NEW YORK STATE | Office of Addiction Services and Supports | Office of Mental Health | Office for People With Developmental Disabilities

2021 Local Services Plan Guidelines for Mental Hygiene Services

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ANDREW M. CUOMO
Governor

ARLENE GONZÁLEZ-SÁNCHEZ, M.S., L.M.S.W.
Commissioner, Office of Addiction Services and Supports

ANN MARIE T. SULLIVAN, M.D.
Commissioner, Office of Mental Health

THEODORE KASTNER, M.D., M.S.
Commissioner, Office for People With Developmental Disabilities

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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 Addiction Services and Supports (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.

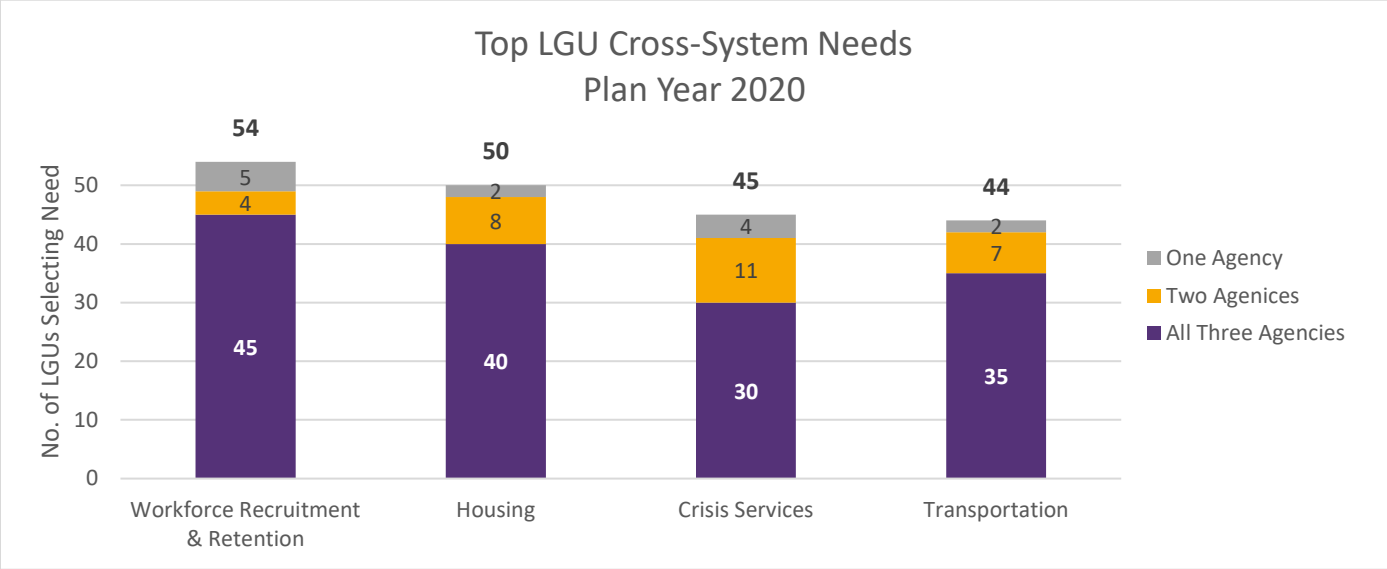
The Goals and Objectives Form is the primary document that LGUs use, as part of local services planning, to communicate and identify their local needs and their goals, objectives, and strategies to address those needs. On the 2020 Goals and Objectives Form, LGUs selected from specific categories to indicate 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 cross-system needs and goals most frequently cited by LGUs in Plan Year 2020 include:

- Workforce Recruitment and Retention (54 LGUs);
- Housing (50 LGUs);
- Crisis Services (45 LGUs); and
- Transportation (44 LGUs).

Figure 1.1 displays the needs LGUs most frequently selected on the 2020 Goals and Objectives Form. As Figure 1 shows, the majority of the top needs selected by LGUs cross multiple mental hygiene agencies. In total, for the top four most selected needs, 93% of LGUs indicated that the needs affect more than one mental hygiene population, and 78% cross all three agencies.

Figure 1.1: Most Frequently Selected LGU Needs, Plan Year 2020



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. 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://webapps.oasas.ny.gov/cps/

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.

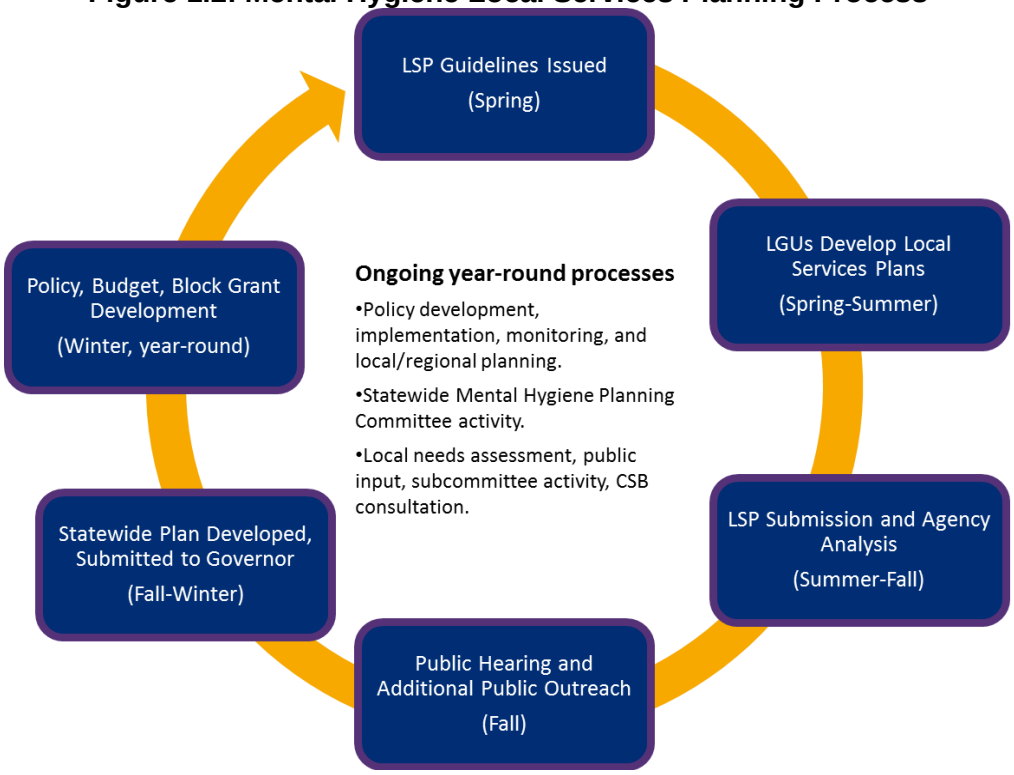
Please see **Appendix I** for information on CPS registration and user roles.

D. Mental Hygiene Local Services Planning Process

When the mental hygiene local services planning process became integrated, OASAS, OMH, and OPWDD established a fixed planning cycle 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: 2021 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 2020
Due date for completed OASAS provider planning surveys in CPS	**Wednesday, April 1, 2020**
Due date for completed LGU Plans in CPS	**Monday, June 1, 2020**

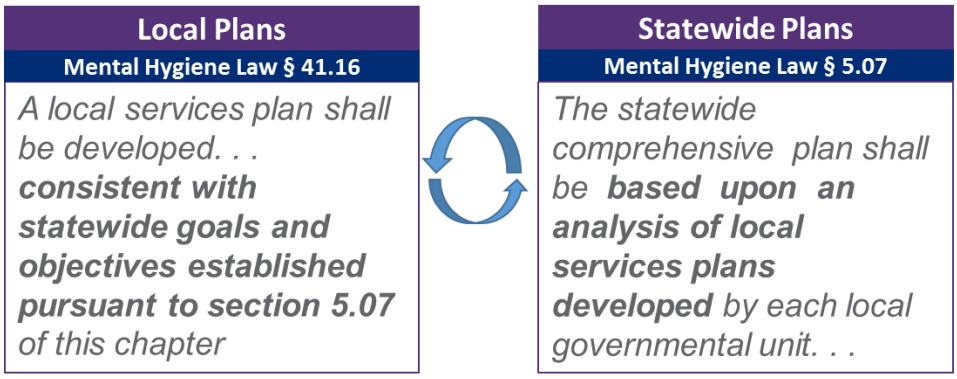
E. Informing Statewide Planning

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. 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.

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. 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. 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. 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

Administering 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 (BH HCBS). 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.

Adult BH HCBS Quality and Infrastructure

The State invested $75 million in infrastructure and quality initiatives for BH HCBS with MCOs to streamline access to Adult BH HCBS. The State has used data to closely manage step-by-step access to BH HCBS by MCO and Health Homes.

The Adult BH HCBS Quality-Infrastructure Program consists of two funding streams: infrastructure funds and a MMC quality pool. These funding streams are intended to work in tandem with Health Home Care Management Agencies and Adult BH HCBS providers to increase BH HCBS utilization. The BH HCBS Quality Fund Program measurement period is aligned with the Infrastructure Program service delivery period to maximize the impact of the funding. As of December 2019, 89 infrastructure contracts have been signed, and BH HCBS assessment uptake increased by 78 percent for providers in infrastructure contracts as opposed to a 28 percent increase for providers not in infrastructure contracts.

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 had previously only been 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 is intended to support delivery system transformation promoting early identification, prevention, and treatment and, in turn, can 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 has taken 3 key policy steps to stimulate the transformation:

1. NYS had made available via a State Plan Amendment, six new services that were either not available in NYS previously or only available to children who met narrow eligibility criteria.
2. NYS has simplified 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
3. Under the aligned 1915(c) Children's Waiver, NYS has established "Level of Care," and an expansion for "Level of Need," criteria to identify subpopulations of children who are likely to benefit from an array of home and community-based services. Beginning no later than 2021, the expansion to 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.

