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

2022 Local Services Plan Guidelines for Mental Hygiene Services

April 2021

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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 (MHPC) 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. The COVID-19 pandemic emerged during the 2021 plan year. As a result of the pandemic, the State agencies, in consultation with the MHPC, created a separate form to gauge the local effects of COVID-19 on mental hygiene populations. So as not to add to the burden of the LSP in a time when counties are already overextended due to COVID-19, the COVID-19 form was made mandatory and the Goals and Objectives Form optional.

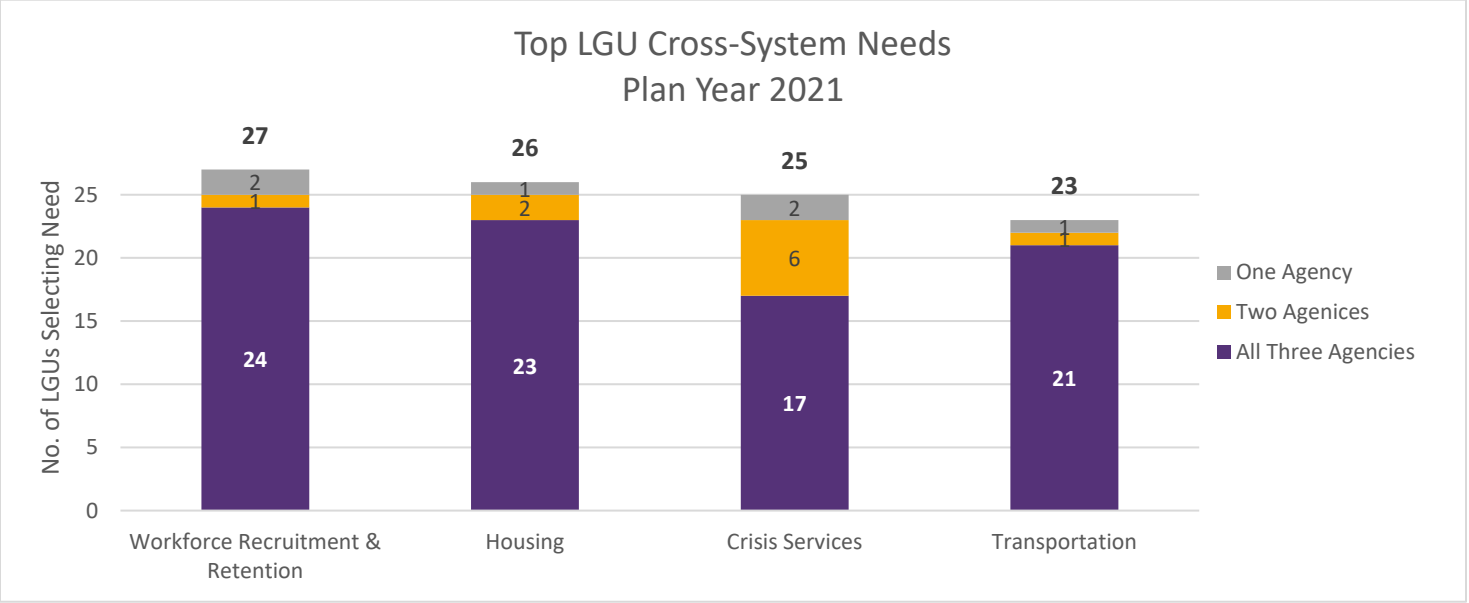
Despite the fact that it was optional for the 2021 plan cycle, 29 LGUs elected to document their needs and plans to address their needs using the Goals and Objectives Form. On the 2021 Goals and Objectives Form, LGUs selected from specific categories to indicate the nature of the unmet mental hygiene 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 2021 include:

- Workforce Recruitment and Retention (27 LGUs);
- Housing (26 LGUs);
- Crisis Services (25 LGUs); and
- Transportation (23 LGUs).

Figure 1.1 displays the needs LGUs most frequently selected on the 2021 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, 94% of LGUs indicated that the needs affect more than one mental hygiene population, and 84% cross all three agencies.

Figure 1.1: Most Frequently Selected LGU Needs, Plan Year 2021



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.

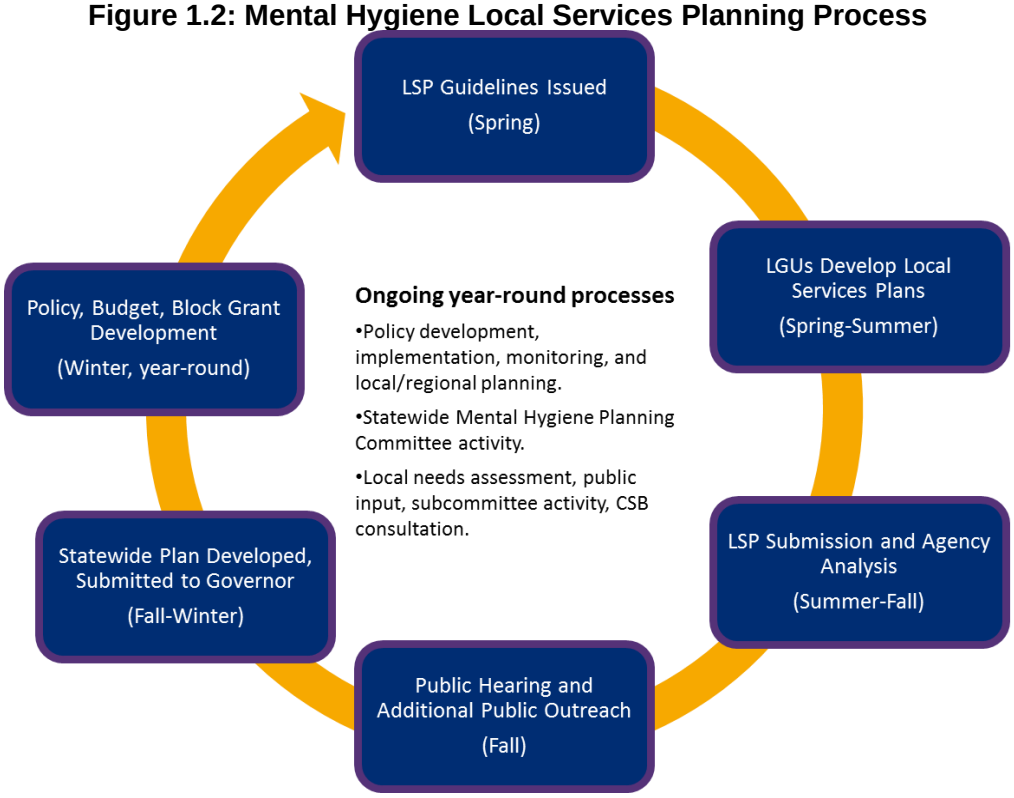
Please see **Appendix I** for information on CPS registration and user roles.

