and
- Regional Addiction Resource Centers

For descriptions of the services listed above and a list of locations please visit the OASAS website at http://oasas.ny.gov/CombatAddiction/RegionalSvc.cfm.

Problem Gambling Resource Centers (PGRCs)

OASAS plans to expand access to client-centered care in seven regions of the state through the development of regional PGRCs. Each PGRC is the central organization within its geographical region that is responsible for the facilitation of problem gambling awareness, community education, prevention, treatment and recovery support, as well as collaborating with local gambling facilities. In addition to facilitating problem gambling services in the regions, the Centers will build collaborative relationships with local gambling facilities to ensure information and referrals are available to people who identify as having a gambling problem.

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

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.

Statewide Prevention Media Campaigns

- *Combat Heroin*
  The Combat Heroin campaign informs and educates New Yorkers about the risks of heroin and prescription opioid use, the signs of addiction, and the resources available to help.
- *Combat Addiction*
  The statewide Combat Addiction 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. As part of the Combat Addiction campaign OASAS, in collaboration with the New York State Media Service Center, produced Reversing the Stigma- a documentary about addiction and recovery and the stigmas that surround them.
- *Talk2Prevent*
  OASAS developed the Talk2Prevent campaign to give parents the information and tools they need to talk to their children about the risks of underage drinking and drug use.
- *Hidden Fentanyl Kills*
  The Hidden Fentanyl Kills campaign consists of ads and information cards warning New Yorkers about the dangers of fentanyl, providing safety tips on prevention, and offering guidance on how to safely respond to a fentanyl overdose.
- *You Can be the Difference*
  The "You Can be the Difference" campaign is designed to provide educators, coaches and families with information and resources designed to curb addiction amongst the youth population in New York State.
- *We Can't Lose Anyone Else*
  The We Can't Lose Anyone Else campaign is designed to save lives, show how New York is leading the fight against addiction and save lives by communicating that help is available. It is also intended to inform the public about the full array of treatment options available to assist anyone impacted by substance abuse, regardless of a person's ability to pay.

Evidence-Based Programs and Strategies (EBPS) for Prevention

OASAS promotes the improvement of the SUD 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. EBPS are a required standard for all service providers and most EBPS provided by OASAS-funded prevention providers are delivered in school settings. OASAS established six Prevention Resource Centers (PRCs) to support local communities' implementation of EBPS. The PRCs disseminate current prevention science, through training and technical assistance, to community coalitions and prevention providers.

Strategic Prevention Framework Partnership for Success (SPF PFS)

In September 2014, SAMHSA awarded OASAS a five-year $8.13 million Strategic Prevention Framework Partnership for Success (SPF PFS) grant. The SPF PFS grant program is intended to prevent the onset and reduce the progression of substance misuse and its related problems while strengthening prevention capacity and infrastructure at the State, tribal, and community levels. OASAS is targeting prevention priorities focused on:

- Prescription drug misuse and abuse among persons aged 12 to 25; and
- Heroin abuse and heroin/opioid overdose prevention among persons aged 12 to 25.

**Strengthening the SUD Clinical Workforce to Meet the Evolving Needs of the Services System**

2018-2019 Enacted Budget Initiatives to Strengthen the SUD Workforce

- *Permanent Exemption to Professional Licensure Requirements*
  Education Law Articles 153, 154 and 163 define the scope of practice for psychologists, social workers, and

mental health practitioners. Since 2002, persons employed in programs regulated, operated, funded or approved by OASAS, have been temporarily exempt from these licensure requirements and this exemption has required multiple legislative reauthorizations. The 2018-2019 Enacted Budget established a permanent exemption of professional licensure requirements for certain unlicensed practitioners funded or approved by OASAS and the other Mental Hygiene agencies.

- *Telehealth Authorized for Credentialed Alcoholism and Substance Abuse Counselors*
  Regulatory modernization was included as part of the 2018-2019 Enacted Budget to authorize payments for services delivered by Credentialed Alcoholism and Substance Abuse Counselors (CASACs) in OASAS-approved settings via telehealth. The Public Health Law was amended to include credentialed alcoholism and substance abuse service counselors as telehealth providers and early intervention providers. This also expanded telehealth reimbursement to permit payment for services delivered wherever the patient was located.
- *Certified Peer Recovery Advocate (CPRA) Services Program Defined*
  The 2018-2019 Enacted Budget established a new Certified Peer Recovery Advocate (CPRA) Services Program and defined the program and services to be provided by CPRAs.

State Funding to Support Recruitment and Retention of CPRAs and Nurse Practitioners

In October 2018, Governor Cuomo announced $5 million in state funding is available to support the recruitment and retention of CPRAs and nurse practitioners to assist New Yorkers suffering from addiction. OASAS will award up to 170 grants to certified outpatient and opioid treatment providers to help secure approximately 120 nurse practitioner and 50 Certified Peer Recovery Advocate positions across the state. Eligible outpatient and opioid treatment programs may apply to receive one-time funding of $25,000 for the recruitment and salary needs for a nurse practitioner position. Eligible outpatient programs may also apply to receive one-time funding of $40,000 for a Certified Peer Recovery Advocate position.