It is anticipated 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 Delivery System Reform Incentive Payment (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 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.

BHCCs are intended to 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 has assisted 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.

Early successes of the BHCCs are reflected in partnerships with Regional Health Information Organizations (RHIO) or qualified entities. Additionally, BHCCs have demonstrated a variety of partnerships and conversations with their local PPS', Federally Qualified Health Centers and private physician and hospital groups Sixteen out of eighteen BHCCs have established formal contracting entities, Independent Practice Associations (IPAs), in order to engage in VBP arrangements.

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

Mental Health Parity

Compliance with Mental Health Parity and Addiction Equity Act (MHPAEA)

In 2008, the federal Mental Health Parity and Addiction Equity Act (MHPAEA) was signed into law. MHPAEA requires group health plans and health insurance issuers to offer mental health and substance use services with equal to or fewer restrictions as medical and surgical services. The Patient Protection and Affordable Care Act of 2010 amended MHPAEA to include individual health insurance coverage.

In 2018, NYS undertook a comprehensive evaluation of the Medicaid fee-for-service delivery system and the program benefits managed through its Medicaid Managed Care Plan (MMCP) contractors to evaluate and document compliance and/or identify potential parity issues that required corrective action. This was done by requesting a comparative analysis of both quantitative and non-quantitative treatment limitations (NQTLs). A full description of the first phase of this work, along with the conclusions are outlined in the State's final report, available here: https://health.ny.gov/health_care/managed_care/reports/docs/2019-04-18_rpt.pdf.

The State is in the process of a phased approach to conduct NQTL evaluations to assess the application of any NQTL to any covered mental health or substance use disorder benefit. A second report will be released upon conclusion of this work. In the next phase of this work, the State will engage in a verification process to substantiate the information submitted by MMCPs regarding the priority NQTLs included in the evaluation phase.

Medical Necessity Criteria Review

Part BB of the FY 2020 NYS Executive Budget requires both commercial and MMCPs to use clinical review criteria that is evidence-based, has been peer-reviewed, is appropriate to the age of the patient, and which has been approved by the Office of Mental Health when making coverage determinations for mental health treatment. Insurers were to submit their clinical review criteria to OMH for approval, who will consult with Department of Financial Services (DFS) and the Department of Health (DOH), by January 1, 2020.

OMH is reviewing clinical review criteria to ensure coverage determinations for mental health services are made in a manner consistent with accepted medical practices and Federal and State behavioral health parity laws.

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 Addiction Services and Supports 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 site-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 December 2019):

79 Approved OMH Host Sites
- 64 with Substance Use Disorder
- 8 with Primary Care
- 7 with both SUD & PC

23 Approved OASAS Host Sites
- 20 with Mental Health
- 2 with Primary Care
- 1 with both MH & PC

9 Approved DOH Host Sites
- 6 with Mental Health
- 0 with Substance Use Disorder
- 3 with both MH & 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 December 2019):

31 Approved OMH Host Sites

- 17 with Substance Use Disorder
- 13 with Primary Care (2 sites also have “co-located” Article 32 licensure)
- 1 with both SUD & PC

8 Approved OASAS Host Sites

- 2 with Mental Health
- 3 with Primary Care

- 3 with both MH & PC

3 Approved DOH Host Sites

- 2 with Mental Health
- 1 with Substance Use Disorder
- 0 with both MH & SUD

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 use disorder services pursuant to a Memorandum of Agreement between OMH and OASAS.	A MHL Article 31 provider must be certified by OASAS if more than 49 percent of its total annual visits are for substance use disorder services. A MHL Article 32 provider must be certified by OMH if more that 49 percent of its total annual visits are for mental health services.

Collaborative Care 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.

[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.

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 13,000 Medicaid patients have benefited from receiving treatment for their depression and anxiety in primary care since the program began in 2015. There are now 280 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 provided, 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] Each month, 25 percent of the payment is withheld, and can be paid retroactively after six months if the practice can attest that the patient has 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 DSRIP 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 Addiction Services and Supports (OASAS) is to improve the lives of all New Yorkers by leading a comprehensive premier system of addiction services for prevention, treatment, and recovery.

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

OASAS oversees a Substance Use Disorder **(**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 system serves about 232,000 people each year, with an average daily enrollment of approximately 100,000 across more than 900 certified programs. During the 2018-19 school year, approximately 4,435,000 residents were reached by a one-time, population-based prevention service and 430,000 youth received a direct prevention service.

Statewide planning for addiction services is organized around three main priorities

- Expand Access to SUD and Gambling Treatment;
- Increase the Reach and Effectiveness of Prevention; and
- Enhance Services and Supports to Promote and Sustain Recovery from SUD.

PRIORITY: Expand Access to SUD and Gambling Treatment

Goal 1: Implement Innovative New Services and Pathways to SUD Treatment

Expanding Access to MAT and Enhancing Treatment Capacity

Medication assisted treatment (MAT) is the use of medications, in combination with psychosocial treatment and supports, to provide a whole-person approach to the treatment of substance use disorders. It is clinically driven with a focus on individualized patient care. MAT for opioid use disorder in particular is the safest approach to care and considered the best practice in the treatment of most patients including pregnant women. OASAS is committed to expanding access to MAT across New York. In 2019, the Agency provided $5 million to support the expansion of MAT at 50 programs, covering all 10 regions of the state.

Centers of Treatment Innovation (COTI)

In April 2017, the Federal Substance Abuse and Mental Health Services Administration (SAMHSA) awarded OASAS approximately $25.3 million per year for a two-year period through the State Targeted Response Grant (STR). SAMHSA also awarded OASAS the State Opioid Response (SOR) grant, effective September 30, 2018, which is a two-year grant for approximately $36.8 million per year as well as a $19.2 million SOR Supplemental grant in March 2019. A key component of OASAS' use of the federal grant funds has been the implementation of 20 Centers of Treatment Innovation (COTI) in 35 high-need counties across the State. These COTI deliver evidence-based, person-centered, and rapidly accessible care to meet the unique needs of people suffering from OUD.

COTI services include:

- mobile treatment;
- in-community peer support;
- telepractice; and
- rapid linkage to MAT.

Linkages with the Broader Healthcare System

OASAS is facilitating linkages between the SUD treatment system and other healthcare providers to ensure a continuum of care that addresses the full range of health needs. To expand access to MAT, OASAS facilitated partnerships between the OASAS treatment system and other healthcare providers to increase access to buprenorphine and provide linkage to treatment. Hospital emergency departments are now working with a local treatment program to offer peer engagement services to individuals seeking care for OUD or when OUD may be among other presenting issues. Even when a person refuses medication to treat OUD in the emergency department, a peer will maintain contact with an individual that can lead to later engagement in treatment.

Homeless Outreach and In-Community Services

Through the inclusion of SUD benefits in the Medicaid managed care benefit package and submission of state plan amendments to the Centers for Medicare & Medicaid Services (CMS), OASAS providers have been given authority to deliver and obtain reimbursement for rehabilitative services provided outside of the clinic walls. This has led to significant innovation for providers who can now go to community-based settings, including housing programs, physician offices, social service settings, or homeless shelters.

Overdose Reversal Training

Naloxone is a medication that revives an individual from an opioid overdose and has saved thousands of New Yorkers' lives. On March 3, 2016, Governor Cuomo announced that independent pharmacies across the state would be able to provide naloxone to their customers without a prescription. The opioid policy reforms enacted in June 2016 mandated insurance coverage for naloxone. The legislation requires insurance companies to cover the costs of naloxone for individuals covered under the policies. In addition, New York implemented Naloxone Co-payment Assistance Program (N-CAP) in August 2017 to expand access to naloxone by subsidizing the cost of co-payments for individuals with prescription coverage as part of their health insurance plan.

Naloxone training is available throughout New York State at OASAS ATCs as well as at DOH-registered training programs in local communities. Through federal grant funding, OASAS expanded naloxone training and the distribution of naloxone kits.

Community Health Access to Addiction and Mental Health Care Project (CHAMP)

The Community Health Access to Addiction and Mental Health Care Project, (CHAMP), was launched in October 2018 to assist people and their families in using their health insurance to access SUD or mental health care, and to identify, investigate, and resolve complaints made by or on behalf of consumers regarding their coverage. The program also helps providers to resolve their patients' insurance problems. People having issues can call a toll-free hotline (888-614-5400) and receive guidance on how to address any problems

Other Innovative, Nontraditional Services

OASAS is rapidly increasing the availability of services that connect people to treatment and assist in keeping them engaged throughout treatment. Much of this expansion is a result of Governor Cuomo's legislative agenda to combat the opioid crisis. In 2016, the Governor's Heroin and Opioid Task Force travelled across the State exploring the importance of providing locally-based services to people affected by addiction. Following these discussions, OASAS launched a series of nontraditional initiatives that offer a broad range of individual and community services. These new, innovative services include:

- 24/7 Open Access Centers
- Peer Engagement Specialists
- Family Support Navigators

New locations of the services above are opening continuously. The OASAS website maintains a list of these services by region https://oasas.ny.gov/recovery/regional-services.

Goal 2: Increase Opportunities for Addictions Treatment in the Criminal Justice System

National research indicates that the mortality rate among individuals during the first month post-release from criminal justice settings is much higher than the general population, and much of this excess mortality is driven by far higher rates of drug overdose death post-release. Using federal grant funds, New York State has implemented treatment transition for individuals with OUD reentering communities from criminal justice settings in 20 local correctional facilities and three state correctional facilities. Individuals receive SUD counseling, education in MAT, and upon release, the option to initiate MAT and a person-centered care plan for linkage to treatment. In addition, another project provides re-entry and support services to individuals with OUD

transitioning from prison or jail back into New York City communities.