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: 2022 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	April 2021
Due date for completed OASAS provider planning surveys in CPS	**Friday, May 28, 2021**
Due date for completed LGU Plans in CPS	**Thursday, July 1, 2021**

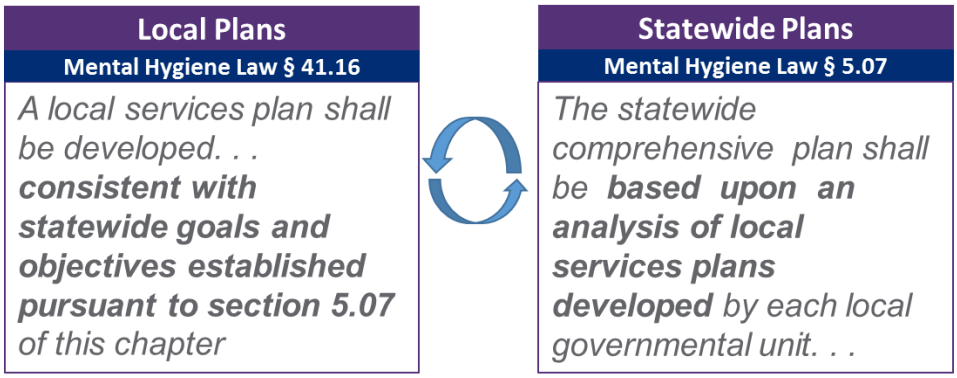
E. Informing Statewide Planning

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 use 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. COVID-19 and Mental Health, Addiction, and Developmental Disability Services

Overview

First identified in Wuhan, Hubei province, China at the end of 2019, the coronavirus disease 2019 (COVID-19) elicited nonspecific symptoms ranging from fever, weakness, dry cough, and shortness of breath to acute respiratory distress syndrome and septic shock. By March 11, 2020 the WHO declared COVID-19 a pandemic as it spread across continental boundaries and began to affect every state in the United States, including New York State. In the weeks and months that followed, the COVID-19 pandemic was felt by the entire NYS mental hygiene system, impacting operations, service delivery, and service recipient outcomes statewide.

i. O-Agency Link-Outreach-Vaccinate (O-LOV) COVID-19 Vaccination Program

OASAS and OMH are collaborating to improve access to COVID-19 vaccinations for eligible individuals within their care systems. The O-Agency Link-Outreach-Vaccinate (O-LOV) vaccination program will include sites at OMH psychiatric centers across the state that will offer both on-site and mobile community vaccination services. More information on this initiative is available at: https://omh.ny.gov/omhweb/o-lov-covid19-vaccine/index.html.

ii. Impact of COVID-19 on Mental Health

The Centers for Disease Control and Prevention (CDC) conducted a study in June 2020 which found that at least 40 percent of adults had at least one adverse mental health or behavioral health condition related to COVID-19. The same study found that 30 percent of adults had symptoms of anxiety disorder or depressive disorder, 26 percent had symptoms of trauma or stress related to the pandemic, and that 10 percent of individuals had seriously considered suicide in the 30 days before completing the survey.

This CDC study also found significant disparities within racial and ethnic groups, with 18 percent of Hispanic respondents and 15 percent of black respondents seriously considering suicide in the 30 days before completing the survey. These disparities align with the disproportionate impact of COVID-19 in Hispanic and Black communities, which saw increased COVID-19 cases, hospitalizations, and deaths when compared to white communities. In addition, surveys of healthcare workers in China, Italy and the United States found 50 percent incidence of one or more mental health issues including depression, anxiety, post-traumatic stress and insomnia. During the COVID-19 pandemic, OMH initiated surveys of consumers, providers, LGU's, and other stakeholders. The OMH Consumer Survey found that approximately 70 percent of respondents reported increases in anxiety and stress during the pandemic, and that significant percentages of respondents reported challenges with housing, income, employment, food and transportation, related to the pandemic.

In addition, the Office of Mental Health has developed and promoted resources to help New Yorkers manage the stress, depression and anxiety that often accompany a crisis situation. In March 2020, at the direction of Governor Cuomo, OMH initiated the COVID-19 Emotional Support Helpline. It was first staffed by mental health professionals and volunteers specially trained to help people cope with the typical stress reactions brought on by emergency and crisis situations. The volunteers provided guidance on managing anxiety, dealing with loss, strengthening coping skills and referrals for community mental health services when needed.

Moving forward, thanks to a grant from the Federal Emergency Management Agency (FEMA), the New York Project Hope Emotional Support Helpline is staffed by crisis counselors who continue to provide free, confidential, and anonymous counseling. Through the Project Hope grant, OMH is also initiating more intensive crisis counseling services through community-based agencies located in NYC and the seven counties across the state most severely impacted by COVID-19, with crisis counselors still available to all New Yorkers through

the Helpline. OMH also developed and distributed guidance and educational materials for New Yorkers on managing anxiety and staying safe during the pandemic and implemented “Coping Circles” the first program of its kind in the nation, which provided free six-week support and resilience virtual group sessions.

Guidance

To aid local communities, mental health providers, and other key stakeholders in New York’s response to COVID-19, the Office of Mental Health (OMH) issued guidance to ensure service continuity throughout the pandemic. This guidance ranged from issues related to the delivery of mental health services, to the immediate fiscal viability of providers, and the workforce adaptations necessary to preserve mental health services in New York State. OMH also hosts numerous webinars, posts comprehensive FAQ’s, and regularly meets with stakeholders to navigate the complex issues posed by the pandemic. For more information about OMH’s guidance related to the COVID-19 state of emergency, please visit: https://omh.ny.gov/omhweb/guidance/.

Disaster and Continuity of Operations Planning

The COVID-19 pandemic has highlighted the need for providers and LGUs alike to plan for disasters and continuity of operations. As overseers of local services, LGUs can play an important role in supporting and assisting in the response to emergency situations. The level of involvement in disaster and continuity of operations planning varies across LGUs, with some LGUs having defined roles in county emergency management plans and others assisting as necessary in respect to the specific emergency.
OMH encourages all providers of mental health services to develop and regularly revise their continuity of operations and disaster plans. Below are resources and guidance which counties and providers can use when planning for these events.

