Mental Health and Substance Use Disorders Community Needs Assessments: Data Resources

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Contents

Introduction 2
Background 2
Resources for Conducting a Needs Assessment 2
New York State Health Data Resources: OMH, OASAS and DOH 2
About the Data 2
NYS Office of Mental Health (OMH) Data Portals 3
Adult Housing 3
Assisted Outpatient Treatment (AOT) Reports 3
Children, Teens and Families Indicators 3
Personalized Recovery Oriented Services (PROS) 3
NYS Office of Mental Health (OMH) Data Tableau Visualizations 4
Assertive Community Treatment (ACT) Reports 4
Consumer Assessment of Care Survey (CACS) 4
County Planning Reports 4
OMH Medicaid Population Characteristics and Service Utilization Trends 4
Patient Characteristics Survey (PCS) 4
Profile of Children in NYS Medicaid with Behavioral Health Needs 4
Youth and Family Assessment of Care Survey (YACS/FACS) 5
NYS Office of Mental Health Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) Application 5
NYS Office of Addiction Services and Supports (OASAS) Resources 5
NYS Department of Health (DOH) Resources 5
Data Sources by Needs Assessment Domains 6
Section I: Description of Communities to Be Served 6
Section II: Physical and Behavioral Health Care Resources 7
Section III: Health Status 9
Section IV: Behavioral Health Care Utilization 9
Section V: Unmet Service Needs 10
Section VI: Consumer Input 11

Introduction

Background

This resource provides a current review of resources collated previously in the NYS DSRIP Region and County Behavioral Planning report (2016).

Resources on how to conduct a community needs assessment are provided by federal partners at the Centers for Disease Control and Prevention (CDC) (Community Needs Assessment (cdc.gov)) and Substance Abuse and Mental Health Services Administration (SAMHSA) (How States Can Conduct a Needs Assessment | SAMHSA).

Resources for Conducting a Needs Assessment

Several tools and approaches are available for gathering input and data for a needs assessment. These include use of demographic and publicly available data, interviews, and focus groups to collect stakeholder input, as well as targeted and focused data collection using surveys and other measurement tools.

The following resources can help guide your needs assessment process:

- Community Health Improvement Navigator from the Centers for Disease Control and Prevention (CDC)
- Planning Culturally and Linguistically Appropriate Services: Guide for Managed Care Plans from AHRQ
- Readiness Assessment & Developing Project Aims module from the Health Resources Services Administration (HRSA) (PDF | 166 KB)

New York State Health Data Resources: OMH, OASAS and DOH

About the Data

New York State provides state and county level data primarily through NYS OPEN Data platform (State of New York | Open Data | State of New York (ny.gov)). Additional health data resources may be found by directly accessing agency web sites such as: the Department of Health (New York State Department of Health (ny.gov)), Office of Mental Health (New York State Office of Mental Health (ny.gov)), Office of Addiction Services and Supports (Office of Addiction Services and Supports | Office of Addiction Services and Supports (ny.gov)), NYC Office of Health and Mental Health (NYC Health).

Data on a number of domains are provided in these resources, including demographics, health care resources, health status, behavioral health care utilization, unmet service needs and consumer input on service systems. This document highlights primarily New

York State specific resources that may be useful for community planning purposes requiring data in these domains. The data resources vary in the level of detail and the time frames available. Please review the information provided below for detail.

NYS Office of Mental Health (OMH) Data Portals

Adult Housing

The Adult Housing Data portal includes a Residential Program Indicators (RPI) report which is a performance measurement tool for adult housing programs in NYS. Users can evaluate agency residential programs based on county, regional, and statewide averages.
The data portal can be found here:
https://my.omh.ny.gov/analytics/saw.dll?dashboard&PortalPath=%2Fshared%2FAdult%20Housing%2F_portal%2FAdult%20Housing&nquser=BI_Guest&nqpassword=Public123#reports

Assisted Outpatient Treatment (AOT) Reports

The AOT reports include up-to-date statistical data on AOT program operations, the demographic and diagnostic characteristics of AOT recipients, and outcomes for AOT recipients.
The data portal can be found here:
https://my.omh.ny.gov/analytics/saw.dll?dashboard&PortalPath=%2Fshared%2FAOTLP%2F_portal%2FAssisted%20Outpatient%20Treatment%20Reports&nquser=BI_Guest&nqpassword=Public123#reports