Over the past few years, OASAS has worked with the Department of Corrections and Community Supervision (DOCCS) and local Sheriffs to expand the availability of MAT services in local and state correctional facilities. OASAS is also forging partnerships with the new Opioid Courts to provide comprehensive assessment and treatment engagement. OASAS-certified treatment programs work with local Opioid Courts to provide on-site, clinical assessment and peer services for individuals referred to the court based on a positive screen for possible OUD.

Goal 3: Promote Individual Choice and Person-Centered Care in SUD Treatment

OASAS is improving the effectiveness and quality of services through Person-Centered Care. Person-Centered Care is a collaborative, holistic approach to treatment. The individual engaged in services directs care to meet their needs in equal collaboration with the treatment provider. Treatment providers will now be required to have a medical professional on staff who can prescribe buprenorphine when medically appropriate. OASAS-certified programs must also accommodate all forms of MAT or make it readily accessible. And providers must guide patients toward individualized recovery goals.

OASAS revised its regulations to make SUD treatment much more person-centered and to lower barriers to MAT so that this life-saving treatment is as accessible and clinically appropriate as possible and released a guidance document on the revised regulations, available at: https://www.oasas.ny.gov/system/files/documents/2019/07/Standards%20for%20OASAS%20Certified%20Programs.pdf. Furthermore, there is an Addendum from the Office of Chief Medical Officer about person-centered medication treatment available at: https://www.oasas.ny.gov/system/files/documents/2019/10/medical-standards-for-certified-programs.pdf as well as guidance about necessary criteria for withdrawal management protocols, which includes emphasizing starting MAT during withdrawal management, at: https://www.oasas.ny.gov/medical-protocols-withdrawal-management.

Goal 4: Strengthen and Support the Addictions Workforce

One of the most common challenges that LGUs and treatment providers report to OASAS is recruiting and retaining qualified staff and peers to deliver services. In January 2019, OASAS awarded nearly $5 million in funding to assist OASAS-certified treatment programs in hiring nurse practitioners and Certified Recovery Peer Advocates (CRPAs). Providers were awarded one-time funding of $40,000 per peer advocate position, and $25,000 per nurse practitioner position. Over 80 providers in all 10 economic development regions received funding to fill 150 positions. Additionally, Governor Cuomo's 2020 Enacted Budget provided $350,000 for a scholarship program for SUD professionals, which is intended to address the critical workforce shortages in the SUD prevention and treatment programs.

Goal 5: Increase Problem Gambling Treatment Admissions

OASAS updated the Problem Gambling Treatment and Recovery Services regulations to allow any OASAS-certified program to apply for a designation on their operating certificate to provide problem gambling-only treatment. The Level of Care for Alcohol and Drug Treatment Referral (LOCADTR) was expanded to include problem gambling. With revenue from casino gambling, OASAS expanded access to client-centered care in seven regions of the State through the establishment of regional Problem Gambling Resource Centers (PGRCs). Each PGRC is responsible for the facilitation of problem gambling awareness, community education, prevention, treatment, and recovery support, as well as collaborating with local gambling facilities to address problem gambling and coordinate referrals for those in need of help.

PRIORITY: Increase the Reach and Effectiveness of Prevention

Goal 1: Follow the Strategic Prevention Framework (SPF) at the State and Local Levels

SAMHSA's Strategic Prevention Framework (SPF), consists of a five-step planning process rooted in two underlying principles (described below). The SPF is designed to guide states, jurisdictions, tribes, and communities in the selection, implementation, and evaluation of effective, culturally appropriate, and sustainable prevention activities. OASAS aims to follow the SPF at both the state and local/community level in order to build the necessary infrastructure for effective and sustainable prevention across the state and within the prevention provider system.

The five-step planning process consists of:

1. Needs Assessment
2. Capacity Building
3. Strategic Planning
4. Implementation
5. Evaluation

The two underlying principles integrated into in each of the five steps are:

- Cultural Competence
- Sustainability

OASAS aims to institutionalize the SPF process at both the state and local levels in order to continue to build and sustain the necessary infrastructure for effective prevention across the state. To begin this effort, OASAS will administer a statewide Youth Development Survey (YDS) in Fall 2020. The YDS will include risk and protective factor, prevalence, and consequence SUD indicators.

Goal 2 : Support Implementation of Evidence-Based Prevention Programs that Meet Local Needs and Yield Proven and Measurable Outcomes

Delivering Evidence-Based Prevention Programs and Strategies to Underserved Areas

OASAS promotes the improvement of the SUD prevention system by using evidence generated by applied scientific prevention research. Evidence-based programs and strategies are developed using outcome studies to document their effectiveness in preventing substance misuse, violence, delinquency, decreasing the risk factors that predict these behaviors and increasing protective factors and are a required standard for all prevention service providers. Comprehensive prevention efforts will continue to focus on underserved, hard-to-reach communities.

The NYS Blueprint for Prevention in Schools

OASAS is working with DOH, OMH, the Gaming Commission, and the State Education Department (SED) to develop a blueprint for prevention in schools. The initiative is an opportunity to develop a strategic plan for delivering prevention services in schools. One particular area of concern that the Blueprint will address is the rapid increase in electronic cigarette ("vaping") use among youth. The Blueprint will build on the Governor's leadership in the fight against youth vaping, including the ban on flavored vaping products.

Goal 3: Support Environmental Prevention Strategies Including Public Awareness Of Alcohol, Drugs, and Problem Gambling

Environmental prevention strategies are mutually reinforcing sets of evidence-based and promising indirect activities, designed to impact population-level reductions in substance use and problem gambling behaviors within communities. They are primarily aimed at influencing behavior through the establishment and enforcement of laws, policies, and regulations regarding access to and availability of alcohol and other substances and gambling for underage youth, combined with the use of media to increase community support. OASAS is continuing to expand efforts to implement environmental strategies, which include raising awareness about the dangers of illicit substances and problem gambling and to educate individuals about available services through use of TV, radio, digital, social media, mass transit, and print advertising campaigns.

Priority- Enhance Services and Supports to Promote and Sustain Recovery from SUD

Goal 1: Facilitate Access to Health, Wellness and Other Critical Supports for Youth and Adults through Recovery Centers and Youth Clubhouses

Recovery Centers

OASAS is committed to Recovery Centers to promote long-term recovery through skill building, recreation, wellness education, employment readiness, civic restoration opportunities, and other social activities. Federal funding has allowed OASAS to open several new Recovery Centers located throughout the state, including in two Tribal Nation territories.

Youth Clubhouses

Youth Clubhouses help individuals in recovery develop social skills that promote prevention, long-term health, wellness, recovery and an addiction-free lifestyle. A variety of services and activities are available, including tutoring and help with homework, college and job preparation, community service opportunities, peer mentoring, and sports, fitness and group entertainment activities. OASAS recently supported the opening of Youth Clubhouses in Tribal Nation communities for youth and young adults in recovery from and at risk of addiction, and their allies.

Goal 2: Support People in Recovery through Housing and Employment Programs and Incentives

Housing Services

Permanent supportive housing (PSH) is a key recovery support service. The priority target populations are individuals and families who are homeless, or at high risk of becoming homeless, with a history of SUD. Housing services include rental subsidies, housing counseling services, family interventions, job development/employment support services, linkage to physical and MH services, and clinical supervision of the direct services and case management staff.

Employment Incentives

Steady employment can be vital to successful recovery from SUD. The 2020 Enacted Budget included the nation's first Recovery Tax Credit program, which provides tax incentives for certified employers who hire people in recovery from substance use disorders in either full- or part-time positions. Beginning in calendar year 2020, up to $2 million will be allocated for this program annually, with employers receiving a maximum credit of $2,000 for each eligible person they hire. OASAS is administering the program in conjunction with the Department of Taxation and Finance.

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 the OMH Transformation Plan has invested over $80 million annualized in State 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:

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. In 2019, the SCC hosted the second annual Prevention Science Forum which focused on early Childhood Mental Health. (0-5 years of age)

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. In 2016, OMH 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 project goals of furthering the implementation of the System of Care approach and 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 project began in Erie, Rensselaer and Westchester counties, working with three HHSCs and four care management agencies. During the project, an additional 15 care management agencies have joined the project from 14 counties. The demonstration has served over 200 youth/families over the four-year project period.

Each child and family simultaneously work with a Health Home care manager trained and certified in HFW model who is assisted by a family peer and a youth peer. 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 team'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.

In February 2020, NYS OMH will be applying to SAMHSA for another four-year System of Care Expansion grant to further the implementation of the System of Care approach and replicating HFW in HHSC statewide.

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 22 sites throughout New York State, with 13 new sites opening since 2016. The 22 currently operating programs are located in the following areas: Albany, Amityville, Binghamton, Buffalo, Garden City, Hartsdale, Middletown, Peekskill, New York City (12 sites), Rochester, Syracuse, and Yonkers.

Suicide Prevention

Nearly 1,700 New Yorkers die by suicide each year. To address this significant public health problem, Governor Cuomo launched the New York State Suicide Prevention Task Force in November 2017, comprised of leaders from state agencies, local governments, not-for-profit groups, and other recognized experts in suicide prevention. The Task Force published its report, *Communities United for a Suicide Free New York*, in April 2019, issuing recommendations in four main categories:

- Strengthening public health prevention efforts
- Integrating suicide prevention in healthcare
- Timely sharing of data for surveillance and planning
- Infusing cultural competence throughout suicide prevention activities

The Task Force also focused on vulnerable populations at greater risk for suicide, with special sub-committees created to examine how to better serve these groups including members of the LGBTQ community, veterans, and Latina adolescents. As OMH continues to address the needs of these special populations, workgroups are also being convened to address suicide risk in black youth and rural communities.

The Suicide Prevention Task Force served to enhance and provide a stronger framework for the ongoing work of the Suicide Prevention Office. OMH is working with State and local partners to implement Task Force recommendations, including the development of a suicide prevention framework being shared with local communities.

