NYS Conference of Local Mental Hygiene Directors, Inc.
Technical Assistance Project

2010 Plan for New York Mental Hygiene Services

County and City Cross-Systems Priorities

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2010 Plan for New York Behavioral Health Services
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I. Executive Summary

By statute, service planning is a core element of the responsibilities vested with the local governmental unit (LGU). Maintaining an effective, ongoing planning process helps to ensure that the voices of consumers, family members, and other stakeholders are heard—and used to shape refinements to the service delivery system. The planning process helps to define service needs and gaps—and provides a framework for aligning available resources with identified priorities. In turn, this should lead to better outcomes for people receiving services, and better value for the system, as resources are deployed to address the most significant needs. The sections that follow provide a brief recap of the efforts that have taken place under the leadership of the NYS Conference of Local Mental Hygiene Directors, Inc. (CLMHD) during the past several years to revitalize and strengthen the planning process, and present highlights from an analysis of the data gathered during the most recent planning cycle. For this analysis, the focus is on local priorities that cut across systems—as well as the strategies being deployed locally to make progress toward these goals.

During 2009, the 57-county and New York City membership of the CLMHD continued working on a multiyear planning initiative. Under the auspices of the Mental Hygiene Planning Committee, previous efforts had centered on collaborating with NYS OMH, NYS OASAS, and NYS OMRDD on the creation of a web-based tool, available through the OASAS County Planning System (CPS) for use by counties to describe planning priorities and progress made toward these priorities on an annual basis. As this process continued in 2009, counties were asked to review the priority areas identified in the prior year and provide updates needed to identify new or evolving **priorities** and to report local progress. For the purpose of planning, *priority outcomes* are defined as: ***"A broad statement of a realistic and desirable goal hoped to be achieved over a period of time."*** They should reflect the mission, vision, and values of the State and local system of services and supports, and be constructed in a way that allows counties to articulate a multiyear plan of action toward outcome achievement.

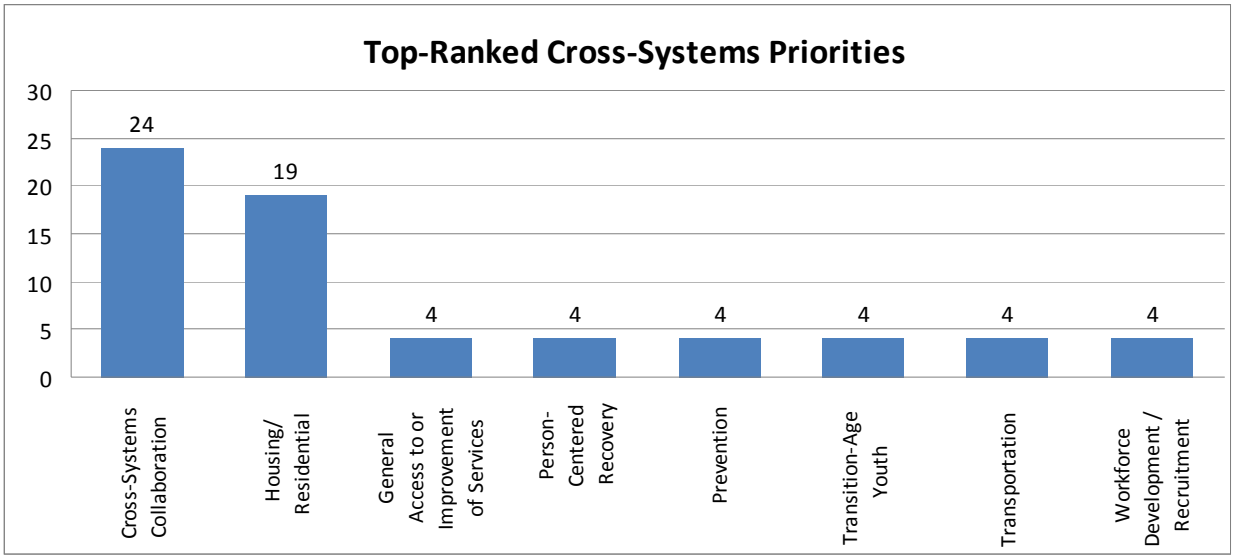
In addition to describing their priority outcomes in narrative format, counties were asked to provide a narrative description of the specific **strategies** being employed to address each priority. For the purpose of this planning exercise, a *strategy* is described as: ***"A measurable statement about what change needs to occur in order to achieve the stated outcome.***" In order to better support analysis and reporting of these data, in addition to a narrative description of their strategies, counties were asked to categorize each one using a dropdown list of focus areas that were developed based largely on the previous year's responses. It was also requested that counties use a series of checkboxes to describe their priorities and strategies along a number of dimensions (including variables such as target population, State agency, service category, demographic information and whether the County had developed an innovative strategy to achieve a given priority).

In order to provide a sense for the relative importance of the local priorities, counties were asked to indicate which of their priorities were among the top two for each disability. The sections that follow provide an overview of this year's planning process, with a specific focus on those cross-systems priorities (i.e., those that counties indicated apply to mental health, substance abuse, and mental retardation/developmental disability services), as well as the strategies identified as most important at the local level. Highlights are summarized in the sections that follow.

Nearly Full County Participation in the 2010 Planning Process

- Consistent with the high level of participation in previous years, it is noteworthy that **98% of the counties participated in the planning process during 2009.** The plan for one County is still under development and not available in time for inclusion in this analysis.
- Counties were asked to submit information describing their most important **priority outcomes** in narrative form. In an attempt to best capture local input and report on priority outcomes, a total of **38 possible summary categories** for priorities were developed by the evaluation team based on analyses of submissions from prior years and drawing upon information used by the Substance Abuse and Mental Health Services Administration (SAMHSA). Evaluators categorized responses based on the focus area(s) that best described counties' self-reported priority outcomes.
- **Counties were asked to categorize their strategies** using a dropdown list of focus areas that were developed based largely on the previous year's responses. As such, local planners described their strategies in narrative form, and then categorized them based on the focus area(s) that best described their strategies.
- A total of **651 priority outcomes were submitted**. Of these, **167 were indicated to cut across all three State agencies** (OMH, OASAS, and OMRDD). Of these, **75 were designated as a top two priority** by the County.
- For the 75 top two priorities that crossed all three agencies, **338 strategies were identified**, or an average of 4.5 strategies per priority.

Top Local Priorities for 2010 Focus on Cross-Systems Collaboration/Service Integration and Housing/Residential Services



- When coding counties' top two cross-systems local priorities using a standardized list of summary categories, **priority outcomes related to enhancing Cross-Systems Collaboration/ Service Integration were reported most frequently** (32% of the outcomes reported).
- Among the top two cross-systems priorities, **Housing/Residential Services was the next-highest** ranked focus area—accounting for 25% of these items**.**

There is General Agreement on the Focus of the Cross-Systems Priorities, but Some Differences are Evident Based on County Characteristics

- **Although the first- and second-ranked priorities do not vary by county characteristics, variability is evident in terms of the third-ranked categories.**
  - **Small counties** prioritized Transportation and Assessment/System Planning/CQI activities.
  - **Middle-sized counties** focused on Workforce Development/Recruitment issues.
  - **Large counties** (excluding NYC) prioritized Person-Centered/Recovery issues, which tied with the second-ranked Housing/Residential service priority.

Rank Order of Outcome Categories by <u>County Size</u>
for Top Two Cross-Systems Priority Outcomes

Priority Outcome Category	Small (Less than 80,000; N=16 Counties)	Middle-Sized (Between 80,000 and 500,000; N=18 Counties)	Large (Greater than 500,000; N=1 County)*
Cross-Systems Collaboration/ Service Integration	1	1	1
Housing/Residential Services	2	2	2 (tie)
Person-Centered/Recovery			2 (tie)
Transportation	3 (tie)		
Workforce Development/ Recruitment		3	
Assessment/System Planning/CQI	3 (tie)		

**Rankings only fell into 1st or 2nd place*

- **Workforce Development/Recruitment tied as the highest-ranked category among downstate suburban counties (see p. 14 for a listing of the counties in this category).**
  - When considering county type (e.g., upstate urban, downstate suburban), consistent with the overall results, the most frequently indicated categories were **Cross-Systems Collaboration and Housing/Residential Services**.
  - One exception was seen among downstate suburban counties, in which **Workforce Development/Recruitment** tied as the highest-ranked category.

OMRDD Regions Exhibited the Most Variability in Rankings of Priority Outcome Categories

- **Cross-Systems Collaboration** and **Housing/Residential Services** were ranked in first or second place, while third-place priority outcomes varied among OMH regions.
- **Cross-Systems Collaboration** and **Housing/Residential** were tied for first or second place with a number of other priority outcome categories among OMRDD regions. OASAS regions showed a similar trend, especially for third-place rankings.

Counties are Engaging in a Wide Range of Strategies to Address Priority Outcomes

- Strategies related to **cross-systems collaboration** focused on **integrating services/treatment and support, improving access to services,** and **licensing/certification/integrated funding**.
- Strategies related to **housing** focused primarily on **developing specialized housing for consumers, providing apartment/rent subsidies,** and **enhancing staff-supported community residences**.
- **Strategies related to other top priorities varied substantially** and focused on the following types of approaches: integrated services for multiple disabilities, case management, self-directed or family-directed supports, person-centered planning, use of evidence-based practices, enhancing transitional supports and services, and staff training.

Counties Share Examples of Local Innovation in Key Areas

- Counties identified 19 strategies being taken that they felt were innovative enough to warrant dissemination across counties. The innovative strategies related to six priority outcomes categories: Cross-Systems Issues, Housing/Residential, Person-Centered/Recovery, Transitional Age Youth, Workforce Development/Recruitment, and Fiscal. Some specific examples are highlighted in this report and will be available for review through the web-based County Planning System (CPS).

Implications

The results of the planning data outlined above and described more fully later in this report represent only the early stages of what is anticipated to be an ongoing process of using this and other information sources to help guide efforts to strengthen system planning and management. On one hand, there is a strong degree of commonality, at a high level, regarding local priorities—**the need to work more efficiently and effectively *across systems* to meet the needs of those served in multiple sectors of the community, and increasing/improving residential services all emerged as key areas of focus in communities across the state.** However, the specific needs do vary by locale—as do the strategies that are either underway or planned to address these needs. By developing mechanisms to share information not only about needs—but about potential solutions—we can continue to move the planning process from a point-in-time snapshot of services, priorities, and gaps to one of effective ongoing management. In addition, by leveraging the technology, information, and content expertise available within the State agencies and at the local level, we can continue to improve the process of planning—and of ongoing system management.

II. Acknowledgments

The membership of the CLMHD should be recognized for its incredible response to the Planning Initiative and for nearly 100% participation in the submission of Behavioral Health Plan Summaries and Priorities for 2010. The very high level of participation is indicative of the importance of local planning. The efforts of Community Services Boards, consumers, families, providers, other stakeholders, and County planning staff must also be recognized for the vital roles they all play in helping to formulate local plans.

The three State Agency Commissioners—NYS OMH Commissioner Michael Hogan, NYS OASAS Commissioner Karen Carpenter-Palumbo, and NYS OMRDD Commissioner Diana Jones Ritter—have shown significant support for this important planning endeavor, including their generous contribution of staff assistance. The strong spirit of collaboration between the Conference and staff from all three State Mental Hygiene agencies has revitalized joint planning efforts and made this unprecedented collaborative planning effort possible. Moreover, the ability to effectively leverage the technical infrastructure developed by NYS OASAS (the County Planning System, or CPS) to support the collection of planning data across all three areas created a number of opportunities to improve the efficiency of the process.

Members of the Joint Mental Hygiene Planning Committee[1], which, in addition to representation from the three State agencies and the CLMHD, includes representation from planning staff from New York City and several counties, played a key role in developing the integrated planning document as well as informing the analytic process.

Dr. Thomas Jewell, Dr. Melissa Affronti, Pamela Fattore, Debra Hodgeman, and Anne Wilder of Coordinated Care Services, Inc. (CCSI), were also helpful in assisting the CLMHD with organizing, categorizing, and analyzing the data from the plan summaries.