## 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 in State Fiscal Year (SFY) 2014-15 and continuing through SFY 2018-19, the OMH Transformation Plan has committed over $90 million annualized in inpatient psychiatric savings into priority community services and supports, with the goals of reducing State and community- operated facilities' inpatient psychiatric admissions and lengths of stay. Nearly $19 million in additional Article 28 reinvestment funds have also been directed across the State as the result of unnecessary community inpatient bed reductions over the past several years. These funds have further developed the critical community services and supports needed to prevent inpatient hospitalization, transition individuals from inpatient settings, and strengthen the community mental health safety net.

### 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 2019-2024, and initiatives including:

Project TEACH

Project TEACH is a program 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 addition to pediatric primary care providers, other providers who offer ongoing treatment to children, such as general (non-child) psychiatrists, may request a consultation – further improving the quality of care available to New York children already engaged with psychiatric treatment providers.

The current funding for Project TEACH runs through 2020 and supports seven Regional Provider sites with child and adolescent psychiatry staffing at 5.25 full time equivalents statewide.

In this funding period, OMH established the Project TEACH Statewide Coordination Center (SCC) to oversee the successful expansion of Project TEACH. The SCC functions include the following: 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 works 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.

In 2018, the SCC expanded Project TEACH to provide maternal health providers access to consultation around maternal mental health issues as well as access to training and assistance with referral and linkage.

Additionally, the SCC is charged with 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. In 2018, the SCC hosted the inaugural Prevention Science Forum - Innovative Practices in Prevention Science, and the New York State Conference on Maternal Depression.

For more information about Project TEACH, including information on how primary care providers can take advantage of this program, please visit: http://projectteachny.org.

Expanding Systems of Care through ACHIEVE

The Systems of Care (SOC) principles are rooted in a philosophy, set of values, and a framework through a coordinated network of community-based services and supports. This model is organized to meet the physical, behavioral, social, emotional, educational, and developmental needs of children and their families in a process that is youth and family guided. Integral to the SOC approach is the promotion of wellness of children and youth across the lifespan by providing supports that build on the strengths of individuals and those that care about them, while addressing each person's cultural and linguistic needs. SAMHSA currently funds over 190 SOC communities nationwide, with several New York counties being current awardees.

For over 30 years, New York has been committed to SOC principles and practices, which has been demonstrated through state, local and federally-funded initiatives that have produced transformational changes in the state's child-serving systems. For the first time, OMH has applied for and received a Statewide SOC grant that will be piloted with demonstration projects in three counties – Erie, Rensselaer and Westchester. This pilot project is known as Advancing Care through Health Integration and Evidence-based Eff ort, or ACHIEVE, which has a project goal of integrating an evidenced based High Fidelity Wraparound (HFW) model with Health Homes Serving Children (HHSC) developed under the Medicaid Redesign and rolled out in December 2016. Under this program, eligible children and youth receive care coordination and access to services.

NYS ACHIEVE is a four-year initiative that integrates the HFW model with the HHSC program for youth and young adults ages 12 to 21, with serious emotional disturbance and high, complex needs. ACHIEVE partners include the

Research Foundation for Mental Hygiene, State and local child-serving agencies, family representatives, and youth partners involved with SOC eff orts throughout the State. These partners will serve a sub-group of youth and families who have more intensive needs such as placement or risk of placement that can be met through the HHSC's standard care management and benefit package.

The ACHIEVE initiative's demonstration projects in Erie, Rensselaer and Westchester counties, will work with two HHSCs per county and four care management agencies. When fully operational, the local demonstrations are expected to serve 60 youth and their families, totaling 191 youth/families over the four-year project period.

Each child and family simultaneously works with a triad team composed of a Health Home care manager, a family peer and a youth peer, who will all be trained in the HFW model. The team will also be trained using a model developed by the Nathan Kline Institute to maintain fidelity to the SOC principle of meeting the child and family's cultural and linguistic needs. The triad's responsibility is to carry out the planning process per the HFW model, in the context of HHSC and to assist in access to and building of both informal and formal supports from a variety of service systems.

OnTrackNY

OnTrackNY is New York's model early psychosis intervention program, which was built on the National Institute of Mental Health-funded Recovery After an Initial Schizophrenia Episode (RAISE) Implementation and Evaluation Study. The RAISE Connection program study developed and tested the outcomes and implementation challenges of a team-based approach to providing an array of pharmacologic and psychosocial services to help young people with recent-onset psychosis keep their lives on track after an initial psychotic episode. The RAISE Connection program had very high rates of engagement, doubled rates of participation in school and work, and increased rates of remission from psychotic symptoms.

The OnTrackNY program treatment teams consist of a team leader, primary clinicians, a supported employment/education specialist, an outreach and enrollment specialist, a psychiatrist and nurse. Each team provides a range of services, including relapse prevention, illness management, medication management, integrated substance use treatment, case management, family intervention and support, supported employment, and education. Results from the OnTrackNY program include improvements in engagement, functioning and symptoms that are comparable to the RAISE Connection program findings. OnTrackNY is currently operating at 21 sites throughout New York State, with 9 new sites opening since 2016. The 21 currently operating programs are located in the following areas: Albany, Binghamton, Buffalo, Farmingville, Garden City, Middletown, New York City (12 sites), Rochester, Syracuse, and Yonkers.