Disaster Planning

SAMHSA Disaster Planning Handbook for Behavioral Health Treatment Programs
HHS Public Health Emergency- Disaster Behavioral Health
Continuity of Operations Planning

SAMHSA Developing a Continuity of Operations Plan
ASPR Tracie-Topic Collection: Continuity of Operations (COOP)/Business Continuity Planning
FEMA Continuity of Operations

iii. COVID-19 and Addiction Services

One of the principal methods OASAS has used to minimize COVID-19 risk for staff and patients has been to maximize the use of telepractice, where possible. In response to the COVID-19 pandemic, OASAS has waived certain regulatory requirements for providing telepractice services in New York for the duration of the declared state of emergency. Inpatient, residential, and opioid treatment programs have been armed with clinical guidance and updated protocols. Personalized screening and assessments are available via telepractice. Medication-assisted treatment can also be started at home via telepractice.

In addition, OASAS recognizes that pandemic-related isolation may lead to increase substance use and related consequences. In response, OASAS has developed a multi-media campaign to highlight the availability of vital addiction prevention, treatment, and recovery services for the duration of the COVID-19 pandemic. Campaign materials are available on the OASAS website at https://oasas.ny.gov/addiction-services-amid-covid-19-campaign.

Updated OASAS policies and resources regarding COVID-19 can be found at: https://oasas.ny.gov/keywords/coronavirus.

iv. COVID-19 and Developmental Disability Services

COVID-19 Response Includes Greater Flexibility in Service Delivery

Since the onset of the pandemic in March of 2020, OPWDD and its voluntary provider partners have worked tirelessly to keep people with developmental disabilities and staff as safe as possible, while continuing to deliver needed services.

OPWDD's COVID-19 response has included efforts to ensure that the service delivery system can be as flexible as possible to meet a variety of situations and needs. Some examples of service system improvements include the expansion of Community Habitation, ability to deliver day services within a residence (Com HabR) and an expansion of services through tele-modalities.

AS the COVID-19 pandemic wanes, the impact of the flexible service delivery initiatives on individuals and their families is being reviewed to determine which features should be made permanent.

B. Integration of Addiction and Mental Health

The Office of Addiction Services and Supports (OASAS) and Office of Mental Health (OMH) held four Listening Sessions between October 16 and November 2, 2020 to explore ways to further integrate addiction and mental health services to better meet the needs of all New Yorkers. During the Listening Sessions, more than 90 stakeholders offered verbal testimony about integrating the two systems and over 70 comments came in through the website that was created for the initiative.

One of the comments that was frequently expressed from multiple consumers and providers was an aversion to using the term "behavioral health" as part of the name of a new, integrated agency, if one is to be created. Stakeholders felt that the word "behavioral" implies a choice on the part of the person suffering from addiction or mental illness.

The other comments made by stakeholders revolved around the following common themes:

- Organizational Culture
- Regulations
- Integrated Care
- Prevention
- Budget
- Access to Services
- Workforce
- Recovery
- Stigma

Comment Summary By Topic

Organizational Culture

Several providers identified the difference in organizational culture between OMH and OASAS as a potential area of opportunity. Observations included differences in communication and collaboration with providers, as well as conflicting strategies and philosophies. Concerns were raised over the impact on employee morale and program effectiveness, and that one agency's needs would be prioritized over the others, with "a stronger one influencing or taking over a weaker one." Other commenters saw opportunities for reimagining the behavioral health model and fostering innovation in prevention, treatment, and recovery while ensuring to "preserve the strength and diversity of both service systems."

Stakeholders expressed concerns with how an integrated agency would address issues such as workforce development, training, licensing and credentialing, and implementing "a protective infrastructure". Some comments focused on the adoption of comprehensive evidence-based practices to deliver fully integrated services and patient-centered care, improve parity and patient outcomes, and eliminate stigma. Some commenters questioned the manner in which resources would be shared and programs evaluated and stressed the need for support and regulatory relief. One comment stressed that "our hope is that if your two systems merge it is a true partnership of integration", with another adding "the fewer silos between our systems of care, the better."

Regulations

Many of the comments received during the listening sessions were focused on regulatory reform and the benefits which a unified service system could offer to recipients, providers, and the MH/SUD systems, if certain reforms were adopted. A few common themes emerged:

- fully integrated licensure and oversight;
- streamlined reimbursement, reporting, and auditing;
- a "no wrong door" service availability for recipients; and
- a single state agency overseeing Medicaid managed care for behavioral health.

Suggestions for an integrated licensure and oversight process were among the most commonly heard from providers and included insights from the perspective of current integrated service providers. Many providers spoke to the improvements in care and various efficiencies that could be attained under integrated programs, ranging from the provision of comprehensive services to individuals with co-occurring disorders, safer environments for recipients and staff, reduced reporting and documentation requirements, improved communication on patient care, and programmatic innovations resulting from new regulatory flexibilities. Likewise, commenters highlighted a need for a unified and streamlined reimbursement process and single state agency oversight for Medicaid managed care for behavioral health, citing the administrative burden and regulatory challenges that have been experienced under the current system.

Comments also favored a "no wrong door" approach to care and the removal of silos between MH and SUD providers, that in the words of one commenter, resulted in the provision of services "using two different philosophies, two different kinds of treatment, two different clinics, with increased administrative burdens."

Integrated Care

Several consumers and providers offered testimony regarding the benefits of integrated care. The stakeholders that discussed integrated care in their public comments were overwhelming in favor of a creating a single agency to address addiction and mental health. Consumers, including family members of people with co-occurring disorders, offered several examples of themselves or their loved ones "getting lost in the cracks" between the addiction and mental health systems. Both consumers and providers mentioned that the burden of navigating between two systems is especially taxing on people who have addiction and mental health needs.

Multiple service providers that provided testimony regarding integrated care mentioned the need to "break the silos" that exist between the two systems in order to provide whole-person care. Providers also mentioned that integrating addiction and mental health services will also make it easier to coordinate with other systems, such as physical health, criminal justice, or social services. Numerous providers offering testimony saw the integration of the two agencies/systems as an opportunity to take the best parts of both systems and create a new agency that meets the needs of the people seeking treatment, rather than trying to force the people seeking treatment into the existing system.