[1] Jean C. Audet, Jr., Director, OASAS Planning Unit**,** Bureau of Planning, Needs Assessment and Statistical Analysis; Mary Coppola, Technical Assistance Manager, NYS Conference of Local Mental Hygiene Directors; Michael Damiano, Assistant Director of Community Services, Allegany County Mental Health Department; Laura Davis, Committee Specialist, NYS Conference of Local Mental Hygiene Directors; Sheila A. Donahue, Director, Office of Evaluation Research, Chairperson, NYS OMH Central Office Institutional Review Board; Philip Endress, Commissioner, Erie County Department of Mental Health; Marcia Fazio, Director of the Office of Planning, NYS Office of Mental Health; Colleen Garrahan, Information Technology Specialist, NYS Office of Mental Health; Sherrie Gillette, Director of Community Mental Health Services, Clinton County; Andrew Heck, Senior Administrative Analyst/Long Range Planning, NYS OASAS Bureau of State/Local Planning and Outcome Management; Thomas Jewell, Director, Evaluation & Services Research, Coordinated Care Services, Inc.; Neilia Kelly, Administrator, Office of Mental Health, Monroe County Department of Human Services; Margaret S. Kennedy, Columbia County Department of Human Services/MHC, Planner/Contract Manager; Scott LaVigne, Director of Community Services, Seneca County Mental Health Department; Ed McCorry, Behavioral Health Administrator, Schenectady County Office of Community Services; Neil Mitchell, Planning Bureau, NYS Office of Mental Retardation and Developmental Disabilities; Michael O'Leary, Director of Community Services, Columbia County Department of Health Services; Michael Orth, Second Deputy Commissioner, Westchester County Community Mental Health Department; Betty Pease, Deputy Director of Planning, NYS Office of Mental Health; Bill Phillips, NYS OASAS Associate Commissioner, Division of Outcome Management and System Investment; Raymond Pierce, Program Operations Specialist, NYS Office of Mental Retardation and Developmental Disabilities; Nora K. Puffett, Director, Office of Mental Hygiene Planning, NYC Department of Health & Mental Hygiene; Cynthia Redshaw, Director of Planning, NYS Office of Mental Retardation and Developmental Disabilities; Mathew Roosa, Director of Planning and Quality Improvement, Onondaga County Department of Mental Health**;** Ed Scudder, Director of Community Services, Herkimer County Mental Health Services; Joe Todora, Director of Community Services, Sullivan County; Anne Wilder, President, Coordinated Care Services, Inc.

III. Background

By statute, service planning is a core element of the responsibilities that are vested with the local governmental unit (LGU). The ability to maintain a meaningful, ongoing planning process is important on a number of dimensions:

- The process provides a regular, structured mechanism for obtaining input from consumers, family members, providers, and other stakeholders about what is working well, as well as opportunities to augment or improve the system.
- It helps directors of community services to define local needs and gaps—and provides a framework for aligning available resources with identified priorities. In addition, by reaching out to consumers, providers, and other stakeholders across systems, effective local planning helps to identify common needs and opportunities to strengthen linkages, improve coordination, and maximize the utility of local resources.
- State agencies also benefit from effective local planning. Policy makers at the State level must have information about the characteristics of people being served and the services and supports that are most needed in order to align resources effectively. This is particularly critical in times where resources are scarce.

Effective planning increases alignment between the needs of the individual and available services and related supports. **This, in turn, should lead to better outcomes for people receiving services and better value for the system as a whole as resources are deployed to address the most significant needs**. Over the past six years, the Conference has provided leadership to efforts aimed at revitalizing and strengthening the planning process, and in supporting more consistent and effective collaboration among State agencies and local planners. Additional information describing the history of this initiative is provided in Appendix A to this report.

Planning for 2010 began with a series of regional education sessions aimed at updating local planning staff, as well as staff at the State agency field offices, about changes to the web-based planning tool and ongoing efforts to collaborate—both among agencies at the State level and with counties at the local level—on a planning process that is both efficient and meaningful. Of note, each of these education sessions was delivered by a team composed of planning staff from NYS OMH, OASAS, and OMRDD, the Conference of Local Mental Hygiene Directors, and a County planning representative.

Local efforts to complete the 2010 Priority Outcome and related planning tools began in May 2009 and were largely completed by mid-July 2009. During this cycle, counties were asked to review the priority areas identified in the prior period and provide updates needed to identify new or evolving priorities and to report local progress. For the purpose of planning, *priority outcomes* are defined as: ***"A broad statement of a realistic and desirable goal hoped to be achieved over a period of time."*** They should reflect the mission, vision, and values of the State and local system of services and supports, and be constructed in a way that allows counties to articulate a multiyear plan of action toward outcome achievement.

In addition to describing their priorities in narrative format, counties were asked to provide a narrative description of the specific ***strategies*** being employed to achieve each priority outcome. A *strategy*, for this exercise, is described as ***"A measurable statement about what change needs to occur in order to achieve the stated outcome."*** In order to better support analysis and reporting of these data, in addition to a narrative description of their strategies, counties were asked to categorize each one using

a dropdown list of focus areas that were developed based largely on the previous year's responses. It was also requested that counties use a series of checkboxes to describe their priorities and strategies along a number of dimensions (including variables such as target population, State agency, service category, demographic information, and whether the County had developed an innovative strategy to achieve a given priority).

Participation for this cycle was nearly 100%, with just three counties experiencing a delay in their process—two of the three counties submitted their data by the end of July. The results from this most recent round of data collection are summarized in the sections that follow. Following an analysis strategy reviewed by the Mental Hygiene Planning Committee, this particular analysis is aimed at addressing the following questions:

1. **What are the cross-systems issues that are most important to counties?**
2. **Does what is considered most important vary by county attributes (e.g., size, geographic location)?**
3. **What strategies are counties using to make progress in those cross-systems priority outcomes described as most important?**
4. **To what extent are the strategies counties are engaging in at the local level targeted toward specific populations?**
5. **What kind of innovation is happening at the local level that warrants dissemination across counties?**

IV. Methodology

1. Priority Outcomes Form, Summary, and Web-Based Tool

Counties utilized a revised version of the County Mental Hygiene Priority Outcomes Form designed in 2008, which allows counties to articulate their goals and objectives across the three mental hygiene agencies. Counties entered their data into the online system and selected from a series of menu options to self-categorize their responses along several dimensions. The following briefly describes the steps taken by counties to complete the planning requirements:

1. Counties entered priority outcome statements (i.e., broad statements of realistic and desirable goals the County hopes to achieve over time) and a detailed description of the outcomes statement.
2. Once entered, counties selected the top two priority outcomes under each disability area.
3. Counties categorized priority outcomes using checkboxes across several domains, including:
    - Current status (i.e., in progress, accomplished, dropped);
    - Anticipated year of completion (i.e., 2009, 2010, 2011, 2012);
    - The State agency to which the outcome applies (i.e., OASAS, OMH, OMRDD);

- Linkages to the State Strategic Framework by selecting goals/destinations for each State agency.

4. Counties provided a narrative description of the specific strategies that would be employed to achieve each priority outcome.
5. Counties identified whether the particular strategy is an innovative practice, and if yes, whether they would like to share the practice with others.
6. Counties categorized their narrative strategies using checkboxes across several domains, including:
   - Current status (i.e., in progress, accomplished, dropped);
   - Anticipated year of completion (i.e., 2009, 2010, 2011, 2012);
   - The focus area to which the strategy applies (counties were able to choose from a list of 13 focus areas such as: Housing, Cross-Systems Collaboration/Service Integration, Transportation, Quality Management, etc.);
   - If the strategy targets a special population, the demographic characteristics of individuals that would be impacted by achieving the priority outcome (i.e., age, gender, disability, race/ethnicity, special population);
   - Stakeholders that might be involved in accomplishing the strategy (e.g., Department of Health/Public Health, Office for the Aging, community-based agencies);
7. Counties also selected up to three local funding priorities (an initiative that can only or best be achieved through new State funds)

The above data, with the exception of local funding priorities, were utilized in developing this report. It is intended that summarized results of the plans will be the focus of discussions and negotiations with each State agency regarding State and County priorities, and inform State agency planning for 2010.

2. Analysis Methodology

This analysis focuses on those priority outcomes that were: 1) indicated as a priority that was cross-systems or cut across all three State agencies; and 2) flagged as one of the County's top two priorities. Each local priority outcome and corresponding strategy submission was reviewed carefully by the project team. In addition to reviewing the narrative responses, the category options and format were also reviewed by members of CCSI's Evaluation and Services Research team with clinical and programmatic expertise, as well as an appreciation for local system management. Subsequently, four distinct analytic approaches were employed to best understand the dataset, summarize the local input, and develop a better understanding of common cross-systems themes and needs. These approaches are summarized as follows:

1. Qualitative Analysis (Coding) of Cross-Systems Priority Outcome Narratives – To provide a concise and streamlined presentation of counties' priority outcomes, the first step of analysis was to categorize priority outcomes according to a coding schema (see Appendix A for a table containing the summary categories). A list of 38 predetermined categories had been refined and established during previous planning years and was utilized by the raters. One trained rater reviewed the narrative priority description provided by the counties, and classified each priority into only one or two (maximum) priority outcome categories that best captured the focus of the

priority. A second trained rater independently reviewed every narrative response and the accompanying classification determination made by the first rater, and indicated agreement or disagreement. The two raters agreed on 92% of the categorizations, and subsequently collaborated to resolve the relatively small number of coding discrepancies. All priority outcome analyses in this report are based on the final list of priority outcome categories.

2. Frequency Analysis of Cross-Systems Priority Outcomes Data Provided by Counties – Counties provided narrative descriptions of their outcome statements and self-classified their responses across a number of other dimensions described above (e.g., applicable State agency). To present a clear picture of the high priority outcomes across the State, our first step was to conduct a frequency analysis of the priority outcomes identified by the County. Subsequently, **using the priority category classifications, a series of frequency analyses was conducted to help us understand those priorities that cut across all three State disability areas—the cross-systems issues AND those priorities that were identified as top two priority outcomes.** For instance, we closely examined the frequency distribution of the top two priority outcome categories for the cross-systems issues by a number of county attributes, such as: the population number represented (i.e., small, middle-sized, and large) and the county type (e.g., upstate suburban or rural). Analyzing the responses by county attributes enabled us to determine the extent to which stronger commonalities or differences were evident both within and across the various subgroups. We also compared frequencies of the cross-systems top two priority outcomes selected within each State agency's region. The majority of this report focuses on the frequency analyses of the cross-systems priority outcomes and answers two of the five questions identified for this report: 1) "What are the cross-systems issues that are most important to counties?"; and 2) "Does what is considered most important vary by county attributes?"

3. Frequency Analysis of Strategies – To answer the third and fourth questions targeted for this report, "What strategies are counties using to make progress in those cross-systems priority outcomes described as most important?" and "To what extent are the strategies counties are engaging in at the local level targeted toward specific populations?", we conducted frequency counts of the number of strategies selected for the top two cross-systems priority categories, the types of strategies and strategy focus items selected for the top two cross-systems priority categories, and the number of strategies targeted toward specific populations.

4. Frequency Analysis and Narrative Review of Innovative Strategies – We counted the innovative strategies related to cross-systems top priority outcomes and compared them to the total population of strategies to answer the fifth question, "What kind of innovation is happening at the local level that warrants dissemination across counties?" We also closely reviewed these strategies to help inform case examples that we provide later in this report.

In reviewing the data described in the sections that follow, it is important to take into consideration the following points:

- While the priority outcome categories and frequency summaries are useful in describing the most frequently identified needs, priorities, and strategies, the underlying descriptive detail is also helpful in understanding issues at the local level. Thus, both levels of data were maintained and are referenced in the subsequent sections of this report.

- While the planning template asked counties to describe their priorities as well as identify and further describe their strategies, this report is based primarily on summary analyses of the top two selected priorities and associated strategies. However, details about additional priorities and strategies can be found by accessing the OASAS County Planning System website at http://cps.oasas.state.ny.us/cps/index.cfm.
- The planning template provided a consistent structure for local feedback and/or categorization of priorities and strategies, but allowed for additional detail for each priority and strategy. In reviewing the results, it is clear that there was a fair degree of variance in County approach. In some cases, priorities and/or strategies were described in a great amount of detail, which helped facilitate categorization. In other cases, only a priority title and one or two sentences of text were provided.

V. Summary of the Number of County Priorities Reported

Table 1 summarizes the total number of priority outcomes reported by counties, as well as the disability areas to which the outcomes apply. Counties reported a total of 651 priority outcomes that encompassed various combinations of disability areas, with the greatest proportions of priorities cutting across all areas (26%) or applying to OMRDD only (25%). The next largest proportion of priorities involved OMH only (17%) and OASAS only (17%). No priorities applied to both OASAS and OMRDD.

Table 1. Total County Priority Outcomes Reported

TOTALS	Total reported across all agencies	OMH only	OASAS only	OMRDD only	OMH & OASAS	OMH & OMRDD	OASAS & OMRDD	OMH, OMRDD & OASAS (All 3)
Total Reported	662	116	111	167	57	44	0	**167**
Percentage	100%	18%	17%	25%	9%	7%	0%	**25%**

VI. Planning Question 1 - What are the cross-systems issues that are most important to counties?

Answer/Summary: On a regional and statewide basis, two areas for cross-systems County planning efforts clearly emerge as top priorities: Cross-Systems Collaboration/Service Integration and Housing/Residential Services. Although increased variability in priorities is seen when expanding the analysis to include the top three focus areas, combinations of these two specific priorities consistently rose to the top of any cut of this data (i.e., by county size, region, etc.).