Suicide Prevention

In 2017, nearly 1,700 New Yorkers died by suicide. To address this significant public health problem, Governor Cuomo has formed the New York State Suicide Prevention Task Force, which includes leaders from state agencies, local governments, not-for-profit groups, and other recognized experts in suicide prevention. First announced in Governor Cuomo's 2017 State of the State, the Task Force will examine and evaluate current suicide prevention programs services, and policies. Members will then make recommendations to increase access, awareness, and support for children, adolescents and adults in need of assistance.

The Task Force is also focusing on suicide prevention that targets high-risk demographic groups and special populations, including members of the Lesbian, Gay, Bisexual, Transgender (LGBT) community, veterans, and Latina adolescents. Veterans in New York State represent more than 15 percent of suicides, while nationally, LGBT adolescents are four times more likely to have attempted suicide than their non-LGBT peers; and Latina adolescents have the highest suicide attempt rates when compared to non-Hispanic peers.

In addition to the ongoing work of the Task Force, OMH's Suicide Prevention Office (SPO) has developed a comprehensive Suicide Prevention Plan that addresses the problem at three levels:

a. Implementation of the Zero Suicide strategy for preventing suicide for individuals in health and behavioral health care settings;

b. A lifespan prevention approach to foster competent and caring communities; and
c. Suicide surveillance and data-informed suicide prevention.

The full version of the SPO's Suicide Prevention Plan 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 have enrolled nearly 3,400 children across New York State since program inception.

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 and Systems of Care (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. 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. 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.

OMH Data Portals

Data-driven and evidenced-based programs are at the center of healthcare reform to ensure the provision of quality behavioral healthcare. This section provides an outline of the different publicly available data resources that OMH publishes for community providers, local governmental units, and other stakeholders to support planning and understanding of mental health services statewide. Both data portals and data books are presented in this section. Data portals are interactive reports that are updated on periodic basis, and allow different filters to be applied to the data based on user preference. Data books are prepared reports containing static data, and do not require additional user prompts. All data portals and data books described in this section can be found on the main OMH website or on the OMH Statistics and Reports webpage: https://www.omh.ny.gov/omhweb/statistics/index.htm.

- Find a Program Portal: The Find a Program portal provides information on all mental health programs in New York State that are operated, licensed or funded by OMH. Program information is generated from the OMH CONCERTS database. CONCERTS is maintained by OMH, with most of the data entered directly by providers via the Mental Health Provider Data Exchange. The Find a Program portal allows you to search for mental health programs using a set of geographic and programmatic criteria. Program details include provider contact information, program characteristics, populations served, and capacity levels (for certain licensed programs).

  Find a Program can be accessed from the main OMH website (omh.ny.gov) or directly at: https://my.omh.ny.gov/bi/pd.

- Psychiatric Services & Clinical Knowledge Enhancement System- PSYCKES Portal: The Psychiatric Services and Clinical Knowledge Enhancement System for Medicaid or PSYCKES (pronounced "sigh-keys") is a Health Insurance Portability and Accountability Act-compliant, web-based portfolio of tools designed to support quality improvement and clinical decision-making in the New York State Medicaid population. Providers with access to PSYCKES can access a portfolio of quality indicator reports at the state, region, county, agency, site, program, and client level to review performance, identify individuals who could benefit from clinical review, and inform treatment planning. Quality reports in PSYCKES are updated monthly, and clinical information is updated weekly.

  Developed by OMH, PSYCKES uses administrative data from the NYS Medicaid claims database to generate quality indicators and summarize treatment histories. This administrative data is collected when providers bill Medicaid for services. All states are required by the federal government to monitor the quality of their Medicaid programs, and many states are using administrative data such as Medicaid claims to support quality improvement initiatives. Quality indicators were developed in consultation with a scientific advisory committee of national experts in psychopharmacology and a stakeholder advisory committee of providers, family members, consumers, and professionals. Since all reports are based on Medicaid data, no data entry by providers is required.

  Access to PSYCKES requires the use of user ID and passcode, which is managed through OMH.

- County Mental Health Profiles Portal: The County Mental Health Profiles portal was designed to facilitate local planning through a collaboration between OMH, the NYS Conference of Local Mental Hygiene Directors, and the interagency Mental Hygiene Planning Committee, which is composed of representatives from the Office for People with Developmental Disabilities (OPWDD), the Office of Alcoholism and Substance Abuse Services (OASAS). The portal consolidates utilization, expenditure, and other data from an array of OMH and non-OMH data systems, and presents content in a standard format that enables responsive and effective local, regional, and statewide planning.

  The County Mental Health Profiles portal can be accessed at: https://www.omh.ny.gov/omhweb/tableau/county-profiles.html

- Adult Housing Portal: Housing is a priority concern for all people. For individuals with mental illness, safe and affordable housing is a cornerstone of recovery. However, stable access to good housing is a fundamental problem for many people with mental illness because of their low incomes, the limited supply and rising costs of low-income housing, and discrimination. To reduce stigma and provide opportunities for recovery, it is preferable that individuals with mental illness live in mixed-use settings.