Prevention

Many representatives from OASAS-funded prevention service providers offered testimony as part of the Listening Sessions. The prevention providers generally supported integrating the two agencies/systems, with the exception of one provider who desired that substance use prevention continue to be carved out separately in an integrated agency. Most providers spoke to the potential benefits of being able to provide comprehensive mental health and substance use prevention, especially because addiction and mental illness often share similar root causes and can be addressed using shared strategies. One OASAS-funded substance use prevention provider mentioned, for example, that they already provide suicide prevention services to the youth they serve, but that this work is not supported by either agency under the present model.

Budget

Providers, families, recipients and advocates provided testimony on the future budgetary implications of a proposed integration. A few comments from families and recipients were concerned with an overall budgetary decrease for mental health (MH) and substance use disorder (SUD) services due to an integration, and a resistance against using fiscal priorities to drive changes in service delivery. Some providers raised issues about the current fiscal viability of MH and SUD services due to reimbursement rates and increasing costs, coupled with the state's budget deficit and the impact of COVID-19. However, many of the comments received were more focused on the potential fiscal benefits of a proposed integration at both the provider and state levels, through consolidation of services and administration, the removal of silos, and other efficiencies. Advocates and providers both voiced strong support for reinvestment of any state savings back into the behavioral health system.

Access to Services

Consumers and their loved ones testified to the need to improve access to addiction and mental health services and the hope that a new agency and redesigned system could achieve this aim. One consumer noted that, in rural areas, services of any kind can be difficult to access and if someone needs to access both addiction and mental health services then traveling to and from both presents an additional burden. Instituting a "no wrong door" approach in an integrated system would be very beneficial to those seeking services, who may face difficulty finding treatment under the present systems.

Workforce

A number of comments were received regarding the current and future workforce priorities of behavioral health providers and their frontline staff. Many commenters stated that the current pay structures for MH/SUD professions were inadequate and posed a challenge in recruitment and retention. Multiple comments encouraged the creation of a universal credentialing process and in particular, the continued support for peer workers and the creation of a singular peer credential. Other comments stressed the need for a "maintenance of expertise" in both fields, with equity between employees certified in their respective professions, and increased opportunities for professional development and multidisciplinary certification. Commenters also raised the improved patient outcomes that could result from an interdisciplinary workforce including increased attention to prevention and trauma informed care, and the "relationship to recovery and social determinants of health."

Recovery

Representatives from the addiction and mental health recovery and peer communities offered comments relating to the importance of recovery services. Recovery advocates stressed their belief that an integrated system should be recovery-oriented and emphasized the important roles peers play in recovery.

Stigma

Multiple comments referenced the stigmatization of individuals diagnosed with mental illnesses and substance use disorders, and how an integrated agency could have an impact on ending these stigmas. Multiple commenters objected to the use of the term behavioral health in the name of the organization, as "those terms are really looked down upon or rejected by many people." One commenter remarked that the current bifurcation of MH and SUD services "led to stigmatization of care" by providers while another stated that joint certification would be important to "de-stigmatizing both disorders amongst both kinds of clinicians" and would yield "true integration." Other commenters voiced support for a system that would allow for a "collective voice" where people are no longer stigmatized due to the association of these services with the criminal justice system.

C. 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.

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.

<u>Value Based Payment (VBP)</u>

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 ongoing transition to VBP, the State tasked each DSRIP Performing 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. Fourteen of eighteen BHCCs have established formal contracting entities, Independent Practice Associations (IPAs), in order to engage in VBP arrangements.

Some BHCCs have successfully entered VBP contracts, particularly level one or indirect arrangements through their IPAs. The work continues to develop in creating sustainable structures and revenue streams, often through offering back office administrative functions and/or data analytics for regional partners.

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.

D. 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.

OASAS oversees one of the nation's largest Substance Use Disorder systems of care with approximately 1,700 prevention, treatment and recovery programs serving over 680,000 individuals per year. This includes the direct operation of 12 Addiction Treatment Centers where our doctors, nurses, and clinical staff provide inpatient and residential services to approximately 8,000 individuals per year.

Statewide planning for addiction services is organized around three main priorities:

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

The following section outlines the major efforts OASAS has made over the past year to address the priorities listed above. More detail on OASAS goals related to these priorities can be found in the OASAS 2020-2024 Statewide Comprehensive Plan, available at:
https://oasas.ny.gov/system/files/documents/2020/02/oasas_statewide_plan_20_24.pdf

PRIORITY: Expand Access to SUD and Problem Gambling Treatment

Increasing the Availability of Mobile Treatment and Telepractice

Governor Andrew M. Cuomo made expanding mobile treatment and telepractice a priority in 2020. Funding for both initiatives is provided through the federal State Opioid Response Grant and awarded through Requests for Applications administered by OASAS. This funding is expanding and enhancing addiction services in underserved areas of the state, allowing more people to access this critical care.

This funding is expanding the Center of Treatment Innovation (COTI) service initiative launched in 2017 as part of the State Targeted Response to the Opioid Crisis Grant. COTI service providers are tasked with expanding access to treatment of opioid use disorder through peer services, mobile service delivery and telepractice

capability. COTI service providers work to break down existing barriers to treatment by connecting people to services in the community.

Mobile Treatment

In 2020, OASAS awarded over $1.8 million in funding to expand mobile treatment across New York. The opioid crisis coupled with the pandemic created a need for addiction services in underserved communities and to help individuals who are unable to travel distances due to lack of transportation or other personal or geographical reasons. The goal of this initiative is to expand the availability and access to addiction treatment services in underserved regions of the state.

Providers in New York State utilize two types of mobile treatment vehicles:

1. Modified vans with the ability to provide counseling services one-on-one or in a small group, and telepractice capability.
2. Full "mobile clinics" with bathrooms, exam space, telepractice capability and the ability to provide the full array of outpatient services.

Below is a listing of the funding awarded to providers to expand mobile treatment across the state. Each provider receiving funding will deliver services throughout the listed region.

Region	**Provider**	**Amount**
Capital Region	Promesa, Inc.	$ 100,000
Central New York	St. Lawrence County Community Services	$ 225,000
Finger Lakes	Huther Doyle	$ 215,488
Long Island	Central Nassau Guidance	$ 208,554
Long Island	Outreach Development Corporation	$ 77,800
Mid-Hudson	Bridge Back to Life Center	$ 225,000
New York City	Bridging Access to Care	$ 225,000
New York City	Promesa, Inc.	$ 225,000
Southern Tier	Finger Lakes Area Counseling and Recovery Agency	$ 100,000
Western New York	Best Self	$ 223,675

Telepractice

OASAS awarded more than $875,000 in 2020 for the purchase and installation of equipment to deliver addiction telehealth services statewide. Expanded telepractice capacity ensures access to critical addiction services for individuals and families who may not otherwise seek treatment. Amid the COVID-19 pandemic, telepractice services are being utilized as a safe means of keeping individuals and families engaged in addiction services and supports. OASAS has temporarily waived certain regulatory requirements for providing telepractice during the pandemic. Over 600 program sites across the state are authorized to deliver telepractice services through the use of telephone and video technology. Five hundred of these programs were rapidly approved via the emergency telepractice waiver and attestation process.