"People with behavioral health disabilities, including developmental disabilities, need access to multiple services and systems in the communities where they live. In order to improve their access to and support from these multiple systems, local providers need to collaborate with other service providers and systems."

Table 2 includes the number of priority outcomes indicated for all three State agencies and ranked as the top two. The table only presents the categories for related outcomes identified most frequently. A complete listing of priority outcome categories, frequencies, and percentages can be found in Appendix B. A total of

"A consistent, stable living situation, with supports as needed, is an essential element in the recovery process and/or in achieving independence and living in the community at the highest level of independence possible."

75 outcomes were reported that cut across all three State agencies and rated as a top two priority. The most frequently reported priority outcome concerned efforts to improve cross-systems coordination/ services integration, including services for people with co-occurring disorders (32%), followed by increasing access to, stability in, or improving housing/residential services (25%). Taken together, these two categories represent 57% of the total cross-systems priority outcomes indicated by counties. It is noteworthy that we drilled down into the Housing/Residential Services category to determine which priorities related specifically to Housing (e.g., need for affordable housing) and which priorities related specifically to Residential Services (e.g., need for residential treatment slots). Findings indicated that 16 (84%) of the 19 priorities referred to housing, while nine (47%) of the 19 priorities referred to residential treatment. Overlap was apparent as many counties described priority outcomes related to both areas.

Table 2. Priority Outcome Categories for Top Two Cross-Systems Priority Outcomes Described by Counties[2]

Priority Outcome Category	Cross-Systems Priority Outcomes Reported	
	75	
	N	%
Cross-Systems Collaboration/Service Integration	24	32%
Housing/Residential Services	19	25%
General Access to and/or Improvement of Services	4	5%
Person-Centered/Recovery	4	5%
Prevention	4	5%
Transitional Age Youth	4	5%
Transportation	4	5%
Workforce Development/Recruitment	4	5%

VII. Planning Question 2 - Does what is considered most important vary by county attributes?

Answer/Summary: Yes. However, the two highest-ranked priority categories ranked tended not to vary much by county attributes. Variability tends to occur when considering the third-ranked categories across the various county attributes examined (i.e., county population, county type, State agency regions).

The top two priority outcome categories were further analyzed by county population, county type, and by State agency region. Tables 3-7 below include data representing these analyses. Priority outcome categories were ranked from first to third place according to the frequencies associated with each category.

1. County Population Size: Although similar across all three county sizes, variability is evident in terms of the third-ranked category areas.

As shown in Table 3, the priority categories ranked in first and second place (Cross-Systems Collaboration/Service Integration and Housing/Residential) did not vary across county population sizes, and as expected, did not differ from the most frequently selected priority outcomes across all agencies overall (Table 1). One minor exception is that Housing/Residential tied with Person-Centered/Recovery for second place in the large counties (Table 3). Small and middle-sized counties varied in outcome priority selection beyond second place, with Transportation and Measurement/CQI/System Assessment tying for third place in the small counties, and Workforce Development/Recruitment as third place for the middle-sized counties. In other words, variability is evident in terms of the third-ranked focus areas:

- **Small counties** prioritized transportation and assessment/system planning/CQI activities.
- **Middle-sized counties** are focused on workforce development/recruitment issues.
- **Large counties** (excluding New York City) prioritized person-centered/recovery issues, which tied with the second-ranked housing/residential services priority.

[2] A total of 45 counties selected priority outcomes that cut across all three State agencies.

Table 3. Rank Order of Outcome Categories by County Size for Top Two Cross-Systems Priority Outcomes[3]

Priority Outcome Category	Small (Less than 80,000; N=16 Counties)	Middle-Sized (Between 80,000 and 500,000; N=18 Counties)	Large (Greater than 500,000; N=1 County)*
Cross-Systems Collaboration/ Service Integration	1	1	1
Housing/Residential	2	2	2 (tie)
Person-Centered/Recovery			2 (tie)
Transportation	3 (tie)		
Workforce Development/ Recruitment		3	
Assessment/System Planning/CQI	3 (tie)		

*Rankings only fell into 1st or 2nd place

2. County Type

"A key change for small rural counties is having both resources and flexibility to respond to treatment needs when they cannot be [met] through the existing treatment services…the ability to mobilize systems, often cross-systems, is the most practical means to meet needs within our community."

Table 4 shows data ranked by popularity of priority outcome across county types for all three State agencies. The cross-systems priority areas for the NYC region were not identified by those counties as the top two and therefore were not included in this table. Again, Cross-Systems Collaboration/Service Integration and Housing/Residential priorities were either ranked in first or second place, or tied for first or second place among all types of counties. However, third-place rankings varied, signifying that similar needs may persist among all county types, but some counties do have unique high priority needs. More specifically, as seen in the table below, beyond the top two ranked priorities, the following types of differences emerged:

- **Upstate urban counties** prioritized Person-Centered/Recovery, Transitional Age Youth, and Workforce Development/Recruitment.
- **Upstate suburban counties** prioritized issues related to Prevention, Inpatient Services, and the Criminal Justice System.
- **Rural counties** prioritized Prevention, Transportation, and Assessment/System Planning/CQI Activities.
- **Downstate suburban counties** prioritized Workforce Development/Recruitment, which was tied for first place with Cross-Systems Collaboration/Service Integration and Housing/Residential services.

[3] County Population Size classifications are based on County data from the Population Estimates Program, Population Division, U.S. Census Bureau, 2000, and are as follows:
Small: Total population of less than 80,000 people
Middle-Sized: Total population of 80,000-500,000 people
Large: Total population of greater than 500,000 people, including New York City

New York City

As shown in Table 4, New York City (NYC) did not identify any outcomes that applied to all three agencies as a top two priority; however, they submitted 51 priority outcomes. The one priority outcome that NYC reported as applying to all three disability areas focused on services for families and individuals with developmental disabilities—in particular, addressing financial barriers and overall service gaps. To address this important issue, NYC plans to streamline the process of providing services to people who are experiencing gaps by creating a mutual funding stream between OMRDD and City and State agencies to address barriers. Examples of progress in 2009 include the DD Council collaborating in a recent housing training, and the DD Council providing materials and instruction on getting services via multiple conference venues.

Table 4. Rank Order of Outcome Categories by County Type for Top Two Cross-Systems Priority Outcomes[4]

Priority Outcome Category	Upstate Urban (N=7 Counties)	Upstate Suburban** (N=3 Counties)	Downstate Suburban* (N=1 County)	Rural (N=22 Counties)	NYC***
Cross-Systems Collaboration	1	2 (tie)	1 (tie)	1	
Housing/Residential	2	1	1 (tie)	2	
Person-Centered/Recovery	3 (tie)				
Transitional Age Youth	3 (tie)				
Workforce Development/ Recruitment	3 (tie)		1 (tie)		
General (Non-Specific) Access to and/or Improve Services		2 (tie)			
Prevention		2 (tie)		3 (tie)	
Inpatient		2 (tie)			
Criminal Justice		2 (tie)			
Transportation				3 (tie)	
Assessment/System Planning/CQI				3 (tie)	

*Rankings only fell into a tie for 1st place

**Rankings only fell into 1st or 2nd place

*** NYC counties did not rank any priority outcomes as top two that cut across all three agencies

[4] County Type classifications are as follows:
Rural: Allegany, Cayuga, Chenango, Cattaraugus, Chautauqua, Chemung, Clinton, Columbia, Cortland, Delaware, Essex, Franklin, Fulton, Genesee, Greene, Hamilton, Herkimer, Jefferson, Lewis, Livingston, Madison, Montgomery, Orleans, Oswego, Otsego, St. Lawrence, Schoharie, Schuyler, Seneca, Steuben, Tioga, Warren, Washington, Wayne, Wyoming, Yates
Upstate Suburban: Dutchess, Ontario, Orange, Putnam, Saratoga, Sullivan, Tompkins, Ulster
Upstate Urban: Albany, Broome, Erie, Monroe, Niagara, Oneida, Onondaga, Rensselaer, Schenectady
Downstate Suburban: Nassau, Rockland, Suffolk, Westchester
NYC: Bronx, Kings, New York, Queens, Richmond

3. OMH Region

"Our entire service structure continues to approach quality improvement through a person-centered approach that considers the individual first, and then seeks to find/create the appropriate supports."

Table 5 exhibits data ranked by popularity of priority outcome across OMH regions. The cross-systems priority areas for NYC and Long Island regions were not identified by those counties as in the top two and therefore were not represented in this table. As expected, all county types most frequently selected the top two categories as Cross-Systems Collaboration/Service Integration and Housing/Residential among OMH regions, but do not share similar priorities beyond these outcome categories. More specifically, beyond the top two ranked priorities, the following differences emerged:

- **Western OMH Region counties** prioritized person-centered/recovery oriented issues.
- **Central OMH Region counties** prioritized issues related to assessment/system planning/CQI activities.
- **Hudson River Region counties** prioritized workforce development/recruitment, prevention, and overall access to services issues.

Table 5. Rank Order of Priority Outcome Categories by OMH Region

Priority Outcome Category	Western (N=10 Counties)	Central (N=16 Counties)	Hudson River (N=9 Counties)	NYC*	Long Island*
Cross-Systems Collaboration	1	1	2		
Housing/Residential	2	2	1		
Person-Centered/Recovery	3				
Assessment/System Planning/CQI		3			
Workforce Development/ Recruitment			3 (tie)		
General (Non-Specific) Access to and/or Improve Services			3 (tie)		
Prevention			3 (tie)		

* NYC and Long Island counties did not rank any priority outcomes as top two that cut across all three agencies

4. OMRDD Region

"For both Mental Health and Mental Retardation Developmental Disabilities, a version of Family Care may present opportunities for our transitional adolescents to address their need for mentoring and a significant adult figure to provide the needed life skill training."

Frequencies of top two priority outcome categories were also compared among OMRDD regions and are presented below in Table 6. The cross-systems priority areas for the Brooklyn, Bernard, Metro, Staten Island, and Long Island regions were not identified by those counties as the top two and therefore were not included in this table. Again, Cross-Systems Collaboration/ Service Integration and Housing/Residential ranked or tied with

other categories as the most frequently selected priority outcome categories. One exception to this trend is the Western region, which did not select Housing/Residential as a cross-systems top two priority outcome. As shown in Table 6, there were many priority outcomes tied in ranking for second or third place. Some similarities can be noted among OMRDD regions (e.g., Prevention tied for second place with other categories in the Hudson Valley, Taconic, and the Western regions); however, the range of priority outcomes selected among regions varies to a much greater extent when compared to the previous geographical analyses. Such an array of priority outcomes within, and possibly among, OMRDD regions suggests that the needs of OMRDD stakeholders might be unique to each specific county.

Table 6. Rank Order of Priority Outcomes by OMRDD Region**

Priority Outcome Category	Central (N=7)	Broome (N=4)	Finger Lakes (N=5)	Hudson Valley* (N=2)	Taconic * (N=5)	Capital District* (N=4)	Sunmount * (N=4)	Western * (N=4)
Cross-Systems Collaboration	1	1 (tie)	1	2 (tie)	1 (tie)	2 (tie)	1	1 (tie)
Housing/Residential	2	1 (tie)	2	1	1 (tie)	1	2 (tie)	
General (Non-Specific) Access to and/or Improve Services	3 (tie)				2 (tie)	2 (tie)	2 (tie)	
Person-Centered/ Recovery	3 (tie)		3					2 (tie)
Prevention	3 (tie)			2 (tie)	2 (tie)			2 (tie)
Transitional Age Youth	3 (tie)				2 (tie)			1 (tie)
Assessment/System Planning/CQI	3 (tie)	3 (tie)					2 (tie)	
Vocational/ Employment	3 (tie)							
Physical Health	3 (tie)							
Workforce Development/ Recruitment		3 (tie)		2 (tie)		2 (tie)		
Inpatient		3 (tie)			2 (tie)			
Psychiatrist		2						
Criminal Justice/ Law Enforcement				2 (tie)				
Transportation					2 (tie)		2 (tie)	2 (tie)
Family					2 (tie)			
Crisis/Emergency/ Respite						2 (tie)		
Evidence-Based Practices/Best Practices						2 (tie)		

Priority Outcome Category	Central (N=7)	Broome (N=4)	Finger Lakes (N=5)	Hudson Valley* (N=2)	Taconic * (N=5)	Capital District* (N=4)	Sunmount * (N=4)	Western * (N=4)
Social Connectedness/ Community Integration						2 (tie)		
Geriatric							2 (tie)	
Funding/Fiscal Viability/Financing Services/Cost-Effectiveness							2 (tie)	
Peer/Consumer							2 (tie)	
General (Child/Youth)								2 (tie)
Information Systems								2 (tie)
Other								2 (tie)

*Rankings only fell into 1st or 2nd place

** Brooklyn, Bernard, Metro, Staten Island, and Long Island regions counties did not rank any priority outcomes as top two that cut across all three State agencies

5. OASAS Region

"Etiology of issues (behavioral versus mental illness or addiction symptomology) is often a source of conflict regarding who should be the primary caregiver at any given point."