  OMH is committed to maximizing access to housing opportunities for individuals with diverse service needs. OMH funds and oversees a large array of adult housing resources and residential habilitation programs in New York State, including congregate treatment, licensed apartments, single room occupancy residences, and supported housing.

  The Adult Housing Portal can be accessed at: https://www.omh.ny.gov/omhweb/statistics/AdultHousingRedirect.html

- County Capacity & Utilization- Calendar Years 2016-2017: OMH's County Capacity and Utilization Data Book includes inpatient and community-based psychiatric service utilization and capacity statistics for calendar years 2016-2017, displayed at the statewide, region, and county levels. The County Data Book also summarizes service utilization based on per capita rates from the US Census population estimates. Inpatient service utilization is summarized separately by provider county of location and by patient county of residence. Community-based service utilization is summarized by provider county only. Both inpatient and community-based service capacity and utilization are displayed separately for the adult (18 and older) and child (under 18) populations, where appropriate. The data presented come from Child and Adult Integrated Reporting System, CONCERTS, Institutional Cost Report, Medicaid, Mental Health Automated

Record System, PCS, and New York State Department of Health Statewide Planning and Research Cooperative System.

This data book can be found at: https://www.omh.ny.gov/omhweb/special-projects/dsrip/ccudb.html.

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.

MyCHOIS (formerly MyPSYCKES)

My Collaborative Health Outcomes Information System (MyCHOIS) is an interactive, web-based platform of evidence-based tools used to promote active participation by consumers in their mental health treatment and recovery. We provide patients with access to their personal health record, assessments to help themselves and their clinicians understand and track treatment preferences, progress, and outcomes, as well as a library of resources and recovery tools to support continued health education. MyCHOIS has three major components: My Treatment Data, which allows Medicaid consumers to view their treatment history; The Learning Center, which provides educational materials and recovery tools; and Assessments and Screenings, which allows consumers to complete different evidence-based tools and screenings that have been assigned to them by their prescriber or treatment team. The program aims to increase empowerment, activation and health literacy amongst patients, improve doctor-patient communication, promote patient-centered care and recovery, and enhance the ability to make data-driven treatment decisions.

## 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

**F. New York State Prevention Agenda 2019-2024: Making New York the Healthiest State in the Nation for People of All Ages.**

The New York State Prevention Agenda 2019-2024 is the Department of Health's (DOH) multi-year state health improvement plan. The goal of the Prevention Agenda is for State and local action 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 Well-Being and Prevent Mental and Substance Use Disorders; and
5. Prevent Communicable Diseases

The vision of the Prevention Agenda for 2019-2024 is that New York is the Healthiest State in the Nation for People of All Ages. To improve health outcomes, enable well-being, and promote equity across the lifespan, the Prevention Agenda, the plan incorporates a Health-Across-All Policies approach and emphasize health aging across the lifespan.

The plan calls for community engagement and collaboration across sectors, 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 across the lifespan. The Prevention Agenda also identifies evidence-based and best practice interventions and offers guidance on related intermediate measures at the local level that help assess progress toward meeting objectives.

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 partners to develop and implement Community Health Assessments and 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 Public Health and Health Planning Council's Public Health Committee will lead the development of the Prevention Agenda 2019-2024 and will be establishing cross-sectoral workgroups to develop the priority-specific action plans. Workgroup members will solicit community feedback, refine goals, identify best practices and ways to measure progress in each of the five priority areas of the Prevention Agenda for this next cycle

The Prevention Agenda 2019-2024 guidance is under development. In the guidance, local health departments and hospitals will be encouraged to develop plans in coordination with local governmental units; particularly in the priority toward promoting well-being and preventing mental and substance use disorders.

## 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.

**All plans must be completed, certified, and submitted in CPS by Monday, June 3, 2019.**
Questions, problems or concerns regarding planning forms or the County Planning System (CPS) may be directed to oasasplanning@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 information input in the 2019 Goals and Objectives Form will be brought forward into the 2020 Form. LGUs can use the 2019 information as starting point for the 2020 but should ensure that each section contains relevant, up-to-date responses.

***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. 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**, overall, has changed over the past year:
○ Improved ○ Stayed the Same ○ Worsened

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

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

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

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

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

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 (up to five for LGUs outside of New York City) objectives.** For those categories that apply to multiple disability areas/state agencies, please indicate, in the objective description, each service population/agency for which this unmet need applies. *(At least one need category must be selected).*

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

(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

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Thank you for participating in the 2020 Mental Hygiene Local Services Planning Process by completing this survey. Any technical questions regarding the County Planning System please contact the OASAS 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 dependence 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.

**Problem Gambling:** Gambling behavior which causes disruptions in any major area of life: psychological, physical, social or vocational. The term "problem gambling" includes, but is not limited to, the condition known as "pathological" or "compulsive" gambling, a progressive addiction characterized by increasing preoccupation with gambling, a need to bet more money more frequently, restlessness or irritability when attempting to stop, "chasing" losses, and loss of control manifested by continuation of the gambling behavior in spite of mounting, serious, negative consequences (as defined by the National Council on Problem Gambling, www.ncpgambling.org).