Funding has been awarded to over 60 providers in more than 20 counties across New York State. Funding can be used to purchase PCs, software, monitors, speakers, laptops, keyboards, or webcams. Below is a summary of the funding awarded:

Region	Number of Counties	Number of Providers	Amount
Capital Region	1	3	$ 45,000
Central New York	1	2	$ 30,000
Finger Lakes	2	4	$ 59,904
Long Island	2	15	$ 192,711
Mid-Hudson	3	5	$ 60,481
Mohawk Valley	2	3	$ 45,704
New York City	5	24	$ 343,121
North Country	2	3	$ 44,300
Southern Tier	2	2	$ 34,725
Western New York	2	2	$ 19,331

Investing in Residential Treatment

New $14 Million Residential Treatment Facility in Central New York

In February 2020, Governor Cuomo announced the opening of Elements of CNY, a 75-bed residential addiction treatment facility in Liverpool, Onondaga County. Elements of CNY is operated by Helio Health and offers multiple levels of residential care for people receiving treatment for addiction, including stabilization, rehabilitation and reintegration. OASAS contributed $14 million for the renovation of the building and is providing more than $1.1 million in annual operational funding for the new facility.

Elements of CNY offers 55 stabilization and rehabilitation beds, and 20 reintegration apartments. This facility is part of New York State's ongoing effort to provide a full continuum of addiction care by offering residential stabilization, rehabilitation, and reintegration services in one place. This allows people to enter treatment at the level that is appropriate for their needs and receive the individualized services that will best support their recovery. Residential treatment services include counseling, skill-building and training, and recreational activities.

New Women's Addiction Treatment Program on Long Island

OASAS, in September, announced the opening of Outreach's Recovery Residence for Women on Long Island. Operated by Outreach Development Corporation, the new 25-bed women's residential treatment program, which opened officially earlier this year, will provide adults with comprehensive addiction treatment services such as early recovery supports, medication-assisted treatment, and trauma informed care. OASAS contributed $1 million in funding for the facility and the Dormitory Authority of the State of New York (DASNY) oversaw construction.

Outreach will be able to serve an additional 50 to 75 women per year as a result of this program. The addition of these beds furthers New York State's efforts to provide a full continuum of residential care for women suffering from addiction in order to better deliver the individualized care that is essential to recovery. By incorporating essential elements of treatment all in one place, the Outreach staff is able to work with each individual to establish a personalized treatment plan which effectively addresses their recovery needs. Additionally, the facility has 24-hour staffing, common living and recreational space, and transportation available to and from Outreach's enhanced outpatient program for women, also in Brentwood. This new facility will offer residential addiction treatment services for women, ages 18 and over from Suffolk and Nassau counties.

Funding to Expand Treatment Facilities in the Southern Tier and Finger Lakes

Approximately $24 million in funding to expand addiction treatment facilities in the Southern Tier and Finger Lakes regions was announced in November 2020. The Phase II expansion of Helio Health's Binghamton Evaluation Center adds 50 new stabilization and rehabilitation beds. This is in addition to the existing 50 medically supervised withdrawal and inpatient rehabilitation beds and will allow the facility to offer comprehensive addiction care to individuals in the Southern Tier region. Contract funding for this project began in July 2020.

Helio Health is also receiving $11 million in capital funding to relocate and expand its Rochester Evaluation Center for Medically Supervised Withdrawal and Stabilization Services. The newly renovated building will increase access to residential addiction treatment services for men and women, ages 18 and over, in the greater Rochester region by providing 24-hour care from medical and clinical staff for patients with mild to moderate withdrawal symptoms within a structured setting. This new 53-bed facility will ensure that each individual receives the necessary services and supports needed to begin the recovery process and successfully transition back into their communities.

Strengthening and Supporting the Addictions Workforce

In January 2020, OASAS announced the award of over $311,000 in scholarship funding under the Addiction Professionals Scholarship Program. This money supports employees at OASAS-certified organizations who are enrolled or accepted into approved master's level or professional certification programs. The goal of the Addiction Professionals Scholarship Program is to assist OASAS-certified providers with professional development, and workforce retention. To receive funding, OASAS providers were required to submit the applications on behalf of their employee. All eligible applicants who applied for this funding received awards.

Below is a summary of awards by region:

Region	Awards	Amount
Capital Region	2	$ 26,400
Central New York	6	$ 83,372
Finger Lakes	3	$ 33,800
Long Island	3	$ 22,836
New York City	5	$ 96,654
North Country	1	$ 3,920
Western NY	4	$ 44,300

PRIORITY: Increase the Reach and Effectiveness of Prevention

"Triple P" Positive Parenting Program

In 2020, OASAS awarded over $680,000 to expand the "Triple P" Positive Parenting Program, an evidence-based prevention practice that has been shown to reduce risky behaviors among youth. The Triple P program has been shown to reduce substance use and juvenile offending, as well as encourage positive social behavior and emotional wellbeing. The program has also demonstrated success in reducing parental depression, stress, anxiety, and family conflict, and increasing positive family interactions.

Funding awarded through this program will help providers establish collaborations with other community partners who are focused on assisting caregivers of at-risk young children ages 12 and younger. Recipients will also provide services, such as training and implementation oversight geared towards parents and families affected by the opioid crisis. The federal State Opioid Response Grant, as administered by OASAS, provided funding for this initiative.