Table 7 shows the rank order of the top two cross-systems priority outcome categories compared across OASAS regions. The cross-systems priority areas for NYC and Long Island regions were not identified by those counties as the top two, and therefore were not included in this table. Again, Cross-Systems Collaboration and Housing/Residential Services ranked as the most frequently selected priority outcome categories, with the exception of the Western Region, where Cross-Systems Collaboration tied with other categories as the most frequently selected and Housing/Residential did not appear at all as a top two priority outcome. Similar to the OMRDD regions, a wide range of priority outcomes were selected among regions beyond those that fell into the most frequently or second most frequently selected priority outcome. This trend is most notable in the Western region where 10 top two priority outcomes ranked in first or second place.

Table 7. Rank Order of Priority Outcomes by OASAS Region**

	Western* (N=5)	Finger Lakes (N=6)	Central (N=9)	Northeastern (N=10)	Mid-Hudson (N=5)	NYC	Long Island
Cross-Systems Collaboration	1 (tie)	1	1	1	2		
Housing/Residential		2	2	2	1		
General (non-specific)				3 (tie)	3 (tie)		
Person-Centered/ Recovery	2 (tie)	3 (tie)					
Prevention	2 (tie)				3 (tie)		
Transitional Age	1 (tie)						
Measurement/CQI/ System Assessment			3				
Vocational/ Employment	2 (tie)						
Assessment/System Planning/CQI		3 (tie)			3 (tie)		
Inpatient					3 (tie)		
Criminal Justice					3 (tie)		
Transportation	1 (tie)			3 (tie)			
Family	2 (tie)						
General (Child/Youth)	2 (tie)						
Increase and/or Improve Information Systems	2 (tie)						
Other	2 (tie)						

*Rankings only fell into 1st or 2nd place

** NYC and Long Island regions counties did not rank any priority outcomes as top two that cut across all three agencies

VIII. Planning Question 3 - What strategies are counties using to make progress in those cross-systems priority outcomes described as most important?

Answer/Summary: The three most frequently selected strategies included integrated services/treatment and supports (47) under the Cross-Systems Collaboration priority outcome category, specialized housing (31) and apartment/rent subsidies (19) under the Housing/Residential Services priority outcome category.

A total of 338 strategies were reported for the 75 corresponding priority outcomes (an average of 4.5 per priority) and 718 strategy focus selections were identified (an average of 2.1 focus items per strategy) to pursue County planning goals. Table 8 presents the three most frequently selected strategy items related to the strategy area and the cross-systems priority outcomes. Of all strategy items, counties selected integrated services/treatment and supports the most times (47), with specialized housing (31) following. All other strategies were chosen 19 or fewer times (Please see Appendix C for a table of all priority strategy items and areas). In addition to general access to and/or improvement of

services as a commonly-chosen top two priority outcome area, strategies including access (i.e., access to services, access to public systems, accessible transportation, accessible housing) were selected at least two or more times under all but one of the priority outcome categories (Workforce Development/ Recruitment), indicating that counties are attempting to improve access to services and/or resources on many different levels of program delivery. Further, strategies for integrated services (i.e., integrated services/treatment and supports, integrated services for multiple disabilities, cross-agency integrated housing) also appeared three or more times under each priority outcome category with the exception of Transportation.

Table 8. Priority Outcomes by Top Three Strategy Items and Corresponding Strategy Area

Priority Outcome Category		
Strategy Area	**Strategy Item**	**Frequency**
Cross-Systems Collaboration/Service Integration (N=19 Counties)		
Cross-Systems Collaboration	Integrated services/treatment and supports	47
	Improve access to services	17
	Licensing/certification/integrated funding approaches	12
Housing/Residential Services (N=18 Counties)		
Housing	Specialized housing (i.e., accessible housing, sober house, cross-agency integrated housing)	31
	Apartment/rent subsidies	19
	Other	14
	Staff-supported community residence	13
General (Non-Specific) Access to and/or Improve Services (N=4 Counties)		
Service Capacity/Access	Increase the number of people served	6
	Integrated services for multiple disabilities	5
	Increase/enhance types of services	5
Person-Centered/Recovery (N=4 Counties)		
Service Engagement	Case management	4
Self-Direction	Self-directed or family-directed supports	4
	Development of person-centered organizational culture	3
	Person-centered planning/Individualized services	3
Cross-Systems Collaboration	Integrated services/treatment and supports	3
Prevention (N=4 Counties)		
Cross-Systems Collaboration	Planning	4
Service Capacity/Access	Increase/enhance types of services	4
Quality Management	Use of evidence-based practices	3
Social Connectedness/ Inclusion/Social Support	Family dynamics and support	3

Strategy Area	Strategy Item	Frequency
Transitional Age Youth (N=4 Counties)		
Cross-Systems Collaboration	Integrated services/treatment and supports	5
Services Engagement	Transitional supports and services	4
Cross-Systems Collaboration	Improve access to services (i.e., entry points, single point of access)	3
Transportation (N=4 Counties)		
Cross-Systems Collaboration	Improve access to services (i.e., entry points, single point of access)	3
	Training	3
Employment/Education	Transition from school to adult services	3
Transportation	Improve access to public systems	3
Workforce Development/ Recruitment (N=4 Counties)		
Cross-Systems Collaboration	Integrated services/treatment and supports	16
Workforce Development	Staff training, including cross-systems issues	7
Cross-Systems Collaboration	Licensing/Certification/Integrated funding approaches	6

IX. Planning Question 4 - To what extent are the strategies counties are engaging in at the local level targeted toward specific populations?

Answer/Summary: Appendix D includes a table of the frequencies of strategies associated with specific populations. Counties most frequently selected "other" or multiple populations to which strategies applied. Given that no clear trends or themes on priority populations could be derived from the data, this table was not included in the narrative of the report.

X. Planning Question 5 - What kind of innovation is happening at the local level that warrants dissemination across counties?

Answer/Summary: Counties reported 25 innovative strategies (19 that were unique) in five priority outcome categories: Cross-Systems Collaboration/Service Integration, Housing/Residential, Person-Centered Recovery, Transitional Age, Workforce Development/Recruitment, and Fiscal. Examples and case studies described below provide further detail on the innovation occurring at the local level.

Table 9 presents the number of strategies related to priority outcomes. Strategies were associated with five priority outcome categories, with Cross-Systems Collaboration/Service Integration and Housing/ Residential representing the highest number of innovative strategies. Alternatively, Person-Centered/ Recovery and Transitional Age Youth were the priority outcome categories with the highest percentage of total strategies that were innovative.

Table 9. Frequency of Priority Outcomes and Associated Strategies Reported as Innovative

Priority Category Outcomes	Total # Outcomes	Total Strategies	Total Strategies Described as Innovative
Total Strategies Indicated for All 3 Top Two State Agencies' Priorities	**75**	**338**	**25**
	N	**N**	**N**
Cross-Systems Collaboration	25	84	10
Housing/Residential	19	78	8
Person-Centered/Recovery	4	22	4
Transitional Age Youth	4	10	2
Workforce Development/Recruitment	4	24	1

1. Examples of Innovative Strategies Related to Top Priorities

Counties indicated that a number of their innovative practices are worthy of sharing with others. Below we provide some brief highlights of innovation related to several of the key priority outcome areas described earlier in this report.

<u>Cross-Systems Collaboration/Service Integration</u>

- Use regularly scheduled community forums to explore expansion of existing collaborative efforts (for children and seniors) to enhance the delivery of comprehensive services to all County residents.
- Mental Hygiene providers licensed by Office of Mental Health (OMH) and Office of Alcohol and Substance Abuse (OASAS) will continue implementing the Co-Occurring System of Care (COSOC) modified American Society of Addiction Medicine (ASAM) dual disorder capable criteria to develop an integrated treatment model for individuals with co-occurring diagnoses of mental illness and chemical dependency.
- Advocate to OMH, OASAS, and OMRDD to develop a statewide initiative that mandates the establishment of a Regional Inter-Office Coordinating Council (IOCC), the establishment of Regional Offices that encompass staff from the three disability areas and the establishment of a SPOA Process for Persons with multiple disabilities to promote integrated service provision and ownership by all systems in developing solutions to access to care.
- Develop and implement Pay for Performance initiative through the 41.35 legislation aimed at improving access to care coordination services and outcomes for high-need populations with a serious mental illness.

Housing/Residential Services

- Explore housing sites, including existing apartment buildings, houses, and land development locations by first identifying a landlord or housing provider to partner with, then developing MOUs with multiple treatment providers to provide case management, and generally exploring all possible housing alternatives for adults.
- A Chemical Dependency Single Point of Access (SPOA) Coordinator will provide assistance and support to providers and consumers to continue to work with the Department of Human Services (DHS) to resolve any perceived DHS systems barriers to accessing residential services.
- Develop a designated supportive housing program for women with Substance Abuse Disorder issues and their children by working collaboratively and across systems to develop this program through the formation of a housing work group dedicated to the creation of this program. Not-for-profit agencies will acquire site control and ownership of a usable parcel of land for this program. Members of the committee will visit model programs around NYS doing this type of work. Finally, various capital funding resources will be pursued.

Person-Centered/Recovery

- Continue development work with the Western New York Care Coordination Program (WNYCCP), a managed care initiative for behavioral health/physical health care integration based upon the principles of person-centered planning in support of recovery. Develop the services and financing model for integration and provision of care coordination services within a managed care context

2. County-Specific Strategies: Case Examples

Detailed case examples of strategies that counties chose as innovative practices worthy of sharing with others are presented below. Strategies from small, medium, and large counties are included. These case examples illustrate the individualized nature of County efforts to address cross-systems priorities and are intended to provide a detailed view of local efforts beyond the aggregate quantitative results.

Example #1: Small Rural Counties
Priority Outcome Category: Cross-Systems Coordination/Services Integration

Of the seven counties that reported innovative strategies, two were rural and small in population: Columbia and Hamilton. Both reported innovative strategies that related to the Cross-Systems Collaboration/Service Integration priority outcome category, but with unique approaches.

Columbia County is currently using the dual disorder capable criteria (Co-Occurring System of Care modified American Society of Addiction Medicine) to serve as a foundation from which to develop a collaborative treatment model for individuals with co-occurring diagnoses. Other activities to promote cross-systems efforts included the formation of a Suicide Prevention Coalition, creation of a co-located OASAS-licensed treatment staff in the OMH treatment clinic, and a cross-training initiative with family member input, which is currently being developed.

Hamilton County also reported an innovative strategy related to the creation of comprehensive service models. They are using collaborations currently in existence, such as initiatives or community forums, to explore ways to enhance the delivery of comprehensive services to all County residents.

Example #2: Middle-Sized Downstate Suburban County
Priority Outcome Category: Cross-Systems Collaboration/Service Integration and Workforce Development/Training

Four medium-sized counties—one rural, two upstate suburban, and one downstate suburban—reported innovative strategies. Since a case study from each County is beyond the scope of this report and in order to represent the downstate counties, an innovative strategy from **Rockland County** will be presented. Rockland County is extensively pursuing methods to improve cross-systems collaboration and training between all three State agencies and to establish a cross-systems certification for evidence-based integrated treatment for individuals with co-occurring disorders. Of the several strategies they reported to achieve this goal, one innovative strategy entails advocating for a statewide Regional Inter-Office Coordinating Council and regional offices with staff representing the three State agencies. In conjunction with the regional offices, a statewide Single Point of Access (SPOA) process for persons with multiple disabilities would also be implemented. Representatives from the blended regional offices and the State field offices would chair the committee. Further, the Adult SPOA and Children's SPOA processes would be enhanced to encompass all three disability areas and extend the number of services available. Rockland stressed the importance of this initiative being implemented statewide to promote standardization and consistency across systems and counties.

Example #3: Large Upstate Urban County
Priority Outcome Category: Housing/Residential

Monroe County is the only large County that reported innovative strategies related to the three State agencies. Monroe County described a number of strategies connected to housing. One innovative practice that is in progress involves a mechanism through which providers would be offered funding incentives according to their success in providing access to housing for populations with serious mental illness. Close monitoring of outcomes, strategies, and incentive structure, as well as additional refinements, are underway. Monroe County has also developed a Chemical Dependency Single Point of Access (CD SPOA) process to ensure timely access to residential services. Over the past year, Monroe County has continued to collaborative with other systems, such as the Department of Human Services, and Mental Health Single Point of Access (MH SPOA), to fine-tune procedures. Further integration has also occurred with CD SPOA and MH SPOA operations.