The specific guidelines for the OMH Suicide Prevention Survey (which follows within this document) further outline the benchmarks established for suicide prevention planning at the local level and additional resources are available on the recently updated Suicide Prevention Center of New York website, which connects individuals, families, communities, schools, and providers with support and resources needed to reduce suicide in New York State.

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 HealthySteps program. HealthySteps is an evidence-based primary care prevention intervention that assists the primary care practitioner to expand the primary focus of physical health to emphasize social-emotional and behavioral health and to help support family relationships. HealthySteps infuses mental health and trauma-informed care into the primary care setting and is facilitated by the addition of the Healthy Steps Specialist (HSS) who is a professional with expertise in child and family development.

Primary care providers are a natural point of contact for families. Typically, an infant has seven well-child visits within the first year of life, often occurring before families have contact with other systems of care. This provides many opportunities for the Healthy Steps Specialist to support the health-care provider in promoting

early healthy social-emotional well-being. This early access provides opportunities to integrate social-emotional well-being with physical health for the youngest children and at a most critical time in brain development.

HealthySteps brings the opportunity to prevent future mental health problems and other poor outcomes though anticipatory guidance and promotion of healthy lifestyles. While prevention is emphasized, HealthySteps also incorporates mechanisms to identify and intervene potential problems early on. Universal screening for the child and consideration of the well-being of the family though maternal depression screening and attention to Adverse Childhood Events (ACES) is included. When needed, facilitated referrals to community resources are provided.

There are currently 17 sites statewide, which have enrolled over 5,000 children across New York State since program inception.

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 and sponsored comprehensive in-person training and virtual learning opportunities 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). Additional resources can be accessed through SAMHSA-HRSA.

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 Professions. Enrollment in the Academy can be done on the Academy of Peer Services website. Information related to the certification of peer specialists can be accessed through the New York Peer Specialist Certification Board.

For more information about peer workforce expansion efforts, please email recipientaffairs@omh.ny.gov/.

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 worked peer advocates on the development of a Youth Peer Advocate credential.

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.

- Patient Characteristics Survey Portal: The Patient Characteristics Survey portal reflects the results of the biennial OMH Patient Characteristics Survey and provides demographic, clinical, and service-related information of those served within the public mental health system during a specified one-week period, as well as annualized estimations based upon the survey week results. The Patient Characteristics Survey portal includes statewide and regional data for the 2013 through 2017 survey years, as well as a trending of select statewide and regional data points for the 2005 through 2017 survey years.

  Due to an exceptional level of cooperation and participation from service providers, the PCS is a reliable resource that assists in the management of New York State's public mental health system, complying with federal reporting requirements, supporting local governments in the local services planning process, and informing the distribution of funding.

  The Patient Characteristics Survey Portal can be accessed at: https://omh.ny.gov/omhweb/tableau/pcs.html.

- 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 Addiction Services and Supports (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. This portal has recently been expanded to include data on inpatient capacity and utilization.

  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://my.omh.ny.gov/bi/ah

- County Capacity & Utilization- Calendar Years 2017-2018: OMH's County Capacity and Utilization Data Book includes inpatient and community-based psychiatric service utilization and capacity statistics for calendar years 2017-2018, 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

New York State makes a greater investment in developmental disabilities services than any state in the nation, and 2020 is expected to continue this trend. This investment allows the Office for People With Developmental Disabilities (OPWDD) to be a leader in providing services and supports to people with developmental disabilities. 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.

Service Delivery System

In 2020, OPWDD will work to transform the service delivery system to one that is more sustainable, equitable, and accessible. This includes strengthening oversight of policy, budget and program operations and undertaking a complete review of the array of service options. OPWDD continues to explore managed care for people with developmental disabilities. Managed care is a payment system in which a Managed Care Organization (MCO) receives money that will be paid to a group or network of providers to plan and deliver all of a person's services, including medical, behavioral and developmental disabilities services and supports.

In August 2018, OPWDD published the first Draft Specialized I/DD Plans-Provider Led (SIPs-PL) Qualification Document, which outlined how specialized managed care organizations can appropriately provide managed care to people with developmental disabilities. We are reviewing comments from the public provided during the public comment period and working with both internal and external stakeholders to determine the next steps. OPWDD anticipates releasing a revised draft for additional public comment in early 2020.

County Engagement & Data Analytics

Commencing in 2019, OPWDD improved collaboration with our partners in county government to offer various perspectives for problem solving and innovation. For instance, OPWDD is participating in the local planning process as a stakeholder on the planning committee. As part of the effort to be responsive to the needs of the counties' local governmental units (LGUs), OPWDD has created a reliable data set to assist counties, which will be provided on an annual basis. OPWDD has also gathered feedback from localities and is exploring opportunities to enhance data sharing and to make additional data available. OPWDD is committed on improving its data infrastructure to inform the delivery of quality services and system performance.

OPWDD has begun participating in" Agency Days" which is hosted by the Conference of Local Mental Hygiene Directors. This provides directors of community services the opportunity to speak with OPWDD leadership to address their concerns and problem solve. In addition, OPWDD is working with the counties to integrate the regional offices into the Regional Planning Committees hosted by the Counties of Local Mental Hygiene Directors.

Residential and Day Supports

OPWDD efforts to increase residential opportunities have resulted in the nation's most robust system of residential supports. Over 6,400 people are authorized to receive residential subsidies and more than 38,000 others live in certified community-based residential programs.

Crisis Services

In 2019, OPWDD received federal approval to provide Crisis Services for Individuals with Intellectual and Developmental Disabilities (CSIDD). This Medicaid State Plan amendment allows OPWDD to capture federal financial participation for crisis response services, doubling service capacity in crisis services with the same investment of state dollars.

OPWDD continues to collaborate with OMH to create new programs to support individuals with severe challenging behaviors. These include a new inpatient unit in Brooklyn and a new Extended Treatment Unit in Queens. OPWDD is also exploring avenues to enhance the skills of primary care and behavioral health providers.

Employment - Direct Support Workforce

The stability of the Direct Support Professional (DSP) workforce is critical to ensuring continued quality supports for people with developmental disabilities. 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 people with developmental disabilities.

In recent years, OPWDD's network of nonprofit providers have seen their rates increase by over $350 million to enhance DSP and clinician wages to help recruit and retain staff. OPWDD is also aggressively exploring building career ladders for direct support professionals, improving recruitment and retention efforts, promoting the developmental disabilities field as a desirable career choice, and improving job quality through training. To address the need for more DSPs, OPWDD has worked with provider organizations to support curriculum development, training and credentialing through BOCES and SUNY. In addition, OPWDD has focused recruitment efforts on veterans leaving military service through public service announcements.

Care Coordination Organizations/Health Home Program

Care Coordination Organizations (CCOs) were launched in 2018 to provide care planning services to people with developmental disabilities through Care Managers. Care Managers help people to coordinate their developmental disability supports and their health and wellness services through the creation of a Life Plan. In 2020, OPWDD will continue to work with CCOs to ensure that all Life Plans are person-centered and meet the needs of people receiving services.

Assessments

Ensuring equity in service access necessitates an accurate assessment. The Coordinated Assessment System (CAS) is a person-centered assessment tool used to assess the strengths, needs and interests of each person. The CAS looks at a person's decision-making, routine daily activities, communication skills and behavior. The information shared helps the person and care manager to develop the Life Plan for person-centered services and supports. OPWDD, in partnership with providers and CCOs, will continue to educate families and people being supported regarding how the CAS is used and how it is administered. OPWDD continues to work with CCOs to make sure Care Managers are following the defined protocols for CAS completion, communicating the results of assessments in a timely manner, and facilitating the use of the CAS to inform person-centered planning.

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 incorporates a Health-Across-All Policies approach and emphasizes healthy 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.

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 1, 2020.
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 2020 Goals and Objectives Form is brought forward into the 2021 Form. LGUs can use the 2020 information as starting point for the 2021 Plan but should ensure that each section contains relevant, up-to-date responses.

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

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. Goals Based On Local Needs-

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)	☐	☐	☐
ab) Problem Gambling	☐	☐	☐
ac) Adverse Childhood Experiences (ACEs)	☐	☐	☐

(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

Thank you for participating in the 2021 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. 2021 Office of Mental Health County Suicide Prevention Planning Survey

County Suicide Prevention Planning Survey Guidance And Designation* Criteria

Overview of **Community United for Suicide Prevention* Designation

Problem Statement: Suicide is a major public health problem in the United States, including in New York State where approximately 1700 individuals die each year. It is the second leading cause of death for New Yorkers ages 15 to 34; and 11th overall [https://wonder.cdc.gov/]. Each year, more New Yorkers die by suicide than in motor vehicle accidents or homicides. Despite prevention efforts, the suicide rate in NYS has stubbornly increased by 25% over the last two decades. Suicide is a complex, multifaceted phenomenon. No one solution will "bend the curve", but with a coordinated community response, preventing suicide is possible.

Background: In November 2017, Governor Cuomo launched a suicide prevention task force to address the growing public health problem of suicide. The Task Force issued recommendations in a report on April 22, 2019 [https://omh.ny.gov/omhweb/resources/publications/suicide-prevention-task-force-report.pdf] called "Communities United for a Suicide Free New York."

Plan: In order to materially support implementation of recommendations contained in the Task Force report, The Office of Mental Health (OMH) with input from the Department of Health (DOH) and other partners, created a Designation Tool to provide guidance and coordination to county-level suicide prevention efforts. The Designation Tool has 3 domains:

- The development and strengthening of best practice public health suicide prevention approaches across the lifespan
- The integration of suicide prevention into local health and behavioral healthcare systems
- Active use of surveillance and quality improvement data to both inform efforts and evaluate progress and outcomes

Counties who demonstrate substantial activity in the 3 domains, along with attention to addressing disparities in risk and the unique cultural needs within each community, will meet criteria for receiving a *"Community United for Suicide Prevention"* designation from New York State. Those counties will be awarded the designation and receive recognition as a part of Suicide Prevention Month.