**Adverse Childhood Experiences (ACEs):** Stressful or traumatic events, including abuse and neglect. They may also include household dysfunction, such as witnessing domestic violence or growing up with family members who have substance use disorders. ACEs are strongly related to the development and prevalence of a wide range of health problems throughout a person's lifespan, including those associated with substance misuse.

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 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 Care Coordination:**
http://www.opwdd.ny.gov/opwdd_services_supports/service_coordination

## B. New York State Prevention Agenda Survey

The following survey is intended to promote alignment with the NYS Prevention Agenda for 2019-2024 as part of local services plan development.

All inquiries regarding this survey should be directed to oasasplanning@oasas.ny.gov.

Background

The New York State Prevention Agenda for 2019-2024 aims to make New York State the Healthiest State in the Nation for People of All Ages. The Prevention Agenda's overarching strategy is to implement public health approaches that improve the health and well-being of entire populations and eliminate health inequities. This strategy includes an emphasis on social determinants of health – the social, cultural and environmental factors that influence health status, and are root causes of poor health and adverse outcomes. An agenda that focuses on social determinants necessitates cross-cutting policy development and support for local implementation.

As part of the Prevention Agenda, counties are required to submit Community Health Assessment and Community Health Improvement Plans to the Department of Health. LGUs responsible for mental hygiene services have often been active partners in the development and implementation of these plans that align with the statewide prevention agenda. The 2019-2024 Prevention Agenda includes goals and interventions specific to behavioral health, and overall health and well-being. Within the Prevention Agenda, available here, please review the Healthy Women, Infants, and Children Action Plan (pgs. 97-153) and the Promote Well-Being and Prevent Mental and Substance Use Disorders Action Plan (pgs. 154-171).

To reach the statewide prevention goals, future local service planning should include implementation of identified or other evidence-based interventions. Localities will need to create or identify metrics and data collection methods to determine impact. In some cases, data or metrics may not exist. Therefore, data collection will need to occur at the county/provider levels. These activities will require the support of all stakeholders.

Questions:

1. Has your LGU developed a plan that aligns with the Statewide Prevention Agenda?
   - ○ No
   - ○ Yes, please explain:

2. Each of the eight goals in the "Promote Well-Being" focus area and "Prevent Mental and Substance Use Disorders" focus area, have an associated intervention. Please select which of the following interventions you have begun or will begin implementing:

| | |
|---|---|
| **Focus Area 1: Promote Well-Being** | |
| **Goal 1.1: Strengthen opportunities to build well-being and resilience across the lifespan** | |
| ☐ | 1.1 a) Build community wealth |
| ☐ | 1.1 b) Support housing improvement, affordability and stability through approaches such as housing improvement, community land trusts and using a "whole person" approach in medical care |
| ☐ | 1.1 c) Create and sustain inclusive, healthy public spaces |
| ☐ | 1.1 d) Integrate social and emotional approaches across the lifespan and establish support programs that establish caring and trusting relationships with older people. Examples include the Village Model, Intergenerational Community, Integrating social emotional learning in schools, Community Schools, parenting education. |
| ☐ | 1.1 e) Enable resilience for people living with chronic illness by increasing protective factors such as independence, social support, positive explanatory styles, self-care, self-esteem, and reduced anxiety. |
| ☐ | 1.1 f) Implement evidence-based home visiting programs |
| ☐ | 1.1 g) Other |
| **Goal 1.2 Facilitate supportive environments that promote respect and dignity for people of all ages** | |