Children, Teens and Families Indicators

NYS OMH Child and Adult Integrated Reporting System (CAIRS) is a secure and confidential HIPAA compliant information system developed and utilized by OMH to record, facilitate, monitor, and evaluate mental health services provided to children and adults with mental health needs in NYS. Youth and family service agencies providing community support and treatment services are included in the CAIRS indicators section of this portal.
The data portal can be found here:
https://my.omh.ny.gov/analytics/saw.dll?PortalPages&PortalPath=%2Fshared%2FKids%2F_portal%2FKids&Page=Home&nquser=BI_Guest&nqpassword=Public123#reports

Personalized Recovery Oriented Services (PROS)

PROS is a program focused on recovery for individuals with mental health conditions. Up-to-date statistical data on the PROS program includes demographic and diagnostic characteristics of PROS recipients, and recipient outcomes.
The data portal can be found here:
https://my.omh.ny.gov/analytics/saw.dll?PortalPages&PortalPath=%2Fshared%2FPROS%2F_portal%2FPROS&Page=Home&nquser=BI_Guest&nqpassword=Public123#reports

NYS Office of Mental Health (OMH) Data Tableau Visualizations

Assertive Community Treatment (ACT) Reports

The ACT Report Tableau presents information about individuals served by the New York State ACT program. Comparisons are shown between ACT teams, OMH regions, and New York State overall.
Tableau visualization can be found here: https://omh.ny.gov/omhweb/tableau/act.html

Consumer Assessment of Care Survey (CACS)

The CACS Report Tableau includes data collected annually from adults in state-operated outpatient, non-residential programs. These reports provide an assessment of consumer perceptions of various dimensions of care and quality of life.
Tableau visualization can be found here: https://omh.ny.gov/omhweb/tableau/

County Planning Reports

The County Planning Reports Tableau displays information about Medicaid-funded mental health service use and expenditures. Reports show average daily use and capacity of mental health inpatient and outpatient services. Statistics on readmission rates for psychiatric reasons are also included.
Tableau visualization can be found here: https://omh.ny.gov/omhweb/tableau/county-profiles.html

OMH Medicaid Population Characteristics and Service Utilization Trends

The OMH Medicaid Population Characteristics and Service Utilization Trends Tableau provides characteristics and service utilization trend data for the NYS Medicaid eligible public behavioral health population.
Tableau visualization can be found here: https://omh.ny.gov/omhweb/tableau/service-trend.html

Patient Characteristics Survey (PCS)

The PCS Tableau provides a snapshot of people served by the NYS public mental health system. Reports show service trends in specific geographic areas compared to nearby areas and the rest of New York State.
Tableau visualization can be found here: https://omh.ny.gov/omhweb/tableau/pcs.html

Profile of Children in NYS Medicaid with Behavioral Health Needs

The Profile of Children in NYS Medicaid with Behavioral Health Needs Tableau provides reports on characteristics and service utilization patterns for NYS Medicaid enrolled children with behavioral health needs.
Tableau visualization can be found here:
https://omh.ny.gov/omhweb/tableau/children.html

Youth and Family Assessment of Care Survey (YACS/FACS)

The Youth and Family Assessment of Care Survey (YACS/FACS) Tableau displays results from NYS OMH Youth and Family Assessment of Care satisfaction surveys. This visualization shows the percent positive of responses to various questions about a child's service.
Tableau visualization can be found here: https://omh.ny.gov/omhweb/tableau/yac-facs.html

NYS Office of Mental Health Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) Application

The PSYCKES application is a comprehensive resource including service utilization and metrics for the behavioral health population. PSYCKES is a HIPAA-compliant web-based application designed to support clinical decision making, care coordination, and quality improvement in New York State.

Access to PSYCKES
OMH grants PSYCKES access at the organizational level, and then access for individual users is managed internally by the organization. To find out whether your organization already has access to PSYCKES, or to find out if your organization is eligible for access, please contact the PSYCKES team.

Information about how to access to the PSYCKES application can be found at the links below:
https://omh.ny.gov/omhweb/psyckes_medicaid/about/#data
https://omh.ny.gov/omhweb/psyckes_medicaid/
PSYCKES utilization reports are available online here:
https://omh.ny.gov/omhweb/psyckes_medicaid/using_psyckes/utilization-reports.pdf
In addition to the links provided, a table of available measures in PSYCKES are included as Appendix II to this document.

NYS Office of Addiction Services and Supports (OASAS) Resources

Much of the NYS OASAS data is accessible through NYS DOH open data (linked above). In addition, OASAS has Admission and Discharge Item Statistics Reports which provide characteristics of patients over time and between programs. You can also use these reports to check other information for a particular program, such as where referrals are coming from.
Admission and Discharge Item Statistics Reports can be found here:
https://apps.oasas.ny.gov/reports_doc/OASAS_reports_course/NYR1_0201/NYR1_0201_0160.html

NYS Department of Health (DOH) Resources

The NYS DOH provides several publicly available data resources on NYS Open Data https://health.data.ny.gov/ including data on health facilities and services, as well as community health, chronic disease, birth, deaths, quality, safety, and care costs.