As noted above, counties are implementing a range of strategies aimed at similar cross-systems priority outcomes. From a peer model of housing to tailored funding incentives, counties have identified the needs of their communities and have established creative strategies to achieve housing outcomes. Cross-Systems Collaboration/Service Integration strategies range from utilizing dual disorder criteria to taking advantage of current collaborative initiatives. While these strategies have been developed through local County processes, many may be applicable to other counties; counties may want to consider how the above strategies may be useful to their own local planning efforts. Detailed strategy

descriptions are available on the web-based County Planning System (CPS) developed and maintained by NYS OASAS. For a case example of how a County might use the CPS, please see Appendix F.

XI. Discussion and Future Directions

Almost all of the counties and the City provided detailed information on their planning priorities and planned strategies for accomplishing priority outcomes for their local mental health services systems. County representatives were asked to self-classify their priorities on several dimensions, including which ones they believe are the top two priorities and to which State agency the priority applies (i.e., OMH, OASAS, and OMRDD). These data were analyzed with a focus on those priorities selected as the top two and which cut across all three State agencies to present a clear picture on the highest priorities applicable to all agencies.

Of the 38 cross-systems priority outcome categories identified, counties were particularly concerned with efforts to improve cross-systems coordination/services integration, including services for people with co-occurring disorders; and increasing access to, stability in, or improving housing/residential services. When comparing the data among county types, varying county population, size, or by State agency regions, these two outcomes consistently ranked in first or second place among the top two priorities, indicating a clear consensus that priority outcomes did not vary significantly by geographical or population attributes. Third-place rankings did range considerably; most notably, OMRDD regions exhibited the widest range of priorities beyond those ranked in first or second place.

Counties also chose from a list of strategy focus areas and strategy items related to the focus areas to further describe areas of planned action related to their priority outcome. Integrated services/ treatment and supports, specialized housing, and apartment/rent subsidies were the most frequently selected strategy items. Further, strategies incorporating access to services or resources and integrated services were a common theme under almost all of the priority outcome strategies. These plans suggest that counties are highly concerned with not only the affordability and appropriateness of housing for people with mental health or developmental disabilities, but that they are also focused on increasing the availability of services and meeting multiple needs at the same time.

County- and City-level planning processes themselves are informed directly through significant input and participation of local consumers, families, providers, and numerous other local stakeholders. These collective plans provide a view of mental health service needs and priorities closer to those who utilize and benefit from those services. Collectively, the County and City plans serve to better articulate overall mental health services planning priorities for the combined 57 counties and the City of New York. This year, the primary function of the aggregated plan and priorities in terms of the cross-systems priorities is to better inform each State agency's 2010 planning processes, as well as to inform other State-level policy makers and funders about cross-systems needs, priorities, and strategies to address these priorities from the local perspective. This detailed report on County and City cross-systems planning priorities for behavioral health services will therefore be shared with the three State agencies. Additionally, this document will be shared with other stakeholders and policymakers in an effort to raise awareness of and advocate for the cross-systems needs and priorities for improving behavioral health services at the County and City level.

Finally, it is important to note that in addition to the more tactical accomplishments related to advancing and refining the collection and analysis of planning data, over the past year the Mental Hygiene Planning Committee has continued a dialogue that is moving the State agencies and counties

toward a common language and protocol to better articulate the needs of individuals and families in our communities. The workgroup has provided a forum for discussing a variety of issues related to disability prevalence, system capacity, service utilization, and quality of care. In addition, members are talking about opportunities to more efficiently advance collective planning efforts by building on the strengths already in place within each agency and at the local level. Of note, a number of counties have begun to collaborate through a "community of practice" for local planners. This forum has been useful in developing a shared vision for what constitutes effective local planning as well as the data, tools, and other resources needed to support this process. The forum is anticipated to provide a means to efficiently share local best practices related to planning as well as to help define common needs to support the planning process.

XII. Appendices

A: Background

B: Summary Categories and Brief Descriptions

C: Top Two Categories for Priority Outcomes Indicated for All Three State Agencies (OMH, OASAS, OMRDD)

D: Priority Outcomes, Strategy Areas, and Strategy Items

E: Populations at which Strategies are Targeted

F: Using the County Planning System (CPS) for Drilldown Analyses

Appendix A: Background

New York State/County Planning History and Recent Advances

During the late 1990s and early 2000s, the traditional New York State and Local Planning process defined in Section 5.07 of the Mental Hygiene Law (MHL) had significantly atrophied. Comprehensive State 5.07 plans were not being produced. While a number of individual counties continued a local planning process and produced County plans, there was no coordinated, locally-based planning process in place to inform the State Office of Mental Health (SOMH) 5.07 plans. The CLMHD, among other groups and advocates, was very active in advocating for reestablishing the planning process and observing the full implementation of Section 5.07 of the MHL. In 2004, the CLMHD began work on an initiative to strengthen the County planning process.

During the first year of the initiative, the CLMHD established a Mental Health Planning Subcommittee under the leadership of Dr. Michael O'Leary, Director of Community Services of Columbia County, as well as a CLMHD Officer. Based on feedback from stakeholders, the CLMHD worked to develop an initial planning template in an effort to standardize local input. Efforts also began to focus on defining the data that counties would need to develop effective plans at the local level. Regular meetings were held with SOMH staff and have continued throughout this project.

Year Two (2005): During the second year, the planning template was finalized after review and input from the CLMHD membership and SOMH. This accomplishment was particularly significant as it provided a comprehensive and consistent format for counties to use to guide the planning process and develop their annual plans. In addition, the SOMH website was expanded to allow for easy access to data needed to support local planning. In a model of cooperation, the CLMHD and SOMH identified, with input from the members, data needed to support local planning. SOMH maintains a number of comprehensive data sources, and generates many routine and specialized reports. However, County users are often not aware of these resources, or may lack the technical staff to access the various SOMH data resources. To address these issues, SOMH enhanced their Bridges website to include a County Planning Reports Menu, which consolidated key reports and data resources, and is organized in a manner consistent with the planning template. CCSI assisted with this component of the planning project and helped to identify appropriate reports and define a process for user-friendly access.

Year Three (2006): During Year Three, the full County planning process was implemented as proposed, returning it to its intended and appropriate role in mental health services. There was an unprecedented response to this revitalized mental health planning exercise, with 100% of counties participating. The planning template used by all counties included a priorities section in which counties identified the three most important mental health priorities and associated target populations and narrative detail, and articulated the County's planning goals for the coming year. Pursuant to the cooperative agreement developed with SOMH, the priorities section was submitted by the counties to the CLMHD, and the Conference summarized the results and submitted them to SOMH for inclusion in the 5.07 Plan. The full County Plans were submitted directly to SOMH and a feedback process was developed to inform the counties, CLMHD, and SOMH regarding the priorities and issues described in the plans.

At the CLMHD spring membership meeting, results from the analysis of the planning priorities were reviewed with the full membership. In addition, CCSI and SOMH presented refinements and updates to the County Planning Reports Menu, which was intended to provide information needed to support local planning. The members also engaged in a dialogue about the revitalized planning process—noting both strengths and opportunities for improvement. While counties appreciated the standardization the

planning template encouraged, there was a strong interest in having access to a web-based tool to support more efficient planning data collection and analysis.

Year Four (2007): During the fourth year, the focus shifted to completing a local review of the priorities submitted in the previous year, providing updates as needed (including new priorities if warranted), and submitting this revised priorities form to the CLMHD and SOMH for review and analysis. The Planning Committee also began to focus on opportunities to make the process more efficient. Many County staff members with responsibility for local planning were already using the OASAS County Planning System (CPS) to submit planning data, and were impressed with its accessibility and ease of use. Thus, the Committee began working with representatives from OASAS and SOMH to determine how best to leverage this technology to advance mental health planning. The parties agreed to develop, as a pilot planning project, a web-based tool to allow counties to review, revise, and submit mental health planning priorities for 2008. The tool was developed within the OASAS CPS as a separate module. Many of the features of the CPS were utilized as part of this process, offering the opportunity for rapid development and significant economies of scale, as well as simplification from the end-user perspective.

In the spring of 2007, counties used this new tool to update their local priorities. Based on feedback obtained during Year Three, counties were able to distinguish among priorities for adult and children's services as well as those focused on systems Issues. In addition to describing their priorities in narrative format, counties were asked to categorize their priorities using a list that had been developed based on the previous year's responses. Counties were again asked to indicate which of the priorities submitted represented their three most important. Consistent with the previous year, 100% of the counties submitted plans for 2008.

During the summer of 2007, planning staff from NYS OASAS and NYS OMRDD were invited to attend a Mental Health Planning Subcommittee meeting to talk about how to continue to evolve the planning process to meet both local and State needs in the most effective way. It is worth noting that this meeting marked the first time planning staff from the three State agencies had ever come together as a group. There was strong agreement to continue meeting as a full group, and the group adopted the following mission statement to guide its activities:

To enhance the partnership between counties and State agencies through the development of an efficient, integrated, uniform planning system that helps to:

- ***Identify and quantify current and emerging needs;***
- ***Support local management and coordination;***
- ***Promote the continued development of person-centered services;***
- ***And ultimately, to inform State policy and budget decisions.***

The expanded group agreed to meet monthly for the rest of the year, and conversations began regarding how to further leverage the capabilities within the CPS to support cross-systems planning. Encouraged by the success of the mental health planning tool pilot, members began working to develop a single planning tool that would provide each State agency with essential local input regarding priority outcome areas, specific populations of focus, and the local strategies that are being deployed to address identified needs. Recognizing that many of the most pressing needs and issues cut across agencies and populations, the planning tool was designed to provide better visibility over cross-systems needs and priorities. By year end, the group had developed the initial specifications for a planning data collection form that would gather the data needed to support all three State agencies using a common tool.

Participation from local County planning staff continued to be strong and was instrumental in helping to define the requirements for the tool.

Year Five (2008): Early in 2008, the Joint Planning Workgroup was designated an official committee of the Inter-Office Coordinating Council (IOCC), and the name was changed to the Mental Hygiene Planning Committee to reflect the broader charge. In March, planning leaders from the three State agencies, together with representation from the CLMHD, hosted two training sessions. Using OMRDD's broadcast video capabilities to allow for participation across the state, the sessions were designed to orient County planning staff and staff from the regional field offices to the new system. Data collection began in the late spring and was largely completed by early August. Participation was nearly 100%, with just two counties experiencing a delay in their process. However, it is important to note that in addition to the more tactical accomplishments related to advancing the collection and analysis of planning data, the workgroup started a dialogue that moved the State agencies and counties toward a common language and protocol to better articulate the needs of individuals and families in our communities. The workgroup provided a forum for discussing a variety of issues related to disability prevalence, system capacity, service utilization and quality of care. In addition, members began discussing opportunities to more efficiently advance collective planning efforts by building on the strengths already in place within each agency.