Additional guidance to inform the completion of this survey and additional resources for the development of a county-level suicide prevention framework can be found at the Suicide Prevention Center of New York's website at https://www.preventsuicideny.org/designation-tool/

Community Prevention Approach[3]: Counties follow a public health approach to coalition building, generating public awareness, implementing prevention strategies, and tracking progress across the lifespan.

1. Evidence-informed interventions are being used and are appropriate to ages and populations.[4]
    a. The coalition has established a process to examine local needs including data on suicide attempts and mortality, community risk (e.g., substance use), and protective factors, to develop prevention priorities.
    b. In selecting interventions for broad population groups (i.e., universal) or targeted high-risk groups, the coalition uses a process to identify effective programs and strategies to implement.

[3] Although the term public health approach may at times be used interchangeably, this domain is entitled "community" instead of "public health" to avoid the connotation of government only led interventions when referring to non-clinical community level interventions.

[4] See examples of interventions identified in the New York State Prevention Agenda: https://www.health.ny.gov/prevention/prevention_agenda/2019-2024/docs/ship/wb.pdf

c. Interventions for individuals already at risk could include programs such as means safety and identifying people at risk early through screening in non-healthcare spaces. [5]
d. Population oriented programs could include programs to strengthen well established protective factors (e.g., social connectedness) or to reduce risk factors for suicide (e.g., evidence-informed interventions to reduce substance use or preventing and mitigating Adverse Childhood Experiences (ACESs) in broad community groups).

2. A formal public commitment is obtained from county leadership in the form of a resolution by the county legislature or community services board to promote and support suicide prevention strategies in all three domains (Public Health, Zero Suicide, and Data).
3. There is the existence of a lead entity or coalition that has primary responsibility for suicide prevention efforts in the county and/or region.
4. Coalition membership reflects the diversity of the community at large, in demographics and organizational representation.
    a. Membership should include a minimum of representation from: mental health, public health, health system/provider group, and people with lived experience (loss survivors and/or attempt survivors). Efforts should also be made to include additional partners such as: substance use disorder treatment provider(s), law enforcement, department of social services, veteran agencies, school districts, colleges, the coroner/medical examiner office, and the business community.
    b. The coalition includes a diverse representation of members from your target population throughout suicide prevention planning, implementation, and evaluation processes.
    c. Strategies are utilized to effectively reduce disparities.
        i. Available data on suicide risk and high-risk groups is used to include formal and/or informal institutions representing the diversity of the community. Community leaders - from churches, senior centers (area agencies on aging), and youth organizations, among others - are involved in and/or supporting coalition efforts.
        ii. Creation of an open dialogue with group members to allow cultural considerations to be communicated, such as preferences regarding personal space, geography, familiarity, and terminology (i.e., culturally appropriate terminology).
        iii. Group members are provided with materials on coalitions, group facilitation, and engagement of all groups.
5. School and university partnerships and presentations exist.
6. There is existence of media collaboration and public relations efforts to increase awareness. Some examples include (but are not limited to) the following:
    a. Dissemination of best practices guidelines on safe reporting – could be accomplished in the following ways:
        i. Invite media organizations to a coalition/leadership meeting during suicide prevention month for a refresher on media best practices
        ii. Send toolkits to local tv stations and papers
    b. Efforts to raise awareness through the promotion of American Foundation for Suicide Prevention (AFSP) or other independent walks or events
7. There is evidence of an effort to research and understand the cultural context of the community and needs of residents in the implementation and assessment of the following:
    a. Public health interventions
    b. Efforts to combat social isolation and hopelessness
    c. Identification of intersects for suicide prevention activities and points of crisis for specific populations

[5] Screening in non-healthcare spaces to identify at risk groups and connect them to supports: Youth (schools, youth criminal justice), Adults (Courts, settings indicating financial distress)

d. Tailoring information and resources to respectfully address the target population's values, beliefs, culture, and language. Use of alternative formats (e.g., audiotape, large print, storytelling) whenever appropriate.
    i. Attention paid to language and vernacular
    ii. Depictions used of like-groups and activities of diverse groups
    iii. Information dissemination takes into consideration the technology gap, variation in literacy, and is placed in locations frequented by the target population.
e. Inclusion strategies are utilized; description of policies and practices that ensure traditionally marginalized communities are being included (e.g. trauma responsive approaches, safe space policies, etc.)

8. A coordinated postvention effort or strategy exists.

Zero Suicide: Counties should be able to demonstrate a county-level and provider-level commitment to Zero Suicide by taking the following actions:

9. As referenced in the above section on Community Prevention, a formal public commitment should be obtained from county leadership in the form of a resolution by the county legislature or community services board that includes a commitment to promoting and supporting adoption and implementation of the Zero Suicide model in health care across the county.
10. Development of a strategic plan to advance implementation of the Zero Suicide model which must include a commitment (in the form of letters) by key identified community providers to adopt the Zero Suicide model[6] – outlining a commitment by agency leadership to systematically prevent suicides among those who are receiving services, by implementing universal screening of individuals for suicide, put those who screen positive on a care pathway with evidence-based interventions, and follow-up monitoring – in the following settings:
    a. Behavioral health services (mental health clinics and substance use disorder settings)
    b. Emergency departments
    c. Primary care settings
    d. Crisis service system
    e. Medical / surgical settings (optional)
11. Effort to research and understand the cultural context of the community targeted by each program to address disparity and the engagement of high-risk groups. Ensure that there is equity in the efforts to apply Zero Suicide protocols.

Data: Counties are utilizing data to inform the development, implementation and evaluation of prevention strategies (among both clinical/Zero Suicide and community domains above) and are making efforts to increase and improve data collected on suicide attempts and deaths.

12. Data is used to identify high risk groups, follow trends, and develop and evaluate prevention strategies.
13. Data is used to identify population groups and the variability in access to services and suicide deaths.
14. Evidence of due diligence to track progress and impact of interventions using a family of three types of measures; input (what program or policy is being implemented); output (how many are participating); and intermediate (what effect did the participation have on attitude, behavior, policy).
15. Investments are made in coroner/medical examiner data collection that includes the circumstances surrounding suicide deaths.
16. Data sharing across participating agencies aimed at preventing suicide attempts and deaths, while in compliance with all applicable state and federal privacy laws (e.g. suicide fatality reviews).

[6] Note, some hospital accrediting agencies, such as the Joint Commission with its suicide prevention national patient safety goal, recently issued standards that incorporate principles of the Zero Suicide model in the form of systematic screening, care pathway development with use of evidence-based interventions, and monitoring after care.

County Suicide Prevention Planning Survey

The purpose of this survey is to develop a state-wide assessment of local suicide prevention approaches. The survey will be used to inform the development of technical assistance and training for county health and behavioral health agencies, suicide prevention coalitions, and the community toward the goal of reducing suicide attempts and deaths. In addition, counties that achieve the benchmarks outlined in the guidance document may receive a *"Community United for Suicide Prevention"* designation from New York State.

Guidance to inform the completion of this survey and additional resources for the development of a county-level suicide prevention framework can be found at the Suicide Prevention Center of New York's website at https://www.preventsuicideny.org/designation-tool/

As part of the County Suicide Prevention Planning Survey process, LGUs may designate an individual who is not employed by the LGU (e.g. local suicide prevention coalition representative) to complete the following survey. This individual will need to register with the OASAS County Planning System to gain access to the survey. If you would like to designate a non-LGU individual to complete the survey, please contact Patricia Bowes for specific instructions. Please note that the LGU has the ultimate responsibility for ensuring that all content within the LSP, including the County Suicide Prevention Planning Survey, is accurate and complete. All questions regarding this survey should be directed to Patricia Bowes at 518-402-7948, or Patricia.Bowes@omh.ny.gov.

Community Prevention Approach

1. Describe in narrative form the evidence-informed interventions being used to address suicide and the population(s) targeted by each intervention. Discuss the process for developing prevention priorities and interventions, the expected impact of the interventions, and the outcome measures used.

2. Describe any formal public commitment to support suicide prevention strategies made in your county including who made it and in what manner (if in written form, attach a copy).

3. Identify the entity who has taken the lead on suicide prevention efforts for the county.

4(a). Describe in narrative form the agencies/organizations and individuals who comprise the membership of the suicide prevention coalition. Discuss the strategy used for building the coalition and whether leadership from individual agencies made a commitment to having a representative serve on the coalition beyond individual staff interest.

4(b). Describe in narrative form the diversity of your coalition and the strategies used to assure the coalition represents the demographics of your community. Discuss your use of data as well as efforts to create public awareness about the group.

4(c). Describe the methods used for establishing effective group facilitation and open and inclusive communication.

5. Describe the level of partnership and collaboration between all schools located in your community (including k-12 and college) and the suicide prevention coalition. Identify whether any school representatives are members of your coalition. Highlight any unique events/activities and opportunities for raising awareness.

6(a). Describe in narrative form efforts made to collaborate with the media. Identify whether any members of the media serve on the coalition and/or regularly participate in activities.

6(b). Describe any public awareness campaigns promoted by the coalition. Discuss the target audience for each one and any unique collaborations. Highlight any successes.

7. Describe efforts to address the unique cultural needs of the population in your community and strategies developed for implementing public health interventions, addressing social isolation, identifying points of crisis

for specific populations, tailoring information and resources, and inclusion strategies to ensure traditionally marginalized communities are being engaged.

8. Describe the postvention efforts within your community including the collaboration between agencies.

Zero Suicide

9. Describe any formal public commitment including who made it and in what manner (if in written form, attach a copy) – including the support for Zero Suicide strategies.