Below is a list of the funding awarded to providers:

Region	Provider		Amount
Central New York	Farnham Family Services	$	100,000
Finger Lakes	CASA Trinity, Inc.	$	43,351
North Country	Alcohol and Substance Abuse Council of Jefferson County, Inc., dba Pivot	$	99,996
North Country	Citizen's Advocates Inc.	$	100,000
Western New York	Erie County Council for the Prevention of Alcohol and Substance Abuse, Inc.	$	100,000
Western New York	Every Person Influences Children	$	74,181
Mohawk Valley	Center for Family Life and Recovery	$	88,200
Mohawk Valley	HFM Prevention Council	$	81,701

PRIORITY: Enhance Services and Supports to Promote and Sustain Recovery from SUD

Supporting People in Recovery through Housing

In February 2020, Governor Cuomo announced the groundbreaking for Happiness House Apartments, a $9.7 million affordable and supportive housing development in Canandaigua, Ontario County that will provide 30 affordable homes for families, seniors and individuals experiencing homelessness. The Happiness House Apartments will consist of 22 apartments for individuals and families and eight apartments for seniors, with four of the senior apartments set aside for older New Yorkers experiencing homelessness.

The Happiness House Apartments will provide an array of on-site supportive social services for residents to include counseling and recovery services for those with a history of substance abuse; individual and group support for older residents fostering memory skills; mobility and social support with an underlying focus on health and wellness; and adult day care, grief counseling and meal delivery services for qualified tenants. Nine households will receive rental subsidies and supportive services funded by OASAS through Governor Cuomo's Empire State Supportive Housing Initiative.

E. 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 June 30, 2021 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, 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)

The Office of Mental Health has issued a Request for Proposals to continue and enhance the work of Project TEACH (Training and Education for the Advancement of Children's Health). This RFP provides for an award of up to $17 million for a five-year contract beginning July 1, 2021. This award will continue to provide pediatric Primary Care Providers access to consultation, referral and linkage services, and training and education. In addition, the awardee will be responsible for coordination of Project TEACH services including development of specialty consultation services, development and delivery of training programs that would be available throughout the state, maintenance of the statewide Project TEACH website, and marketing and promotion of the program. The RFP also expands the Maternal Mental Health Initiative which provides maternal health providers with access to consultation, training and assistance with referral and linkage around maternal mental health issues.
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

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 directed. 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 was piloted with demonstration projects in three counties – Erie, Rensselaer and Westchester – and grew to include 17 counties. This pilot project has goals of furthering the implementation of the System of Care approach and integrating an evidenced based High-Fidelity Wraparound (HFW) model within Health Homes Serving Children (HHSC).

During the initial four-year pilot, a New York State model of HFW was developed and implemented, serving approximately 300 youth and young adults ages 12 to 21 with serious emotional disturbance and complex needs. Pilot partners include the Research Foundation for Mental Hygiene, State and local child-serving agencies, family representatives, and youth partners involved with SOC efforts throughout the State.

Each child and family simultaneously work with a Health Home care manager trained and certified in HFW model. The pilot also developed training and supported capacity building for family and youth peer providers prior to the transition to Medicaid billing.

Additionally, a mapping and planning model was developed to help NYS counties to convene all child-serving systems to examine entry points, available services, barriers/challenges to access, and gaps/needs in the community. This planning resulted in county action plans to make systemic changes utilizing the SOC framework.

NYS OMH was awarded a second SAMHSA SOC Grant in September 2020 to further the implementation of the System of Care approach and replicating HFW in HHSC statewide. New components will include collaborating with school districts to improve school mental health systems, through assessment against national benchmarks, as well as the development of two rural SOC projects in Essex and Yates Counties.

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 peer specialist, a psychiatric care provider (psychiatrist or psychiatric nurse practitioner) and a nurse. Each team provides a range of services, including evidence based psychopharmacology; primary care coordination; case management; cognitive behavioral therapy (CBT)-informed psychotherapy; evidence-based treatments for comorbidities including substance use disorders; crisis intervention and suicide prevention; trauma assessment; family support and education; supported employment and education and peer support. Evaluation findings of the OnTrackNY

program include improvements in symptoms, improvements in occupational and social functioning and decreases in hospitalization. OnTrackNY is currently operating at 23 sites throughout New York State, with 14 new sites opening since 2016. The 23 currently operating programs are located in the following areas: Albany, Amityville, Binghamton, Buffalo, Garden City, Hartsdale, Middletown, Peekskill, New York City (13 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 through 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 through maternal depression screening and attention to Adverse Childhood Events (ACES) is included. When needed, facilitated referrals to community resources are provided. There are currently 14 OMH supported sites distributed statewide representing diverse populations. The sites have provided comprehensive services to over 6,000 children and their families 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 with 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 OMH Statistics and Reports webpage: https://www.omh.ny.gov/omhweb/statistics/index.htm.

- Patient Characteristics Survey Portal: The Patient Characteristics Survey (PCS) 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 PCS portal includes statewide and regional data for the 2013 through 2019 survey years, as well as a trending of select statewide and regional data points for the 2005 through 2019 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 PCS 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 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 across four separate workbooks:

Part I: Medicaid Utilization
The Medicaid Utilization section displays Medicaid utilization and expenditure data for the Medicaid eligible public mental health population in New York State from 2014 forward.

Part II: MH Inpatient Use
The Mental Health Inpatient Use report displays average daily inpatient census and population rates of utilization by region and county of residence for psychiatric inpatient settings in New York State, including general hospitals, private hospitals, State psychiatric centers and residential treatment facilities.

Part III: Outpatient Capacity
The Mental Health Outpatient and Housing Program Capacity report displays housing, outpatient service and clinic capacities for regions and counties of providers across New York State.

Part IV: Readmissions
The Psychiatric Readmission report displays the rates of readmission to psychiatric inpatient facilities and to emergency room settings for psychiatric reasons within 30 and 90 days of discharge from a psychiatric inpatient facility.

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

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 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.

F. Planning for Developmental Disability Services

The New York State Office for People With Developmental Disabilities (OPWDD) is responsible for coordinating services for New Yorkers with developmental disabilities, including intellectual disabilities, cerebral palsy, Down syndrome, autism spectrum disorders, Prader-Willi syndrome and other neurological impairments. OPWDD provides services directly and through a network of approximately 600 nonprofit service providing agencies, with about 80 percent of services provided by the private nonprofits and 20 percent provided by state-run services.

Supports and services, which include Medicaid funded long-term care services such as habilitation and clinical services, as well as residential supports and services, are primarily provided in community settings across the state.

In addition to these Medicaid services, OPWDD also provides New York State-funded family support services, which are designed to assist families in providing care for their loved ones who live full-time in their family home, and employment supports, which include ongoing job coaching, job matching, and vocational training.