Appendix B: Summary Categories and Brief Descriptions

Category #	Summary Category
1	**CASE MANAGEMENT** - Increase access to and/or improve case management/care coordination
2	**CLINIC** - Increase access to and/or improve clinic services
3	**CRIMINAL JUSTICE/LAW ENFORCEMENT** - Increase access to and/or improve criminal justice/forensic/court-based services; decrease criminal justice involvement; improve law enforcement and/or public safety
4	**CRISIS/EMERGENCY/RESPITE** - Increase access to and/or improve crisis/acute/respite services; make changes to the crisis service system
5	**CROSS-SYSTEMS/COD** - Increase and/or improve **cross-systems coordination/services integration** (MH, CD, OMRDD, PH); better services for people with **co-occurring disorders (COD)**; improving collaboration across various community agencies is also included in this category; address **regulatory issues** related to cross-systems barriers
6	**CLC** - Increase access to and/or enhance **culturally and linguistically competent** services
7	**EDUCATION** - Increase access to and/or improve education-related opportunities or services for consumers; increase in education or other meaningful activities
8	**FAMILY** - Increase access to and/or improve family services and/or family-driven services, such as wrap-around and CFT; strengthen families/support families/focus on family needs
9	**GERIATRIC** - Increase access to and/or enhance geriatric/older adults' services
10	**HOUSING/RESIDENTIAL** - Increase access to, stability in, and/or improve housing/residential services
11	**INPATIENT** - Increase access to and/or improve inpatient services; increase number of inpatient beds
12	**PEER/CONSUMER** - Increase access to and/or improve peer support/peer services; improve consumer involvement in the system; peer/consumer advocacy
13	**PERSON-CENTERED/RECOVERY** - Increase access to and/or improve person-centered/ recovery-oriented services; make changes to services so they are more **consumer-driven**, person-centered/recovery-oriented
14	**PHYSICAL HEALTH** - Increase access to and/or improve services related to physical health and wellness; improve physical health and wellness; improve medical care
15	**PREVENTION** - Increase access to and/or improve prevention/prevention services/community education/screenings; reduce stigma via community education; gambling prevention
16	**PSYCHIATRIST** - Increase access to and/or improve psychiatrist services/availability
17	**TRANSITIONAL AGE** - Increase access to and/or improve transitional services for young adults/older adolescents
18	**TRANSPORTATION** - Increase access to and/or improve transportation services/supports
19	**VOCATIONAL/EMPLOYMENT** - Increase access and/or improve vocational/employment services; increase in consumers' retained employment/vocation

Category #	Summary Category
20	
21	**GENERAL** (**NON-SPECIFIC)** - Increase availability of and access to and/or improve services (non-housing; not referring to specific service/program capacity; not elsewhere specified)
22	**GENERAL** - Increase/enhance **adult** services (general or other non-specific)
23	**GENERAL** - Increase/enhance **child/youth** services (general or other non-specific)
24	**SPOA** - Improve coordination and/or **centralize coordination of services** (e.g., SPOA)
25	Improve consumers' **abstinence** from substances/decrease **symptomatology**
26	Improve and/or increase consumers' **self-direction/independence**/economic self-sufficiency
27	Promote, improve, and/or increase consumers' **social connectedness/community integration**/community Inclusion
28	Increase and/or improve use of **evidence-based practices/best practices**/promising practices
29	**Workforce development**/training/**recruitment**/retention
30	Increase access to and/or improve approaches to **increase retention and engagement in outpatient treatment**/reduce utilization of psychiatric beds
31	Increase **funding/fiscal viability/financing services/cost-effectiveness** (average cost)/fiscal analysis/fiscal efficiencies/other fiscal (non-specific)
32	Address and/or improve **billing practices and documentation/ medical necessity** issues/ prevent monetary givebacks
33	Address **clinic restructuring** (mental health); put into place systems/structures to successfully respond to clinic restructuring
34	Increase and/or improve **information systems/**general data collection and/or analysis/IT
35	**ASSESSMENT/SYSTEM PLANNING/CQI** - quality management/**performance measurement**/system monitoring/**planning/needs assessment**/consumer satisfaction assessment and CQI/improve services and/or service delivery
36	Capital improvement/physical plant/space
37	OTHER (specify): _____ (e.g., emergency/disaster MH; services for teens; reduce fiscal reporting burdens; address general regulatory issues not related to cross-systems concerns)
38	**VETERANS** - Increase access to and/or improve services for veterans

Appendix C: Top Two Categories for Priority Outcomes Indicated for All Three State Agencies (OMH, OASAS, OMRDD)

Categories for Priority Outcomes	Total Outcomes Reported	
Total Priority Outcomes Indicated for All Three State Agencies	**75**	
	N	**%**
CROSS-SYSTEMS/COD - Increase and/or improve **cross-systems coordination/services integration** (MH, CD, OMRDD, PH); better services for people with **co-occurring disorders (COD)**; improving collaboration across various community agencies is also included in this category	**24**	**32%**
HOUSING/RESIDENTIAL - Increase access to, stability in, and/or improve housing/residential services	**19**	**25%**
GENERAL (**NON-SPECIFIC)** - Increase availability of and access to and/or improve services (non-housing; not referring to specific service/program capacity; not elsewhere specified)	**4**	**5%**
PERSON-CENTERED/RECOVERY - Increase access to and/or improve person-centered/recovery-oriented services; make changes to services so they are more **consumer-driven**, person-centered/recovery-oriented	**4**	**5%**
PREVENTION - Increase access to and/or improve prevention/prevention services/community education/screenings; reduce stigma via community education	**4**	**5%**
TRANSITIONAL AGE - Increase access to and/or improve transitional services for young adults/older adolescents	**4**	**5%**
TRANSPORTATION - Increase access to and/or improve transportation services/supports	**4**	**5%**
Workforce development/training/**recruitment**/retention	**4**	**5%**
MEASUREMENT/CQI/SYSTEM ASSESSMENT - Quality management/ **performance measurement**/system monitoring/**planning/needs assessment**/consumer satisfaction assessment and CQI	**3**	**4%**
FAMILY - Increase access to and/or improve family services and/or family-driven services, such as wraparound and CFT; strengthen families/support families/focus on family needs	**2**	**3%**
INPATIENT - Increase access to and/or improve inpatient services; increase number of inpatient beds	**2**	**3%**
PSYCHIATRIST - Increase access to and/or improve psychiatrist services/availability	**2**	**3%**
VOCATIONAL/EMPLOYMENT - Increase access and/or improve vocational/employment services; increase in consumers' retained employment/vocation	**2**	**3%**
CRIMINAL JUSTICE - Increase access to and/or improve criminal justice/forensic/court-based services; decrease criminal justice involvement	**1**	**1%**
CRISIS/EMERGENCY/RESPITE - Increase access to and/or improve crisis/acute/respite services; make changes to the crisis service system	**1**	**1%**

Categories for Priority Outcomes	Total Outcomes Reported	
	N	%
GENERAL - Increase/enhance **CHILD/YOUTH** services (general or other non-specific)	1	1%
GERIATRIC -Increase access to and/or enhance geriatric/older adults' services	1	1%
Increase and/or improve information systems/general data collection and/or analysis/ IT	1	1%
Increase and/or improve use of evidence-based practices/best practices/ promising practices	1	1%
Increase funding/fiscal viability/financing services/cost effectiveness (average cost)/fiscal analysis/fiscal efficiencies/other fiscal (non-specific)	1	1%
OTHER (specify): _____ (e.g., emergency/disaster MH; services for teens)	1	1%
PEER/CONSUMER - Increase access to and/or improve peer support/peer services; improve consumer involvement in the system; peer/consumer advocacy	1	1%
PHYSICAL HEALTH - Increase access to and/or improve services related to physical health and wellness; improve physical health and wellness; improve medical care	1	1%
Promote, improve, and/or increase consumers' social connectedness/ community integration/community Inclusion	1	1%
Address and/or improve billing practices and documentation/medical necessity issues/prevent monetary givebacks	0	0%
Address clinic restructuring (mental health); put into place systems/structures to successfully respond to clinic restructuring	0	0%
Capital improvement/physical plant/space	0	0%
CASE MANAGEMENT - Increase access to and/or improve case management/ care coordination	0	0%
CLC - Increase access to and/or enhance **culturally and linguistically competent** services	0	0%
CLINIC - Increase access to and/or improve clinic services	0	0%
EDUCATION - Increase access to and/or improve education-related opportunities or services for consumers; increase in education or other meaningful activities	0	0%
GENERAL - increase/enhance **ADULT** services (general or other non-specific)	0	0%
Improve and/or increase consumers' self direction/independence/economic self-sufficiency	0	0%
Improve consumers' abstinence from substances/decrease **symptomatology**	0	0%
Increase access to and/or improve approaches to increase retention and engagement in outpatient treatment/reduce utilization of psychiatric beds	0	0%
SPOA - Improve coordination and/or **centralize coordination of services** (e.g., SPOA)	0	0%
VETERANS - Increase access to and/or improve services for veterans	0	0%

Appendix D: Priority Outcomes, Strategy Areas, and Strategy Items

Priority Outcomes and Top Strategies				Strategy Frequency	
				N	%
Cross-Systems Collaboration/Service Integration/Better COD Services				**85**	**100%**
Strategy Area	*Strategy Items*	Criminal Justice	Legal services	1	100%
		Cross-Systems Collaboration	Access to services	17	17%
			Advocacy	1	1%
			Integrated services/treatment and supports	47	48%
			Licensing/certification/integrated funding approaches	12	12%
			Other	2	2%
			Planning	9	9%
			Training	10	10%
		Employment/ Education	Supported employment/job development/employment counseling/vocational training	1	50%
			Transition from school to adult services	1	50%
		Health and Wellness	Counseling/clinical services general health screening and referral	1	14%
			General health screening and referral	2	29%
			Other	3	43%
			Prevention	1	14%
		Quality Management	Corporate compliance/licensing/certification/standards compliance	1	6%
			Cost-effectiveness	2	11%
			Incident management	1	6%
			Performance accountability	2	11%
			Quality of life	1	6%
			Risk assessment	1	6%
			Use of evidence-based practices	8	44%
			Utilization/readmission rates	2	11%
		Service Capacity/ Access	Case management	2	7%
			Eligibility	2	7%
			Emergency services (crisis residence, respite beds, respite services, outreach, crisis intervention)	4	14%
			Family treatment/support	1	4%
			Information and referral/outreach	1	4%
			Integrated services for multiple disabilities	11	39%
			Number of people served	1	4%
			Other	1	4%
			Outpatient clinic services (CDT, clinic, partial hospitalization, IPRT, PROS, PMHP, ACT, AOT, telepsychiatry)	4	14%
			Types of services	1	4%
		Service Engagement	Assessment	1	9%
			Case management	4	36%

Priority Outcomes and Top Strategies				Strategy Frequency	
				N	%
			Crisis intervention	1	9%
			Early diagnosis and treatment	1	9%
			Medication management	1	9%
			Other	1	9%
			Respite	1	9%
			Transitional supports and services	1	9%
		Social Connectedness/ Inclusion/Social Support	Community partnership	3	75%
			Peer supports and interaction	1	25%
			Community partnership	3	75%
		Workforce Development	Clinical services recruitment and retention/licensing/ certification	2	12%
			Diversity training/development/talent management	1	6%
			Other	1	6%
Housing/Residential				18	78
Strategy Areas	*Strategy Items*	Cross-Systems Collaboration	Access to services (i.e., entry points, single point of access)	4	20%
			Advocacy	1	5%
			Integrated services/treatment and supports	7	35%
			Licensing/certification/integrated funding approaches	1	5%
			Other	1	5%
			Planning	5	25%
			Training	1	5%
		Employment/ Education	Day treatment/day programs or services	1	50%
			Other	1	50%
		Health and Wellness	Other	1	100%
		Housing	Apartment/rent subsidies	19	19%
			Facility-based intensive treatment	2	2%
			Family-like/shared living (family care, foster care)	4	4%
			Home ownership	2	2%
			Homeless shelter/emergency housing/respite	5	5%
			Other	14	14%
			Personal care/homemaker services/independent living assistance/family support	4	4%
			Specialized housing (i.e., accessible housing, sober house, cross-agency integrated housing)	31	31%
			Staff-supported community residence	13	13%
			Transitional residence/halfway house	6	6%
		Quality Management	Performance accountability	1	50%
			Utilization/readmission rates	1	50%
		Self-Direction	Peer support/natural support	1	50%
			Person-centered planning/individualized services	1	50%

Priority Outcomes and Top Strategies				Strategy Frequency	
				N	%
		Service Capacity/ Access	Case management	1	11%
			Integrated services for multiple disabilities	1	11%
			Number of people served	3	33%
			Number of providers	1	11%
			Peer-run services/natural supports/community support services	1	11%
			Types of services	2	22%
		Service Engagement	Counseling	1	50%
			Early diagnosis and treatment	1	50%
		Social Connectedness/ Inclusion/Social Support	Community partnership	4	24%
			Family dynamics and support	1	6%
			Natural/social supports	7	41%
			Other	1	6%
			Peer supports and interaction	4	24%
		Transportation	Accessible transportation	1	50%
			Natural/peer transportation support	1	50%
		Workforce Development	Direct support recruitment and retention	1	20%
			Other	2	40%
			Staff training, including cross-systems issues	2	40%
GENERAL (NON-SPECIFIC) increase availability of and access to and/or improve services (non-housing; not referring to specific service/program capacity; not elsewhere specified)				4	27
Strategy Areas	*Strategy Items*	Cross-Systems Collaboration	Access to services (i.e., entry points, single point of access)	4	20%
			Integrated services/treatment and supports	3	43%
			Planning	1	14%
			Access to services (i.e., entry points, single point of access)	3	43%
			Integrated services/treatment and supports	3	43%
			Planning	1	14%
		Employment/ Education	Supported employment/job development/employment counseling/vocational training	2	50%
			Transition from school to adult services	2	50%
		Health and Wellness	Crisis intervention	1	25%
			Cross-disabilities and first responders training	1	25%
			General health screening and referral	1	25%
			Prevention	1	25%
		Other	Other	1	100%
		Quality Management	Performance accountability	1	50%
			Utilization/readmission rates	1	50%
		Self-Direction	Self-advocacy/empowerment	1	50%
			Self-directed or family-directed supports	1	50%
		Service Capacity/ Access	Case management	1	4%
			Eligibility	1	4%
		Service			