10. Describe the size and scope of health and behavioral health care in your community including the identification of providers who have adopted the Zero Suicide model. Discuss the goal development for increasing the adoption of Zero Suicide by community providers in the following settings: behavioral health services, emergency departments, primary care settings, crisis services, and medical/surgical settings. The strategy should identify benchmarks for the first year. Describe your efforts to reach the initial benchmarks along with your level of success.

11. Describe in narrative form the demographics of your community including the identification of populations considered to be at higher risk of suicide. Discuss efforts made to understand how those communities access health care and identify barriers to access and how those barriers have been addressed to assure equity.

Use of Data

12. Describe how data is used to identify groups at high risk for suicide, follow trends, and develop and evaluate prevention strategies.

13. Describe how data is used to identify population groups and the variability in access to services as well as suicide deaths.

14. Describe the process for utilizing input, output, and intermediate measures in tracking the progress of identified interventions.

15. Describe the level of collaboration with the county coroner/office of the medical examiner and investments made in data collection within that office.

16. Describe in detail how data is shared across participating agencies (in compliance with all applicable state and federal privacy laws) aimed at preventing suicide attempts and deaths.

Designation Consideration

17. Would you like your county to be considered for the *Community United for Suicide Prevention* Designation in 2020? It is acknowledged that suicide prevention planning requires ongoing effort and achieving the identified benchmarks may be a multi-year project. All plans will be reviewed, and feedback provided, but priority will be given to those counties which select to apply for the designation this year.

- ○ Yes
- ○ No

C. 2021 Office of Mental Health County Cultural Competence Survey

Introduction

The New York State Office of Mental Health believes everyone should have an equal opportunity for mental wellness. This means removing obstacles and implementing services and policies aimed at reducing disparities in access, quality, and treatment outcomes for historically marginalized, underserved and unserved populations. These populations include but are not limited to; people of color, members of the LBGTQ community, older adults, rural New Yorkers, Veterans, immigrants, people with disabilities (including physical), and people who have limited English proficiency. The New York State Office of Mental Health's multifaceted approach to supporting behavioral health equity includes:

- The creation of a multi-year Strategic Plan for Culturally Competent Accessible Mental Health Services (2019-2021);
- Strengthening policy and regulatory standards related to improving patient care for historically marginalized populations;
- Leveraging the contributions of the Office of Mental Health's two Centers of Excellence in Culturally Competence Care;
- Fostering new and emerging community partnerships with organizations and stakeholders representing minority and historically marginalized populations.

Reducing Disparities and Behavioral Health Equity

Behavioral Healthy equity is met through an elimination of disparities, statistically significant differences in results between vulnerable groups and their reference group, after controlling for other individual characteristics (i.e., race, spoken language, mental health status, disability status, substance use and socioeconomic status). For example, when comparing health results for members with versus without a serious mental illness (SMI), if the results for members with a SMI are statistically significantly lower than the results for members without a SMI (while taking into account people's individual characteristics) people with a SMI would be categorized as having a "worse result" (a.k.a., a health disparity) on that measure. It is through this lens that the Office of Mental Health grounds its efforts to improve outcomes for members of historically marginalized populations.

Data/Demographics (Statewide)

It is important that all entities that regulate, fund or provide behavioral health services collect, analyze and use data in determining unmet need, identifying disparities in quality/access/treatment outcomes, and to adequately plan for service system improvements.

This is generally done using a simple three step framework:

1. Determining Unmet Need: Comparing general demographic data (Census, NYSED's Student Information Repository System (SIRS) - Enrollment) with demographic data of those currently being served in the catchment area;
2. Assessing access, quality and treatment outcomes in such a way that differences in results for special populations can be identified, including the examination of suicide and self-harm data to identify populations at risk for suicide (HHS Office of Minority Health- Minority Population Profiles, NYS Health Connector- Suicide and Self-Harm Dashboard); and
3. Planning for BH Equity: Informing planning activities with unmet needs data and identified disparities in access, quality and treatment outcomes (HHS Office of Minority Health- Minority Population Profiles).

CLAS Standards

The National CLAS Standards are a set of 15 action steps intended to advance health equity, improve quality, and help eliminate health care disparities by providing a blueprint for individuals and health and health care organizations to implement culturally and linguistically appropriate services.

The National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations to improve practices and policies aimed at reducing disparities and moving towards behavioral health equity. The Standards include a Principal Standard "Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs" along with guidance in the following areas:

- Governance, Leadership and Workforce
- Communication and Language Assistance
- Engagement, Continuous Improvement, and Accountability

Cultural Competence Survey

Please answer the following questions related to the LGU's efforts on reducing disparities and working toward behavioral health equity for historically unserved, underserved, and/or marginalized populations.

These questions should be answered from the perspective of the LGU as the government entity responsible for the planning and oversight of local mental health systems, rather than from the perspective of the LGU as a service provider.

All questions regarding this survey should be directed to Matthew Canuteson at 518-473-8955 or matthew.canuteson@omh.ny.gov.

1. Is there a person responsible for activities related to the reduction of disparities in access, quality and treatment outcomes for special/marginalized populations?

- ○ YES, within the LGU (Please briefly describe): _____
- ○ YES, within another local government body (e.g. local health department) which is partnered with the LGU (Please briefly describe): _____
- ○ NO (Please detail any barriers to these efforts): _____
- ○ OTHER (Please provide any additional comments): _____

2. Is there a written plan for activities to identify and reduce disparities in access, quality and treatment outcomes for special/marginalized populations and does this plan includes concrete objectives, strategies, and an implementation timetable?

- ○ YES, developed by the LGU (Please briefly describe): _____
- ○ YES, developed by another local government body (e.g. local health department) which is partnered with the LGU (Please briefly describe): _____
- ○ NO (Please detail any barriers to these efforts): _____
- ○ OTHER (Please provide any additional comments): _____

3. Do you use current data identifying cultural/language needs, underserved populations and emerging population trends to meet the changing needs of your catchment area?

- ○ YES, led by the LGU (Please briefly describe): _____
- ○ YES, led by another local government body (e.g. local health department) which is partnered with the LGU (Please briefly describe): _____
- ○ NO (Please detail any barriers to these efforts): _____

- ○ OTHER (Please provide any additional comments): _____

4. Do you utilize data (e.g. Census, NYSED's Student Information Repository System (SIRS) - Enrollment) to inform workforce recruitment practices specific to the unique needs of the catchment area?

- ○ YES, led by the LGU (Please briefly describe): _____
- ○ YES, led by another local government body (e.g. local health department) which is partnered with the LGU (Please briefly describe): _____
- ○ NO (Please detail any barriers to these efforts): _____
- ○ OTHER (Please provide any additional comments): _____

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: _____

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• •
• •

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

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: ______________________________

CSB Member: ☐ Yes ☐ No

Represents: ______________________________

Email Address: ______________________________

Name: ______________________________

CSB Member: ☐ Yes ☐ No

Represents: ______________________________

Email Address: ______________________________

Name: ______________________________

CSB Member: ☐ Yes ☐ No

Represents: ______________________________

Email Address: ______________________________

Name: ______________________________

CSB Member: ☐ Yes ☐ No

Represents: ______________________________

Email Address: ______________________________

Name: ______________________________

CSB Member: ☐ Yes ☐ No

Represents: ______________________________

Email Address: ______________________________

Name: ______________________________

CSB Member: ☐ Yes ☐ No

Represents: ______________________________

Email Address: ______________________________

Name: ______________________________

CSB Member: ☐ Yes ☐ No

Represents: ______________________________

Email Address: ______________________________

Name: ______________________________

CSB Member: ☐ Yes ☐ No

Represents: ______________________________

Email Address: ______________________________

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

G. Mental Health Subcommittee Roster

Subcommittee Chair

Name: ______________________

CSB Member: ☐ Yes ☐ No

Represents: ______________________

Email Address: ______________________

Name: ______________________

CSB Member: ☐ Yes ☐ No

Represents: ______________________

Email Address: ______________________

Name: ______________________

CSB Member: ☐ Yes ☐ No

Represents: ______________________

Email Address: ______________________

Name: ______________________

CSB Member: ☐ Yes ☐ No

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CSB Member: ☐ Yes ☐ No

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CSB Member: ☐ Yes ☐ No

Represents: ______________________

Email Address: ______________________

Name: ______________________

CSB Member: ☐ Yes ☐ No

Represents: ______________________

Email Address: ______________________

Name: ______________________

CSB Member: ☐ Yes ☐ No

Represents: ______________________

Email Address: ______________________

Name: ______________________

CSB Member: ☐ Yes ☐ No

Represents: ______________________

Email Address: ______________________

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: ______________________

CSB Member: ☐ Yes ☐ No

Represents: ______________________

Email Address: ______________________

Name: ______________________

CSB Member: ☐ Yes ☐ No

Represents: ______________________

Email Address: ______________________

Name: ______________________

CSB Member: ☐ Yes ☐ No

Represents: ______________________

Email Address: ______________________

Name: ______________________

CSB Member: ☐ Yes ☐ No

Represents: ______________________

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Name: ______________________

CSB Member: ☐ Yes ☐ No

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CSB Member: ☐ Yes ☐ No

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Name: ______________________

CSB Member: ☐ Yes ☐ No

Represents: ______________________

Email Address: ______________________

Name: ______________________

CSB Member: ☐ Yes ☐ No

Represents: ______________________

Email Address: ______________________

Name: ______________________

CSB Member: ☐ Yes ☐ No

Represents: ______________________

Email Address: ______________________

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 2021 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 2021 local services planning process.

Thank you for participating in the 2021 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 **Wednesday, April 1, 2020**. 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 **Wednesday, April 1, 2020**. 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 **Wednesday, April 1, 2020**. 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. 2021 OASAS Provider Workforce Development and Talent Management Survey

OASAS is seeking information to quantify the feedback we have heard about the obstacles in recruiting and retaining qualified staff. The survey asks OASAS Treatment providers to report on a variety of staffing related topics. The information will be used to demonstrate the needs related to the Substance Use Disorder workforce.