Choice in Service Options

Self-Direction provides the opportunity for people with intellectual and/or developmental disabilities to select a combination of OPWDD-authorized services and supports based on their strengths and needs to help them live as independently as possible. This is accomplished by providing enrollees with individualized budgets that are used to purchase the services they choose, the staff and/or organizations that provide them, and a schedule that works for them. OPWDD has prioritized investments in Self-Direction and increased the number of individuals self-directing to 20,100, an increase of 159 percent over the past four years.

Clinical Services

Clinical Services include physical therapy, occupational therapy, psychology, speech and language pathology, medical/dental services and health care services. Clinical services can enhance a person's quality of life while providing them the treatment they need to help the person remain in their current residential setting within the community.

Day Programs

Day programs and employment services focus on providing participants the personal, social and vocational supports needed to live in their community. Programming varies depending upon each person's unique needs and interests. These services aim to assist individuals to acquire, retain or improve their self-help, socialization and adaptive skills, including communication, travel and other areas of adult education. In the past five years, the number of individuals receiving day and employment services have increased by roughly 6,200, an increase of 11 percent.

Employment Supports

OPWDD offers a number of employment supports to individuals, including;
Pathway to Employment - Pathway to Employment is a time limited service designed to develop a career and vocational plan. The purpose of this service is to discover the person's strengths, abilities, social skills and

career interests. Through vocational experiences, the person can determine the occupations most aligned with their skills or determine what skill development is needed for their desired job.

Community Pre-Vocational Services - Provides community vocational experiences and social skill development to enhance a person's employability. Community Based Pre-Vocational services prepare an individual for employment, foster independence to the greatest extent possible, and develop a career and vocational plan that informs decisions about the needed services.
Employment Training Program - ETP offers people who have experienced challenges in finding employment an opportunity to gain experience with an employer interested in hiring them following a successful internship. OPWDD will pay the wages for a period of time with the expectation that the employer will then hire the person. The purpose of this program is to increase employment for individuals who have significant challenges by customizing the jobs and allowing the person to demonstrate their value to the employer.

Supported Employment Program- The SEMP program develops employment opportunities that match the persons unique skills and abilities and provides job coaching to support the person on the job to meet their individual needs in order to maintain competitive employment in the community.

Respite

Respite services provide temporary relief to family caregivers, helping people with developmental disabilities live at home with their families for longer periods. Respite can be provided in the home or out of the home, during the day, evenings or overnight and often helps families better meet the needs of their loved one with a developmental disability. Over the past five years, the number of individuals receiving respite services has increased by approximately 4,000, an increase of 22 percent.

Crisis Services

In 2020, OPWDD replaced the START program with Crisis Services for Individuals with Intellectual and Developmental Disabilities (CSIDD) and began receiving federal financial support for the program. CSIDD offers crisis prevention and response services to people who have both developmental disabilities and complex behavioral needs, as well as to their families and those who provide supports. Services are available 24 hours a day, 7 days a week to OPWDD eligible individuals age 6 and over who meet CSIDD eligibility. The goal of CSIDD is to build relationships and supports across service systems to help people remain in their homes and communities and enhance the ability of the community to support them.

Residential Services

OPWDD provides a robust community-based residential program, offering residential services and supports based on an individual's needs, goals and preferences. Residential programs are licensed by OPWDD to provide varying levels of housing and related services and are operated by OPWDD or nonprofit agencies. Additional residential services include, but are not limited to: adaptive skill development; assistance with activities of daily living; community inclusion and relationship building; training and support for independence in travel; adult educational supports; and development of social, leisure, self-advocacy, informed choice and appropriate behavioral skills.

OPWDD currently supports 6,700 people through rental subsidies while 36,000 individuals currently live in certified community-based residential programs funded with $5.2 billion in public resources annually. In FY 2022, in keeping with ongoing efforts to enhance our ability to deliver person centered services, OPWDD will increase access to residential services in the most integrated settings by expanding the options available to individuals across our continuum of supports, including rent-subsidized apartments with wrap-around support, supportive group homes and Family Care. OPWDD will also assist people who have aged-out of their residential schools to move to appropriate adult residential opportunities.

Care Coordination Services

OPWDD provides people with developmental disabilities the opportunity for all of their health care needs, including habilitative, physical, mental health, and dental to be coordinated in one place through Health Home Care Management provided by a choice of seven Care Coordination Organizations. This approach enables each person to be treated holistically, based on their unique needs, while improving care, especially for people with a variety of health-care system needs. An alternative form of care management, which is also provided through the Care Coordination Organizations is Basic Home and Community Based Services (HCBS) Plan Support. Basic HCBS Plan Support services is a very minimal coordination option and does not include coordination of health care or mental health services.

G. 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 Tuesday, June 1, 2021.
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

For Plan Year 2022, the Mental Hygiene Goals and Objectives Form is an optional 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 2021 Goals and Objectives Form is brought forward into the 2022 Form. LGUs can use the 2021 information as starting point for the 2022 Plan but should ensure that each section contains relevant, up-to-date responses.

Instructions for completing the Goals and Objectives Form

The first section of the Goals and Objectives Form asks LGUs to identify if their overall local needs for each disability have changed over the last year. Local needs generally do not change significantly from one year to the next; years of planning, policy change and action are required for real change. Please indicate below if the overall needs of each disability population got better or worse or stayed about the same over the past year. Completion of these questions is required for submission of the form.

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

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

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

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

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

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

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

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

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

Please describe any unmet **developmental 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, need to be clear, focused and achievable. The following instructions promote a convention for developing and writing effective goal statements and actionable objectives based on needs, state or regional initiatives or other relevant areas.

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

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

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

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

y) Developmental Disability Care Coordination			☐
z) Other Need 1 (Specify in Background Information)	☐	☐	☐
aa) Other Need 2 (Specify in Background Information)	☐	☐	☐
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 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 and 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. COVID-19 Pandemic Effects on Mental Hygiene Services Delivery System Survey

Instructions

Mental Hygiene service delivery for Plan Years 2021 and 2022 has been affected by the COVID-19 pandemic. The State Mental Hygiene agencies (OASAS, OMH, OPWDD) are using this Local Services Planning Form to collect vital information from Local Government Units (LGUs) about the challenges of providing services to the Mental Health, Substance Use Disorder, and Developmental Disability populations during the COVID-19 pandemic.