| | |
|---|---|
| ☐ | 1.2 a) Implement Mental Health First Aid |
| ☐ | 1.2 b) Implement policy and program interventions that promote inclusion, integration and competence |
| ☐ | 1.2 c) Use thoughtful messaging on mental illness and substance use |
| ☐ | 1.2 d) Other |
| **Focus Area 2: Mental and Substance Use Disorders Prevention** | |
| **Goal 2.1: Prevent underage drinking and excessive alcohol consumption by adults** | |
| ☐ | 2.1 a) Implement environmental approaches, including reducing alcohol access, implementing responsible beverage services, reducing risk of drinking and driving, and underage alcohol access |
| ☐ | 2.1 b) Implement/Expand School-Based Prevention and School-Based Prevention Services |
| ☐ | 2.1 c) Implement Screening, Brief Intervention, and Referral to Treatment (SBIRT) using electronic screening and brief interventions (e-SBI) with electronic devices (e.g., computers, telephones, or mobile devices) to facilitate delivery of key elements of traditional SBI |
| ☐ | 2.1 d) Integrate trauma-informed approaches into prevention programs by training staff, developing protocols and engaging in cross-system collaboration |
| ☐ | 2.1 e) Other |
| **Goal 2.2 Prevent opioid overdose deaths** | |
| ☐ | 2.2 a) Increase availability of/access and linkages to medication-assisted treatment (MAT) including Buprenorphine |
| ☐ | 2.2 b) Increase availability of/access to overdose reversal (Naloxone) trainings to prescribers, pharmacists and consumers. |
| ☐ | 2.2 c) Promote and encourage prescriber education and familiarity with opioid prescribing guidelines and limits as imposed by NYS statutes and regulations. |
| ☐ | 2.2 d) Build support systems to care for opioid users or those at risk of an overdose |
| ☐ | 2.2 e) Establish additional permanent safe disposal sites for prescription drugs and organized take-back days |
| ☐ | 2.2 f) Integrate trauma informed approaches in training staff and implementing program and policy |
| ☐ | 2.2 g) Other |
| **Goal 2.3 Prevent and address adverse childhood experiences (ACEs)** | |
| ☐ | 2.3 a) Address Adverse Childhood Experiences and other types of trauma in the primary care setting |
| ☐ | 2.3 b) Grow resilient communities through education, engagement, activation/mobilization and celebration |
| ☐ | 2.3 c) Implement evidence-based home visiting programs |
| ☐ | 2.3 d) Other |
| **Goal 2.4 Reduce the prevalence of major depressive disorders** | |
| ☐ | 2.4 a) Strengthen resources for families and caregivers |
| ☐ | 2.4 b) Implement an evidence-based cognitive behavioral approach such as Peter Lewinsohn's Coping with Depression course, Gregory Clarke's Cognitive-Behavioral Prevention Intervention |
| ☐ | 2.4 c) Implement the Combined Parent-Child Cognitive-Behavioral Therapy (CPC_CBT) |
| ☐ | 2.4 d) Other |
| **Goal 2.5 Prevent suicides** | |
| ☐ | 2.5 a) Strengthen economic supports: strengthen household financial security, and policies that stabilize housing |
| ☐ | 2.5 b) Strengthen access and delivery of suicide care – Zero Suicide (a commitment to comprehensive suicide safer care in health and behavioral health care systems) |
| ☐ | 2.5 c) Create protective environments: reduce access to lethal means among persons at risk of suicide; integrate trauma informed approaches; reduce excessive alcohol use |
| ☐ | 2.5 d) Identify and support people at risk – Gatekeeper Training, crisis intervention, treatment for people at risk of suicide, treatment to prevent re-attempts, postvention, safe reporting and messaging about suicide |
| ☐ | 2.5 e) Promote connectedness, coping and problem-solving skills: social emotional learning, parenting and family relationship programs, peer norm program |
| ☐ | 2.5 f) Other |

| Goal 2.6 Reduce the mortality gap between those living with serious mental illnesses and the general population | |
|---|---|
| ☐ | 2.6 a) Implement a multilevel intervention model that focuses at the individual, health systems, community and policy-levels. This model describes a comprehensive framework that may be useful for designing, implementing and evaluating interventions and programs to reduce excess mortality in persons with SMD. |
| ☐ | 2.6 b) Implement integrated treatment including concurrent therapy for mental illness and nicotine addiction |
| ☐ | 2.6 c) Support and strengthen licensing requirement to include improved screening and treatment of tobacco dependence by mental health providers |
| ☐ | 2.6 d) Other |

Please describe your efforts implementing the interventions selected above (if any). Also, if you selected an "other" category from any set of interventions above, please describe it here:

3. Have you engaged any local or regional partners in implementing actions related to the New York State Prevention Agenda (e.g., Local Health Department, hospital or hospital system, substance use disorder prevention coalition)?
   - ○ No
   - ○ Yes, please explain:

4. As data and metrics related to the Prevention Agenda's behavioral health interventions may not exist, has your LGU considered how to track progress of implementation?
   - ○ No
   - ○ Yes, please explain:

5. Has your LGU identified statewide policies that assist or impede implementation of Prevention Agenda interventions?
   - ○ No
   - ○ Yes, please explain:

6. Is your LGU planning for Prevention Agenda alignment by Article 31 and 32 clinics via implementation of evidence-based practices? If so, please describe, and include relevant details on any LGU support of data protocols that would assist clinics in determining outcomes.
   - ○ No
   - ○ Yes, please explain:

7. Are the Prevention Agenda's cross-cutting goals and priorities (e.g., environmental concerns, chronic illness reduction) addressed in your health department's Community Health Assessment and Community Health Improvement Plan? If so, how will your LGU support these cross-cutting goals and priorities?
   - ○ No
   - ○ Yes, please explain:

8. DSRIP funding has advanced many projects related to the overall improvement of behavioral health and well-being. Of these projects supported by DSRIP, are there local prevention opportunities that your LGU could build upon and sustain?
   - ○ No
   - ○ Yes, please explain:

9. Aside from Prevention Agenda activities, please identify any of the following social determinants of mental health that you are addressing in your community:

☐ Un/Underemployment and Job Insecurity
☐ Food Insecurity
☐ Adverse Features of the Built Environment
☐ Housing Instability or Poor Housing Quality
☐ Discrimination/Social Exclusion
☐ Poor Education
☐ Poverty/Income Inequality
☐ Adverse Early Life Experiences
☐ Poor Access to Transportation
☐ Other

Please describe your efforts in addressing the selections above:

10. In your county, do you or your partners offer training related to strengthening resilience, trauma-informed or trauma-sensitive approaches?

a) ○ No

○ Yes

b) If yes, please list

Title of training(s):

How many hours:

Target audience for training:

Estimate number trained in one year:

11. New to the 2019-2024 cycle of the Prevention Agenda is the incorporation of a Health-Across-all-Policies approach, initiated by New York State in 2017, which calls on all State agencies to identify and strengthen the ways that their policies and programs can have a positive impact on health. As part of this effort, New York State was designated as the first Age-Friendly State in the nation by the American Association of Retired Persons (AARP).