WHEN ANSWERING THE FOLLOWING QUESTIONS, PLEASE ONLY ADDRESS STAFF AT YOUR AGENCY'S TREATMENT PROGRAMS.

All inquiries regarding this survey should be directed to Julia Fesko at 518-457-6511 or at Julia.Fesko@oasas.ny.gov.

The data section of this year's Workforce Development and Talent Management Survey will focus on Medical staff, LMSWs and Peers so we can evaluate data for these titles. These are the titles that we've targeted funding for in the past or are pending changes (i.e. Social Work Licensure exemption).

1) Please indicate how many FTEs of each title your agency employs:

Category	Number of Part-Time Staff	Number of Full-Time Staff	Number of Part-Time Vacancies	Number of Full-Time Vacancies
Peers				
a) Certified Recovery Peer Advocate				
b) Certified Recovery Peer Advocate - Provisional				
c) Certified Addiction Recovery Coach				
d) Certified Peer Specialist				
e) Non-Certified Peer				
Social Workers with NO LCSW Supervisor performing Counseling functions.				
f) Bachelor of Social Work - NO CASAC				
g) Master of Social Work, license eligible – NO CASAC				
h) Licensed Master Social Worker (LMSW) – NO CASAC				
Medical Staff				
i) Physician				
j) Psychiatrist				
k) Nurse Practitioner				
l) Physician Assistant				
m) RN				
n) LPN				

2) For the Medical Staff listed above please indicate which specialty designations they have.

a) Of the total Physicians employed, how many have the following designations:

- ➔ Primary Care _____
- ➔ Board Certified in Addiction Medicine _____
- ➔ DATA-2000 Waiver _____
- ➔ Other, please specify _____

b) Of the total Psychiatrists employed, how many have the following designations:

- ➔ Addiction Psychiatry _____
- ➔ Addiction Medicine _____
- ➔ DATA-2000 Waiver _____

➔ Other, please specify _____

c) Of the total Nurse Practitioners employed, how many have the following designations:

➔ Psychiatry _____
➔ Family _____
➔ DATA-2000 Waiver _____
➔ Other, please specify _____

d) Of the total Physician Assistants employed, how many have the following designation:

➔ DATA-2000 Waiver _____
➔ Other, please specify _____

e) Of the total RNs employed, how many have the following designation:

➔ CARN designation _____
➔ Other, please specify _____

Loan Forgiveness

Loan Forgiveness can be a useful tool to attract and retain talent. The questions below are about your program's participation in state and federal loan forgiveness programs. Please click on the highlighted links for more information about each program.

3) Is your program a HRSA National Health Service Corps approved site for their loan forgiveness program?

○ Yes
○ No

3a) If yes, which type of loan forgiveness is your program eligible for (check all that apply) and indicate the number of employees participating in them:

Type of Program	Number of Employees
☐ NHC LRP NHSC LRP Fact Sheet	_____
☐ NHC SUD Workforce LRP NHSC SUD Workforce LRP Fact Sheet	_____
☐ NHC Rural Community LRP NHSC Rural Community LRP	_____

4) Has this been a useful recruitment/retention tool for your program?

○ Yes
○ No

4a) If no, please explain why: [ ]

5) If you are not an approved site please check which factors below apply:

☐ Not in a federally designated shortage area
☐ We are in a federally designated shortage area but did not apply
☐ We do not know if we are in a federally designated shortage area and are unsure how to apply
☐ Other - please explain [ ]

6) Please indicate if your agency or employees have taken advantage of the following loan forgiveness programs and the number of employees currently taking advantage of these programs.

Program	Number of employees
Doctors Across NY	_____
Loan Forgiveness for Licensed Social Workers	_____
New York State 'Get on Your Feet' Loan Forgiveness Program	_____
Loan Forgiveness for Public Service Employees	_____

7) Please indicate any additional Loan Forgiveness programs your agency or employees have taken advantage of: [ ]

D. 2021 OASAS Prevention Provider Survey

The following survey is designed to provide OASAS with provider-level information regarding prevention providers involvement with their local substance use prevention coalition(s) as well as their experience with completing the first required OASAS Prevention Annual Report.

Questions related to this survey should be directed to Maria Valenti at Maria.Valenti@oasas.ny.gov.

Part I - Coalition Involvement

Implementing environmental strategies can promote changes in community attitudes, norms and behaviors which can lead to reductions in alcohol, other drug use and problem gambling behavior. Community coalitions can often assist to facilitate, implement, and sustain effective substance use prevention environmental change strategies. The purpose of this survey is to assess your agency's involvement with local community coalitions in the agency's service catchment area.

1. Does a provider representative actively participate in your local substance use prevention coalition?

- ○ No
- ○ Yes, please provide the coalition name
  Coalition Name:

2. Do you currently host a substance use prevention coalition at your provider agency?

- ○ No
- ○ Yes, please provide the coalition name
  Coalition Name:

PART II- Prevention Annual Report

The Division of Prevention Services requires all providers to evaluate their program effectiveness and submit an Annual Report that demonstrates the impact of their prevention services for youth, families, and/or communities they serve. This year providers were asked to evaluate one of every four of their Evidence Based Practices (EBP) and one of every four of their non-EBPs that they implement in a given year. This may have required providers to take stock of available program evaluation resources in order to complete these requirements appropriately.

3. Which barriers did you experience when evaluating your programming? Please check all that apply.

- ☐ Administration and organization of the pre and post tests
- ☐ Difficulty in having students take the survey
- ☐ Accessing appropriate survey tools
- ☐ Collecting data in a systematic way
- ☐ Storing surveys in a secure location
- ☐ Entering data in a software package (e.g., excel)
- ☐ Analyzing data
- ☐ Lacking staff time to dedicate to evaluation
- ☐ Lacking stakeholder buy-in to conduct pre/post surveys
- ☐ No barriers experienced
- ☐ Other, please describe:

4. Which barriers did you experience when writing your Annual Report? Please check all that apply.

- ☐ Knowing what information to put in the separate sections
- ☐ Determining needs assessment

☐ Aligning needs assessment to program selection
☐ Knowing how to present data findings
☐ Knowing how to interpret data
☐ Determining which programs to highlight in the report
☐ Lacking staff time to dedicate to writing the report
☐ Understanding how to use the findings to plan future prevention programming
☐ No barriers experienced
☐ Other, please describe:

5. What technical assistance methods would be most useful for completing the next years' annual report?

☐ Webinar(s) with evaluation experts
☐ Written resources and guide books on program evaluation
☐ Peer sharing calls with other providers who are evaluating the same program or similar program
☐ Being able to ask questions to other providers who have successfully evaluated a program in the past
☐ Knowledge of online resources available for program evaluation
☐ Other, please describe:

6. What are the qualifications of the staff providing prevention counseling? Please check all that apply.

☐ Non-credentialed or non-licensed staff
☐ Credentialed Prevention Specialist
☐ Credentialed Prevention Professional
☐ RN
☐ Licensed Master Social Worker
☐ Licensed Clinical Social Worker
☐ Licensed Mental Health Counselor
☐ CASAC
☐ Other, please describe:

E. 2021 OASAS Peer Support Services Outpatient and OTP Program Survey

This survey is intended to promote alignment with OASAS Regulation 822.7(f)(12) requiring OASAS certified outpatient treatment programs to offer peer support services delivered by Certified Recovery Peer Advocates (CRPAs) and to provide feedback to OASAS on current peer supervision practices. If you have any questions regarding content, please contact Marialice.ryan@oasas.ny.gov.

BACKGROUND

Peer services allow individuals to draw from their personal experiences to provide help and support to individuals in early recovery and/or ambivalent about recovery. Integrating peer support into the service delivery system of addiction treatment programs helps to advance the needs of individuals and families across the various stages of recovery. Please access OASAS website for more information- https://www.oasas.ny.gov/providers/peer-integration. Please have a program director or a peer supervisor complete this survey.

Questions

1. How many hours of peer support services does your program offer in a week?
   - ○ 0-20 hours a week
   - ○ 20-30 hours a week
   - ○ 30-40 hours a week
   - ○ More than 40 hours a week

   If peer services are not offered, please explain why:

2. Does your program provide peer services via a subcontract with another entity such as a recovery center?
   - ○ Yes
   - ○ No

3. Does each Program Reporting Unit (PRU) or program have the capability to provide peer services?
   - ○ Yes
   - ○ No

     If no, does your organization have a plan to build more capacity across programs?
     - ○ Yes
     - ○ No

4. Do you plan to hire Peers in SFY 2020-2021?
   - ○ Yes
   - ○ No

     If Yes, how many of each below:
     __ Part -Time
     __ Full-Time
     __Volunteer

5. What support do you need to hire Peer FTEs?

6. Do your clinicians when doing assessments offer the appropriate individuals the opportunity to meet with a Certified Recovery Peer Advocate prior to, or coinciding with their appointment?
   - ○ Yes
   - ○ No
     Have you identified a peer supervisor?
     - ○ Yes
     - ○ No

7. Does the QHP your program selected to function as a peer supervisor also have a caseload?
   - ○ Yes
   - ○ No

8. Did your peer supervisor(s) complete peer supervision training within the past year?
   - ○ Yes
   - ○ No

9. Does the supervisor of your peer supervisor utilize the peer supervision competencies?
   - ○ Yes
   - ○ No

10. What is the frequency of peer supervision, for the peers?
    - ○ Every week
    - ○ 2 times per month
    - ○ 1 time per month
    - ○ None
    - ○ Other

11. What is the frequency of supervision for the peer supervisor?
    - ○ Every week
    - ○ 2 times per month
    - ○ 1 time per month
    - ○ None
    - ○ Other

12. Does your program's culture support direct observation and feedback to peers as a component of your supervisory process?
    - ○ Yes
    - ○ No