SECTION I: OVERALL MENTAL HYGIENE NEEDS RELATED TO COVID-19

1. COVID-19 Needs Assessment by Population (Required)

Please explain why or how the overall needs have changed due to the COVID-19 pandemic and the results from those changes. The first question asks about cross-system needs and the questions that follow ask about each mental hygiene system individually.

d. Evaluate your local mental hygiene service system's (i.e., mental health, substance use disorder and problem gambling, and developmental disability populations) performance during the COVID-19 pandemic:
[ ]

Please specifically note,

- Any **cross-system** issues that affect more than one population;
- Any performance issues related to specific racial/ethnic groups;
- Any differences between adult services and children's services;
- Actions being taken to develop best practices in the future.

e. Indicate how your **mental health service providers** have performed during the pandemic:
[ ]

f. Indicate how your **addiction needs and services**, overall, have been affected by the COVID-19 pandemic:
[ ]

g. Indicate how the needs of the **developmentally disabled population**, overall, have been affected by the COVID-19 pandemic:
[ ]

SECTION II: SYSTEM-SPECIFIC QUESTIONS

OMH Questions-

1. OMH Service Access during COVID

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

i. INPATIENT (State PC, Article 28/31 Inpatient, Residential Treatment Facilities)

○ Increased ○ No Change ○ Decreased ○ Don't Know

ii .OUTPATIENT (Clinic, ACT, Day Treatment, PROS, Continuing Day Treatment, Partial Hospitalization)

○Increased ○No Change ○Decreased ○Don't Know

iii. RESIDENTIAL (Support, Treatment, Unlicensed Housing)

○Increased ○No Change ○Decreased ○Don't Know

iv. EMERGENCY (Comprehensive Psychiatric Emergency Programs, Crisis Programs)

○Increased ○No Change ○Decreased ○Don't Know

v. SUPPORT (Care Coordination, Education, Forensic, General, Self-Help, Vocational)

○Increased ○No Change ○Decreased ○Don't Know

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

[ ]

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

i. INPATIENT
(State PC, Article 28/31 Inpatient, Residential Treatment Facilities)

○Increased ○No Change ○Decreased ○Don't Know

ii. OUTPATIENT (Clinic, ACT, Day Treatment, PROS, Continuing Day Treatment, Partial Hospitalization)

○Increased ○No Change ○Decreased ○Don't Know

iii. RESIDENTIAL (Support, Treatment, Unlicensed Housing)

○Increased ○No Change ○Decreased ○Don't Know

iv. EMERGENCY (Comprehensive Psychiatric Emergency Programs, Crisis Programs)

○Increased ○No Change ○Decreased ○Don't Know

v. SUPPORT (Care Coordination, Education, Forensic, General, Self-Help, Vocational)

○Increased ○No Change ○Decreased ○Don't Know

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

[ ]

2. Capacity Changes during COVID

Since March 1, 2020, please describe capacity changes within each of the following program categories
i. INPATIENT
(State PC, Article 28/31 Inpatient, Residential Treatment Facilities)

○Increased ○No Change ○Decreased ○Don't Know

ii. OUTPATIENT (Clinic, ACT, Day Treatment, PROS, Continuing Day Treatment, Partial Hospitalization)

○ Increased ○ No Change ○ Decreased ○ Don't Know

iii. RESIDENTIAL (Support, Treatment, Unlicensed Housing)

○ Increased ○ No Change ○ Decreased ○ Don't Know

iv. EMERGENCY (Comprehensive Psychiatric Emergency Programs, Crisis Programs)

○ Increased ○ No Change ○ Decreased ○ Don't Know

v. SUPPORT (Care Coordination, Education, Forensic, General, Self-Help, Vocational)

○ Increased ○ No Change ○ Decreased ○ Don't Know

County Adaptations/Efficiencies/Post-COVID Reorganizations

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

○ No
○ Yes (please describe)

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

○ No
○ Yes (please describe)

4. Disaster and Continuity of Operations Planning

a. How many mental health providers within your county implemented existing disaster plans?

—

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

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

—

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

c. Did your county LGU or Office of Emergency Management (OEM) assist any mental health providers in the development or revision of disaster plans?

○ LGU

- OEM
- Both
- None

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

d. Does your county LGU have a plan for ensuring that provider continuity of operations plans are developed and maintained?

- No
- Yes

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

e. Does your county LGU have a responsibility for directly providing mental health services as part of the county's comprehensive emergency management plan?

- No
- Yes

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

f. Is your county LGU engaged with the Regional Health Preparedness Coalition?

- No
- Yes

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

OASAS Questions-

1. OASAS Service Access during COVID

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

Increased No Change Decreased Don't Know

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

b. How has COVID-19 affected the delivery of and demand for addiction treatment services in your county?

Increased No Change Decreased Don't Know

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

c. How has COVID-19 affected the delivery of and demand for addiction <u>recovery</u> services in your county?

○ Increased ○ No Change ○ Decreased ○ Don't Know

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

d. How has COVID-19 affected the delivery of and demand for <u>problem gambling treatment</u> services in your county?

○ Increased ○ No Change ○ Decreased ○ Don't Know

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

2. County Adaptations/Efficiencies/Post-COVID Reorganizations

a. During COVID-19, apart from telehealth, did your county or addition service providers within your county develop any innovative services or methods of program delivery that may be continued? If yes, please describe.

○ No
○ Yes (please describe)

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

○ No
○ Yes (please describe)

<u>OPWDD Questions</u>-

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

○ No
○ Yes (please describe)

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

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

Final Question-

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

C. 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[1]: 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.[2]
    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.

[1] 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.

[2] 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. [3]
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

[3] 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[4] – 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).

[4] 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. Though OMH will not be providing the Community United for Suicide Prevention designation in 2021, would your LGU seek to be considered for this designation in the future?

- ○ Yes
- ○ No

D. Community Services Board Roster (New York City)

Community Services Board Chair:

Name: _____
☐ Physician ☐ Psychologist
Represents: _____
NYC Borough: _____
Term Expires: Month _____ Year _____

Email Address: _____

Name: _____
☐ Physician ☐ Psychologist
Represents: _____
NYC Borough: _____
Term Expires: Month _____ Year _____

Email Address: _____

Name: _____
☐ Physician ☐ Psychologist
Represents: _____
NYC Borough: _____
Term Expires: Month _____ Year _____

Email Address: _____

Name: _____
☐ Physician ☐ Psychologist
Represents: _____
NYC Borough: _____
Term Expires: Month _____ Year _____

Email Address: _____

• • •

• • •

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

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
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: ______________________

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: ______________________
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.

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 2022 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 2022 local services planning process.

Thank you for participating in the 2022 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 **Friday, April 30, 2021**. 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. 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 **Friday, April 30, 2021**. 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)

B. 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 2021-2022?
   - ○ 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 well-being 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.