Does your LGU have policies and procedures in place to support the positive environmental, economic, and social factors that influence the health and well-being of all residents, especially older adults?

○ No
○ Yes, please provide examples:

## C. 2020 Office of Mental Health Agency Planning Survey (Value-Based Payment)

**2020 County Local Plan Services—VBP Survey**

The purpose of this survey is to promote continued and improved access to quality mental health services in Medicaid Reform (DSRIP/Value Based Payment). All questions regarding this survey should be directed to Melissa Staats, MA MSW, at 518-408-8533, or Melissa.Staats@omh.ny.gov.

**Background**
On April 14, 2014, New York received a waiver from the federal government that allowed the state to reinvest $8 billion in federal savings generated by Medicaid Redesign Team (MRT) reforms and support the redesign of the health care delivery system. Of this, $6.42 billion is used to support Delivery System Reform Incentive Payments (DSRIP). The DSRIP program promotes community-level collaborations and focus on system reform, specifically a goal to achieve a 25 percent reduction in avoidable hospital use over five years. DSRIP projects focus on system transformation, clinical improvement and population health improvement. All DSRIP funds are based on performance linked to achievement of project milestones.

***DSRIP serves as a bridge to value-based payment in New York State.***
https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/ DOH website

**DSRIP Performing Provider Systems (PPS)**
Organizations responsible for implementing DSRIP goals via Project Plans are called Performing Provider Systems. Many counties report the value PPS brings to communities as they provide resources that support efforts currently not funded by Medicaid.
*DSRIP Project Lists*
https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/dsrip_project_toolkit.htm
https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/pps_map/index.htm (PPS Statewide)

**Value Based Payment (VBP)—Reduce Costs/Improve Quality**
The New York State Medicaid managed care system is transforming from one that pays for service volume to one that rewards value, as defined by the intersection of cost and quality. This transformation is detailed in the NYS VBP Roadmap for Medicaid Payment Reform.
https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_library/docs/2017-11_final_vbp_roadmap.pdf

Further details regarding VBP readiness and implementation can be found at:
https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_reform.htm &
https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_providers/index.htm

**NYS Behavioral Health (BH) Value Based Payment (VBP) Readiness Program**
The BH VBP Readiness Program provides funding over 3 years to selected BH provider networks that have formed a Behavioral Health Care Collaborative (BHCC), beginning in 2017. There are 19 BHCCs across the state receiving this funding.
A BHCC is a network of providers delivering the entire spectrum of behavioral health services available in a natural service area. The BHCC includes, but is not limited to, all licensed/certified/designated OMH/OASAS/Adult BH HCBS programs and service types. The Readiness Program is designed to achieve two overarching goals:

1. Prepare behavioral health providers to engage in VBP arrangements by facilitating shared infrastructure and administrative capacity, collective quality management, and increased cost-effectiveness; and
2. Encourage VBP payors, including but not limited to MCOs, hospitals, and primary care practices, to work with BH providers who demonstrate their value as part of an integrated care system.

https://www.omh.ny.gov/omhweb/bho/bh-vbp.html
https://omh.ny.gov/omhweb/bho/bh_vbp_readiness_overview_9152017.pdf

New York State's goal is to have the vast majority of total managed care payments tied to VBP arrangements by 2020. DSRIP funding to support BHCCs and PPS projects ends March 31, 2020.

**Questions**

1. Have the PPS supported your LGU and community? For example, support for efforts such as: addressing gaps in services, promoting evidence based and best practices, and facilitating clinical integration.

a) ○ No
○ Yes

b) Please provide more information:

2. Has your LGU planned for PPS project sustainability beyond March 31, 2020?

a) ○ No
○ Yes

b) Please explain:

3. Are there any behavioral health providers in your county in VBP arrangements?

a) ○ No
○ Yes

b) Please explain (if "yes" include steps providers have taken to execute contracts):

4. Is the LGU aware of the ways in which managed care organizations and mental health providers plan to leverage VBP resources to implement evidence and best practices like, but not limited to, Collaborative Care Model (CCM), Dual Diagnosis Integration, or Self-Help and Peer Support Services?

a) ○ No
○ Yes

b) Please explain:

5. Is the LGU aware of the development of In-Lieu of proposals?

a) ○ No
○ Yes

b) Please explain:

6. Can your LGU support the BHCC planning process?

a) ○ No
○ Yes

b) Please explain:

7. Does your county have access to data and IT systems that will support further transformation to VBP and outcomes management?

a) ○ No
○ Yes

b) Please explain:

**D. 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 <u>two</u> 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.***

Indicate the number of CSB members who are or were consumers of **mental health** services:

Indicate the number of CSB members who are parents or relatives of persons with **mental illness**:

(End of survey)