Priority Outcomes and Top Strategies				Strategy Frequency	
				N	%
			Emergency services (crisis residence, respite beds, respite services, outreach, crisis intervention)	2	8%
			Information and referral/outreach	2	8%
			Inpatient clinical services (including forensics)	1	4%
			Integrated services for multiple disabilities	5	19%
			Number of people served	6	23%
			Other	1	4%
			Outpatient clinic services (CDT, clinic, partial hospitalization, IPRT, PROS, PMHP, ACT, AOT, telepsychiatry)	2	8%
			Types of services	5	19%
		Service Engagement	Crisis intervention	1	20%
			Early diagnosis and treatment	2	40%
			Medication management	1	20%
			Respite	1	20%
		Social Connectedness/ Inclusion/ Social Support	Community partnership	2	50%
			Natural/social supports	1	25%
			Peer supports and interaction	1	25%
		Workforce Development	Staff training, including cross-systems issues	2	100%
PERSON-CENTERED/RECOVERY				4	22
Strategy Areas	*Strategy Items*	Cross-Systems Collaboration	Access to services (i.e., entry points, single point of access)	2	33%
			Integrated services/treatment and supports	3	50%
			Planning	1	17%
		Employment/ Education	Supported employment/job development/employment counseling/vocational training	1	50%
			Work benefits and entitlements information	1	50%
		Health and Wellness	Other	1	100%
		Housing	Family-like/shared living (family care, foster care)	1	100%
		Other	Other	2	100%
		Quality Management	Consumer/family satisfaction/perception of care	2	40%
			Cost-effectiveness	1	20%
			Performance accountability	1	20%
			Utilization/readmission rates	1	20%
		Self-Direction	Development of person-centered organizational culture	3	27%
			Person-centered planning/individualized services	3	27%
			Self-advocacy/empowerment	1	9%
			Self-directed or family-directed supports	4	36%
		Service Capacity/ Access	Case management	2	33%
			Information and referral/outreach	1	17%
			Other	1	17%

Priority Outcomes and Top Strategies				Strategy Frequency	
				N	%
			Outpatient clinic services (CDT, clinic, partial hospitalization, IPRT, PROS, PMHP, ACT, AOT, telepsychiatry)	1	17%
			Types of services	1	17%
		Service Engagement	Case management	4	100%
		Social Connectedness/ Inclusion/Social Support	Community partnership	1	25%
			Peer supports and interaction	1	25%
			Recreation	1	25%
			Support/drop-in center	1	25%
Prevention				4	20
Strategy Areas	*Strategy Items*	Cross-Systems Collaboration	Access to services (i.e., entry points, single point of access)	2	18%
			Integrated services/treatment and supports	2	18%
			Licensing/certification/integrated funding approaches	2	18%
			Planning	4	36%
			Training	1	9%
		Other	Other	1	100%
		Quality Management	Cost-effectiveness	2	33%
			Performance accountability	1	17%
			Use of evidence-based practices	3	50%
		Service Capacity/Access	Emergency services (crisis residence, respite beds, respite services, outreach, crisis intervention)	1	8%
			Family treatment/support	1	8%
			Information and referral/outreach	1	8%
			Number of people served	1	8%
			Other	1	8%
			Outpatient clinic services (CDT, clinic, partial hospitalization, IPRT, PROS, PMHP, ACT, AOT, telepsychiatry)	2	17%
			Peer-run services/natural supports/community support services	1	8%
			Types of services	4	33%
		Social Connectedness/ Inclusion/Social Support	Community partnership	1	14%
			Family dynamics and support	3	43%
			Peer supports and interaction	2	29%
			Support/drop-in center	1	14%
		Workforce Development	Staff training, including cross-systems issues	1	100%
TRANSITIONAL AGE - Increase access to and/or improve transitional services for young adults/older adolescents					
Strategy	*Strategy*	Cross-Systems Collaboration	Access to services (i.e., entry points, single point of access)	3	25%
			Integrated services/treatment and supports	5	42%
			Planning	2	17%
			Training	2	17%

Priority Outcomes and Top Strategies				Strategy Frequency	
				N	%
		Employment/ Education	Supported employment/job development/employment counseling/vocational training	1	50%
			Transition from school to adult services	1	50%
		Housing	Other	1	100%
		Services Engagement	Assessment	2	25%
			Case management	2	25%
			Transitional supports and services	4	50%
TRANSPORTATION - Increase access to and/or improve transportation services/supports					
Strategy Areas	*Strategy Items*	Cross-Systems Collaboration	Access to services (i.e., entry points, single point of access)	3	50%
			Training	3	50%
		Employment/ Education	Supported employment/job development/employment counseling/vocational training	2	33%
			Transition from school to adult services	3	50%
			Work benefits and entitlements information	1	17%
		Health and Wellness	General health screening and referral	1	50%
			Prevention	1	50%
		Transportation	Access to public systems	3	50%
			Accessible transportation	2	33%
			Natural/peer transportation support	1	17%

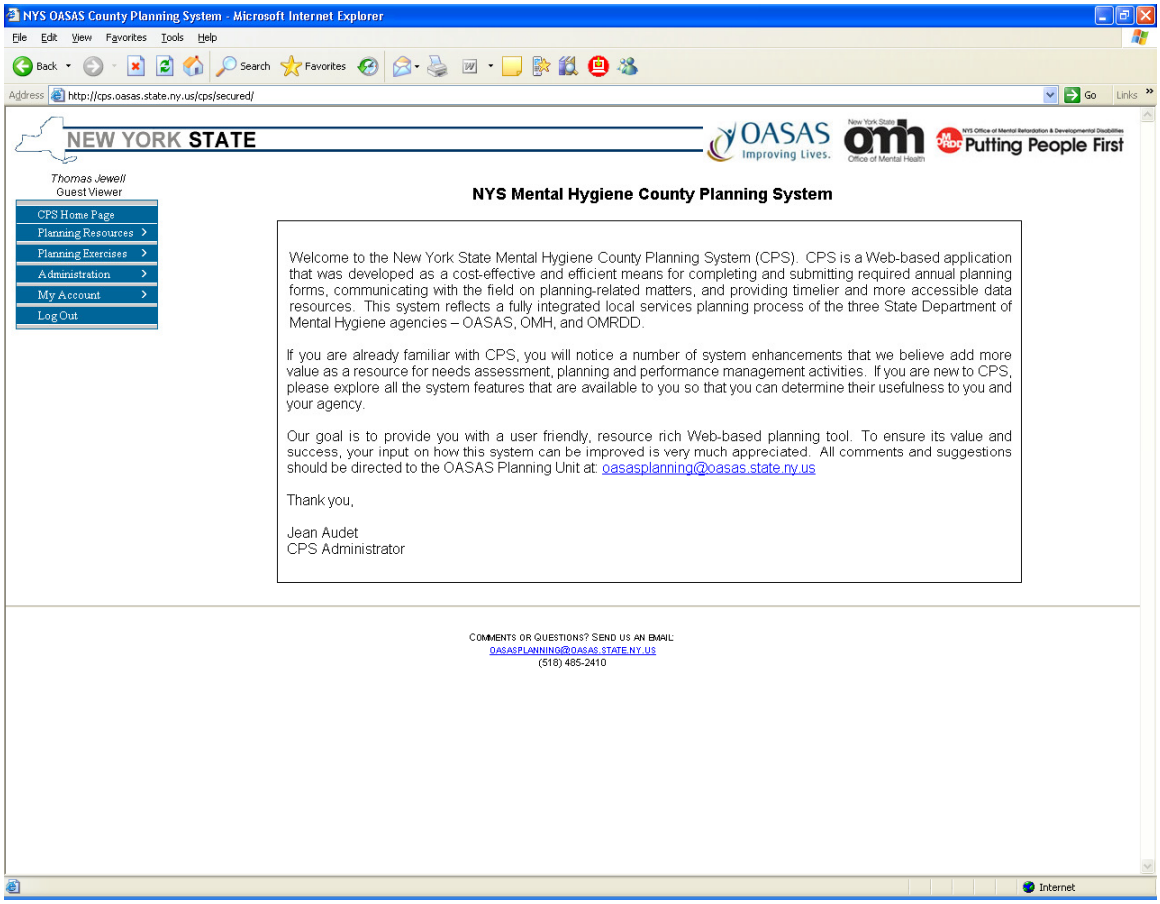
Appendix E: Populations at which Strategies are Targeted

Population(s)	N	%
TOTAL Specific Population Strategies and Percentage	**248**	**35%**
Other	**73**	**10%**
Male, female, no special population targeted, all ages, all races/ ethnicities	**21**	**3%**
Male, female, other, all ages, all races/ethnicities	**19**	**3%**
Adolescents, young adults	**13**	**2%**
Adults, other	**10**	**1%**
Seniors, all races/ethnicities	**8**	**1%**
Adolescents, other	**6**	**1%**
Young adults, male, female, no special population targeted, all races/ethnicities	**5**	**1%**
Young adults, other	**5**	**1%**
Adolescents, young adults, adults, male, female, families, parents, all races/ethnicities	**4**	**1%**
Adolescents, young adults, adults, male, female, families, parents, persons in the criminal/juvenile justice system, all races/ethnicities	**4**	**1%**
Adolescents, young adults, all races/ethnicities	**4**	**1%**
Adults	**4**	**1%**
Adults, male, female, other, all races/ethnicities	**4**	**1%**
Persons with behavioral challenges, other	**4**	**1%**
Seniors	**4**	**1%**
Seniors, male, female, no special population targeted, all races/ ethnicities	**4**	**1%**
Young children, children, adolescents, female, parents, persons with specific diagnostic category, persons in the criminal/juvenile justice system, persons in protective services/child welfare system, all races/ethnicities	**4**	**1%**

Appendix F. Using the County Planning System (CPS) for Drilldown Analyses

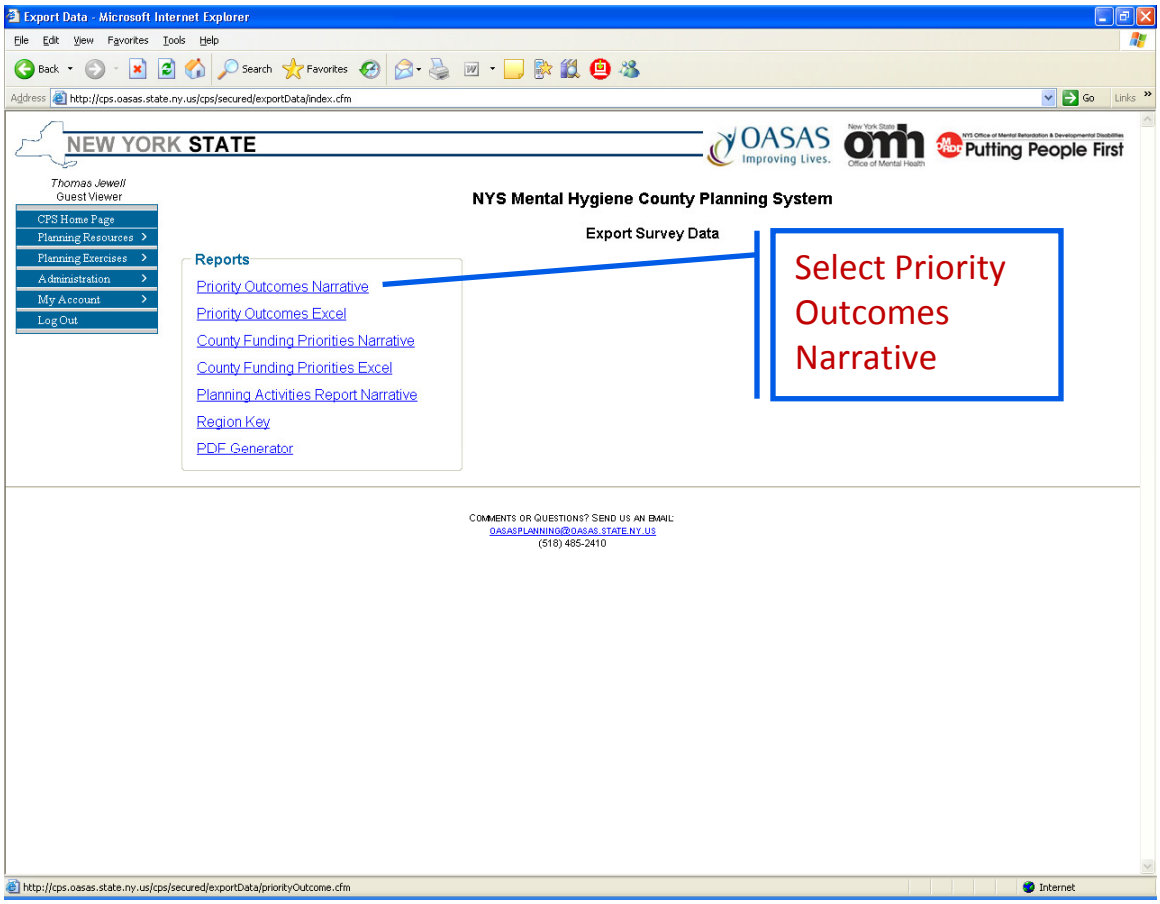
<u>Putting Planning Data to Work</u>: County planners may use the OASAS County Planning System (CPS) to support a variety of drilldown analyses. For instance, a County planner may be interested in knowing: What other counties are placing a priority on cross-systems issues related to transitional age youth, and what strategies are they employing to achieve their priority outcomes? To answer these questions, local planning staff would take the following steps.