13. If your program has multiple PRUs, is there a peer supervisor within each program?
    - ○ Yes
    - ○ No

14. Does your peer supervisor(s) develop individualized professional development plans with each peer supervisee?
    - ○ Yes
    - ○ No

15. Does your peer supervisor(s) utilize Appendix 3 within the peer supervision competencies to assess and evaluate the peer's demonstration of each peer competency?
    - ○ Yes
    - ○ No

16. Are peer support services identified within the client's treatment plan as a strategy to help achieve a client's specific goal?
    - ○ Yes
    - ○ No

        If yes, do all progress notes document how the peer service helped the client to achieve a specific goal?
        - ○ Yes
        - ○ No

17. Does your program utilize peer services protocols to identify specifically the 1:1 peer service provided to a client and identify how those peer services relates to a specific client's treatment plan goal(s)?
    - ○ Yes
    - ○ No

18. Do your peers conduct outreach and engagement "in-community"?
    - ○ Yes
    - ○ No

19. Do your peers provide pre-admission services?
    - ○ Yes
    - ○ No

20. Do you provide peer support services within continuing care?
    - ○ Yes
    - ○ No

21. Has your program developed safety and travel policies and procedures/protocols for "in-community" work?
    - ○ Yes
    - ○ No

22. Does your program provide cell phones to your peer(s)?
    - ○ Yes
    - ○ No

23. Has your program completed the Organizational Readiness to Integrate Peers Self-Assessment Tool?
    - ○ Yes
    - ○ No

24. Has your program requested technical assistance from the OASAS Peer Integration Bureau?
    - ○ Yes
    - ○ No

        If No, would you like to receive TA from the PI Bureau?
        - ○ Yes

○ No

25. Do you collect data to monitor client outcomes – retention and engagement?
    ○ Yes
    ○ No

26. Does your program have a plan to measure the effectiveness of peer services vis a vis client engagement and retention outcomes?
    ○ Yes
    ○ No

27. Please describe how your program promotes self-care and wellness:

28. Has your organization encountered challenges recruiting peers for employment?
    ○ Yes
    ○ No
    Please explain:

29. Has your organization encountered challenges with the retention of peers?
    ○ Yes
    ○ No
    Please explain:

30. Please share any additional comments or suggestions:

Peer Support Services Survey Glossary

Appendix 3

Peer supervisors and CRPAs may utilize the tool to routinely assess the peer's progress meeting CRPA competencies. The tool identifies behavioral indicators for each CRPA competency so that supervisors and peers together can know when a peer is meeting a specific competency or needs more coaching to achieve the competency

Certified Recovery Peer Advocate (CPRA)

OASAS requires that within all 822 programs, peer services must be provided by a CRPA or CRPA-P. Requirements to become a Certified Recovery Peer Advocate include 46 hours of training, 26 hours of supervision, 500 hours of work/volunteer experience within two years and passing of the International Certification & Reciprocity Consortium (IC & RC) exam. A CRPA-P is in the process of obtaining the 500 hours work experience. For more certification information go to the New York Certification Board.

Continuing Care

In order to allow for continuous connection to treatment over time, OASAS has included continuing care in the new PART 822 regulations. This will allow programs to discharge an individual from an outpatient episode of active care in an outpatient setting (outpatient clinic or Opioid Treatment Program) into continuing care. The person will be able to access counseling, peer services, medication assisted treatment and recovery supports following treatment for an indefinite period. For some, this may be for only a few months as they transition to recovery supports in the community, for others it may be for many years.

In-Community

The Title 14 NYCRR Part 822 regulations allow for services to be provided offsite, or outside the clinic's 4 walls. OASAS worked with the NYS Department of Health (NYS DOH) and the Federal Centers for Medicare and

Medicaid Services (CMS) to obtain approval for Medicaid reimbursement for Part 822 clinic services that are provided off-site. Programs can offer services to patients in the community, at a school, court setting or other site where addiction patients may need clinic services. Please note, this specifically excludes correctional settings-jails, prisons. All services that can be provided and billed in a clinic are eligible to be provided in the community, including peer services. For Medicaid billing, this provision applies to Medicaid Managed Care only until the OASAS State Plan moving services to Rehab is approved.

Services must be provided to individuals who are enrolled in an outpatient program or seeking services from an OASAS certified Part 822 Outpatient Clinic or Opioid Treatment Program (OTP). They must be delivered in accordance with a treatment plan that follows all OASAS and Medicaid billing regulations or delivered as a part of an assessment or continuing care plan. Treatment plans must identify services to be provided offsite and the progress note must identify the clinical or peer staff member who delivered the service and the setting in which it was delivered. All services must be delivered in accordance with confidentiality requirements.

OASAS Regulation 822.7(f)(12)

Required services. Each program must directly provide the following: 1) admission assessment, including, if clinically indicated, a screen for problem gambling; 2) treatment/recovery planning and review; 3) trauma-informed individual and group counseling; 4) medication assisted treatment; 5) toxicology testing (not required for significant others unless clinically indicated; 6) post-treatment planning; 7) medication administration and observation and medication management; 8) brief intervention and brief treatment; 9) collateral visits; 10) complex care coordination; 11) outreach; and 12) peer support services.

Organizational Readiness to Integrate Peers Self-Assessment Tool

OASAS has developed a tool to help outpatient providers assess their readiness to integrate non-clinical peer support services within their programs. There is no score; rather, the assessment is designed to help providers identify their current capacity to implement peer support services. The tool contains embedded resource links that may be helpful to providers as they explore the integration of peers.

Peer Supervision Competencies

In 2017, a national workgroup conducted a systemic literature review and process to develop a document of standardized competencies each Peer Supervisor working within an addiction system should demonstrate. Document included.

Peer Supervision Training

Is a two- day supervisory training developed by organizations that includes the core competencies for Peer Supervisors and Peer Professionals (Certified Recovery Peer Advocates) working in a variety of clinical and non-clinical community-based settings. 12 hours*

Peer Supervisor

Peer Supervisors must be QHPs in the organization. Supervisors play a key role in the successful integration of CRPAs in the work place. Supervision benefits employees, employers and service recipients. Please review the Peer Supervision Competencies document, especially Appendix 3 that begins on page 31. Please note, if your program contracts with another entity for the delivery of peer services, a peer supervisor within your program must provide supervision to any CRPAs that are working within your program, even if they are employed by another entity.

Peer Support Services

OASAS defines a peer as an individual who uses their knowledge acquired through lived experience related to substance use, to support the recovery goals of individuals with addictions. Peers are natural support experts, relationships they establish can lead to increased feelings of support, safety, and wellbeing among the individuals they serve. Through a combination of lived experience and professional training, peers provide an array of face-to-face peer support services with an individual impacted by addictions.

Policies and Procedures/Protocols

Policy, procedures and protocols consist of information which specifies an organization's standards of practice that may include professional, legislative, regulatory and other business requirements.

Pre-admission Services
Services provided prior to admission can assist a person in need to stabilize while beginning the treatment process. Peer Services, Medication Assisted Treatment, Brief Intervention, when provided prior to admission can smooth the path to engagement in treatment. If you have further questions please contact the Practice Innovation and Care Management (PICM) Mailbox, PICM@oasas.ny.gov for further assistance.

Professional Development Plans
A professional development plan is a list of actionable steps for achieving your career goals. A professional development plan helps you gain specific insight into how you can reach your career aspirations, such as earning a new certification or finding a mentor who can advise you.

Program Reporting Unit (PRU) - A Program Reporting Unit (PRU) number is the number assigned to individual programs of a provider. It is assigned to a service at a specific site. A provider may have several different services operating at the same site, so each service would have its own PRU number. For example, an outpatient program would have a different PRU number assigned to it than an outpatient rehab program even if they are located at the same address.

QHP
Qualified health professional (QHP) means any of the professionals listed below, who are in good standing with the appropriate licensing or certifying authority, as applicable, with a minimum of one year of experience or satisfactory completion of a training program in the treatment of substance use disorders:

(1) a credentialed alcoholism and substance abuse counselor (CASAC) who has a current valid credential issued by the office, or a comparable credential, certificate or license from another recognized certifying body as determined by the office;
(2) a counselor certified by and currently registered as such with the National Board for Certified Counselors;
(3) a rehabilitation counselor certified by the Commission of Rehabilitation Counselor Certification;
(4) a therapeutic recreation therapist certified by the National Council on Therapeutic Recreation or the American Therapeutic Recreation Association; or a person who holds a baccalaureate degree in a field allied to therapeutic recreation and, either before or after receiving such degree, has five years of full-time, paid work experience in an activities program in a health care setting;
(5) a professional licensed and currently registered as such by the New York State Education Department to include: (i) a physician who has received the doctor of medicine (M.D.) or doctor of osteopathy (D.O.) degree; (ii) a physician's assistant (PA); (iii) a certified nurse practitioner; (iv) a registered professional nurse (RN); (v) a psychologist; (vi) an occupational therapist; (vii) a social worker (LMSW; LCSW), including an individual with a Limited Permit Licensed Master Social Worker (LP-LMSW) only if such person has a permit which designates the OASAS-certified program as the employer and is under the general supervision of a LMSW or a LCSW; and (viii) a mental health practitioner including: a licensed mental health counselor (LMHC), a marriage and family therapist (LMFT), a creative arts therapist (LCAT), and licensed psychoanalyst; and any mental health practitioner with a limited permit.

Treatment Plan
OASAS recognizes there is no universal *treatment plan* that's right for everyone. Treatment plans are to be self-directed by each individual client and should include goals, objectives and strategies developed by the individual client and clinician working together. OASAS has issued guidance on person centered care.

Wellness
Wellness is an active process of becoming aware of and making choices toward a healthy and fulfilling life. Wellness is more than being free from illness, it is a dynamic process of change and growth.

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.