## E. Community Services Board Roster (Counties Outside NYC)

**LGU: _____**

**Community Services Board Chair**

Name: _____
☐ Physician ☐ Psychologist
Represents: _____
Term Expires: Month _____ Year _____
Email Address: _____

Name: _____
☐ Physician ☐ Psychologist
Represents: _____
Term Expires: Month _____ Year _____
Email Address: _____

Name: _____
☐ Physician ☐ Psychologist
Represents: _____
Term Expires: Month _____ Year _____
Email Address: _____

Name: _____
☐ Physician ☐ Psychologist
Represents: _____
Term Expires: Month _____ Year _____
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.***

Indicate the number of CSB members who are or were consumers of **mental health** services:

Indicate the number of CSB members who are parents or relatives of persons with **mental illness**:

(End of survey)

## F. 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.***

## G. Mental Health 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: _____

Name: _____

CSB Member: ☐ Yes ☐ No

Represents: _____

Email Address: _____

Indicate the number of mental health subcommittee members who are or were consumers of mental health services:

Indicate the number of mental health subcommittee members who are parents or relatives of persons with mental illness:

***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.***

***New York State Mental Hygiene Law requires that "each subcommittee for mental health shall include at least two members who are or were consumers of mental health services, and at least two members who are parents or relatives of persons with mental illness."***

***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. Developmental Disabilities 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: _____

Name: _____ Name: _____

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

Represents: _____ Represents: _____

Email Address: _____ 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.***

**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 2019 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 2019 local services planning process.***

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Thank you for participating in the 2019 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 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 County Planning System (CPS) 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 to measure 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 able 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 1, 2019**. 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 1, 2018**. 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 |
|---|---|---|

| | PRU | Program Name | Services Provided On-site | Services Provided Off-site | Hours/Week Worked as a Health Coordinator | Hourly Rate (dollars) | Services Provided On-site | Services Provided Off-site | Hours/Week Worked as a Health Coordinator | Hourly Rate (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).

| | PRU | Program Name | Service Provided On-site | Service Provided Off-site | Hours per Week Worked as a Health Coordinator | Hourly Rate (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. Clinical Supervision Contact Information Form (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 soon 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 1, 2019**. 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 |
|---|---|---|---|
| + | | | |

(end of survey)

## C. OASAS Program Electronic Health Record (EHR) and Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) Program Survey

The following survey is designed to provide OASAS with program-level information regarding two topics that are integral to ensuring that individuals with Substance Use Disorders (SUDs) receive the highest quality care. Part I asks about Electronic Health Record (EHR) usage and Part II collects information regarding the treatment of individuals identifying as lesbian, gay, bisexual, transgender or questioning (LGBTQ).

Questions related to this survey should be directed to Carmelita Cruz at Carmelita.Cruz@oasas.ny.gov.

### PART I- Electronic Health Record (EHR) Survey

An Electronic Health Record (EHR) is a computerized record of health information about individual patients. Such records may include a whole range of data in comprehensive or summary form, including demographics, medical history, medication and allergies, immunization status, laboratory test results, radiology images, vital signs, personal information like age and weight, and billing information. Its purpose is to be a complete record of patient encounters that allows the automation and streamlining of the workflow in health care settings and increases safety through evidence-based decision support, quality management, and outcomes reporting.

The purpose of Part I of this survey is to assess your agency's status on the adoption of an EHR, and which EHRs are most commonly used by OASAS-certified programs.

**1. Does your program use an electronic health record?**

- ○ No
- ○ Yes, please provide the company and product names of your EHR below:
  - Company Name (e.g., Allscripts, Netsmart, Core Solutions, etc.): _____
  - Product Name (e.g., Paragon, CareRecord, Cx360, etc.) _____

### PART II- Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) Policy and Technical Assistance Survey

Research suggests that Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) individuals face health disparities linked to societal stigma, discrimination, and denial of their civil and human rights. OASAS recognizes that culturally sensitive treatment often results in more effective treatment. In order to protect the rights of LGTBQ individuals receiving Substance Use Disorder (SUD) treatment OASAS issued Local Services Bulletin (LSB) 2017-04 "Affirming Care for Lesbian, Gay, Bisexual, Transgender and Questioning Clients in OASAS Programs."

The purpose of Part II of this survey is to gather background information regarding the LGBTQ populations served by OASAS-certified SUD treatment programs so that OASAS may develop technical assistance for providers in order to deliver the best possible care to LGBTQ individuals.

2. Is your program aware of Local Services Bulletin (LSB) 2017-04 "Affirming Care for Lesbian, Gay, Bisexual, Transgender and Questioning Clients in OASAS Programs"

○ No ○ Yes

3. In your opinion and not relying on data reported to OASAS, please estimate the percentage of total clients treated over the course of a year that identify as lesbian, gay, bisexual, transgender or questioning _____ %

4. Does your program require technical assistance to comply with the requirements of the LSB?

- ○ No
- ○ Yes, I need assistance with the following (check all that apply)
  - ☐ a) Developing policies and procedures

☐ b) Staff training on affirming LGBTQ care
☐ c) Staff training on evidence-based practices, such as delivering trauma informed care
☐ d) Other, please describe: [ ]

(End of survey)

## 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 help 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 can 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. |