STEP 1: Log onto the CPS via the website http://cps.oasas.state.ny.us/cps/index.cfm.

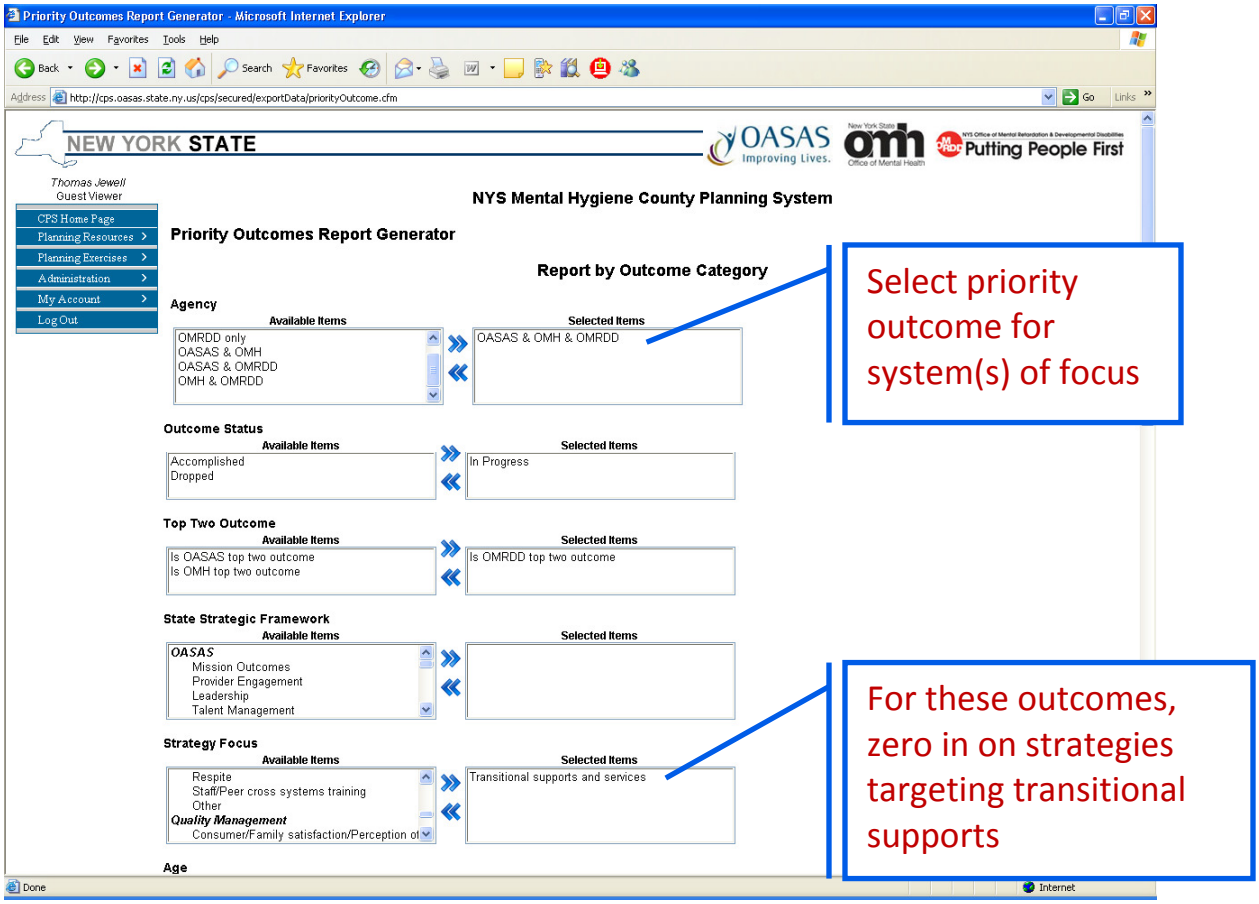


STEP 2: Select Administration, then select Export Data.

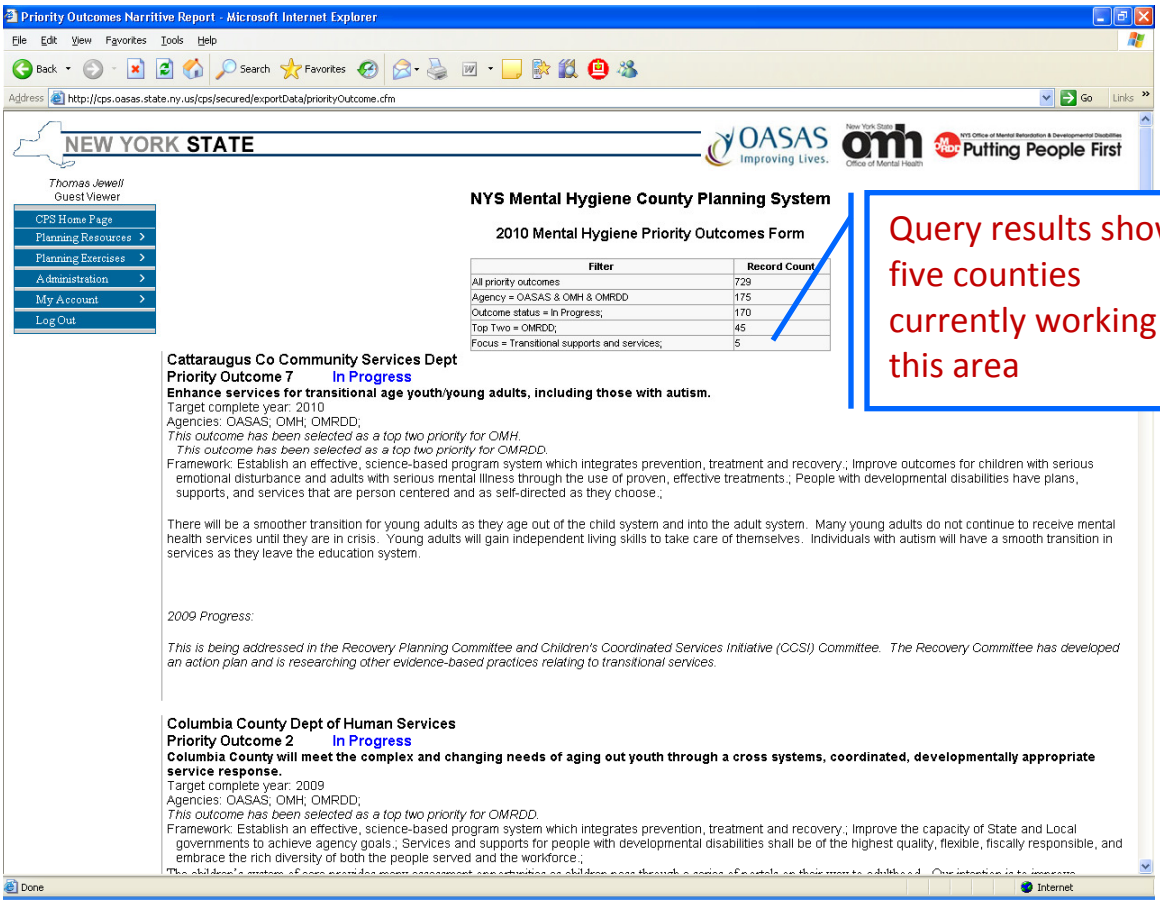
STEP 3: Select Priority Outcomes Narrative, which will bring you to the Priority Outcomes Report Generator screen.



STEP 4: Select the priority outcome for the desired system(s) of focus. Under the Outcome Status heading, select goals that are In Progress. Then, for these outcomes, zero in on strategies targeting transitional supports. Click Submit.

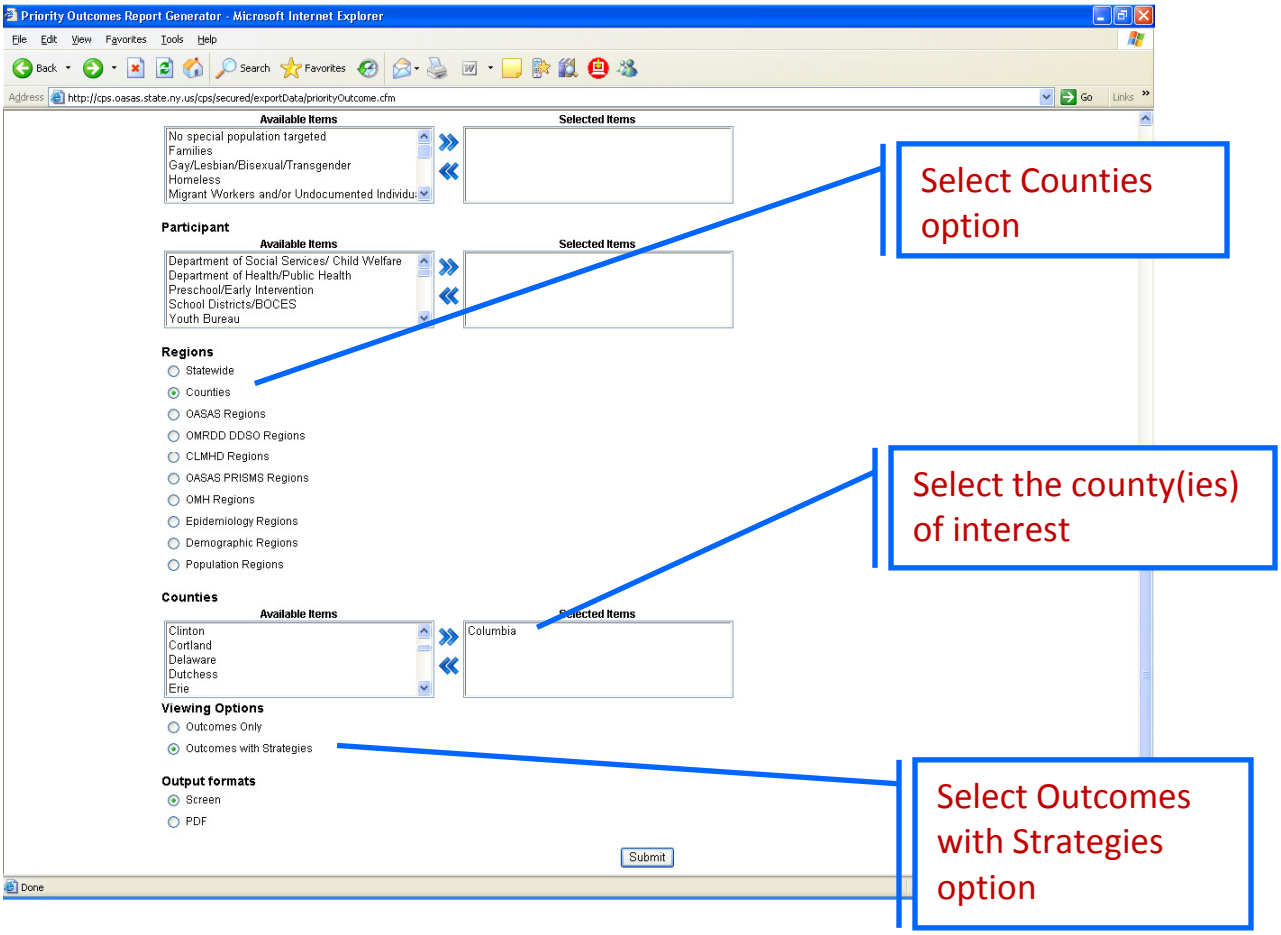


STEP 5: Review the priorities other counties have established related to transitional age youth. As the example below illustrates, five counties identified priorities related to transitional age youth. This report view displays the narrative detail regarding these local priorities. At this point, some County planners may discontinue the CPS inquiry and contact counties directly for discussion. Other planners may wish to use the CPS to further drill down in order to learn more about the specific strategies that counties are pursuing in this area (see next step).



STEP 6: After determining that Columbia County's priority is most closely related to your own, hit the Back button on the web browser to return to the Priority Outcomes Report Generator. Complete the process described in Step 4; however, at the bottom of the page, do the following:

- **Select Counties under the Regions heading**
- **Select Columbia County under the Counties heading**
- **Select Outcomes with Strategies under the Viewing Options heading**



STEP 7: Review the priority outcomes and the associated strategies related to transitional age youth as described by Columbia County.