In addition to the NYS Open Data portal, the NYS DOH has also recently created a compilation of several resources and reports called the NYS Health Connector. The NYS Health Connector can be found here: https://nyshc.health.ny.gov/web/nyapd/home
Within the NYS Health Connector, you can find information about the following relevant topics

- Hospital emergency room visits by frequency, diagnosis, and by region (at the county level): https://nyshc.health.ny.gov/web/nyapd/emergency-department-visits-in-new-york
- Health plan quality ratings (including Medicaid and Medicare): https://nyshc.health.ny.gov/web/nyapd/5-star-quality-health-plan
- Other resources on the NYS Health Connector include cost of deliveries, cost of spinal surgeries, flu tracking, obesity rates, suicide and self-harm.

The NYS DOH provides the NYS Health Profiles site to help individuals find and compare health care providers, this includes information on hospitals, nursing homes, home care, hospice, adult care, and other providers: https://profiles.health.ny.gov/hospital/index#5.79/42.868/-76.809.

Data Sources by Needs Assessment Domains

Section I: Description of Communities to Be Served

Section I describes the geographic service area and characteristics of the population to be served, including special populations. Many relevant data points can be sourced from the US Census American Community Survey (ACS). The most updated estimates from the ACS include 1-year estimates for 2019 and 5-year estimates for 2019. All ACS data can be found here: https://data.census.gov/cedsci/all?g=0400000US36%240500000

Population Characteristics

The following items related to population characteristics can be located using the corresponding tables from the ACS.

Population, Gender, Race, Ethnicity and Age

- US Census ACS Estimated Population data can be found here: Table DP05
- Estimates by Gender, Race & Ethnicity, and Age can be found here: Table DP05

Income, Education, Unemployment and Poverty

- Median Household Income data can be found here: Table S1901
- Educational Attainment data can be found here: Table S1501
- Unemployment data can be found here: Table DP03
- Below Poverty Line data can be found here: Table S1701

- Cash Public Assistance and Food Stamps/SNAP Benefits data can be found here: Table B09010

Health Insurance Status

- Public Health Insurance Coverage data can be found here: Table S2704
- No Health Insurance Coverage data can be found here: Table S2702
- Unemployed with Public Health Insurance data can be found here: Table C27014
- Unemployed with No Health Insurance data can be found here: Table S2702

Special Populations, Foreign born and Primary Language

- Total and percent of Medicaid Beneficiaries data can be found here: Table S2704
- Medicaid Population by Age Group (Adults and Children) data can be found here: Table S2704
- Medicaid Population by Eligibility (Dual and Non-dual) data can be found here: Table S2704
- Special Population (Disabled) data can be found here: Table S1810
- Special Population (Veteran) data can be found here: Table B21001
- Foreign Born data can be found here: Table DP02
- Special Population (Foster Care) data can be found using the NYS DOH open data dataset: Children in Foster Care, by County, annually: Beginning 1994 https://data.ny.gov/Human-Services/Children-in-Foster-Care-Annually-Beginning-1994/hfc5-3hsu
- Special Population (Jail) data can be found using the NYS DOH open data dataset: Jail Population by County: Beginning 1997 https://data.ny.gov/Public-Safety/Jail-Population-By-County-Beginning-1997/nymx-kgkn

Section II: Physical and Behavioral Health Care Resources

Section II describes existing physical and behavioral health care resources including facilities, practitioners, and services.

Inpatient Physical Health Care Facilities & Outpatient Physical Health Care Facilities

The Health Facility General Information dataset from the NYS DOH contains the locations of Article 28, Article 36, and Article 40 health care facilities and programs from the Health Facilities Information System (HFIS). Article 28 facilities are hospitals, nursing homes, diagnostic treatment centers and midwifery birth centers. Article 36 facilities are certified home health care agencies, licensed home care services agencies, and long-term home health care programs. Article 40 facilities are hospices. The dataset currently only contains the locations of hospitals and hospital extension clinics. The dataset can be found here: https://health.data.ny.gov/Health/Health-Facility-General-Information/vn5v-hh5r

The NYS DOH also provides a list of all Ambulatory Surgical Services by city and ZIP code: https://www.health.ny.gov/regulations/hcra/provider/provamb.htm

The NYS DOH provides data about nursing homes. The Nursing Home dataset includes facility demographic information, inspection results, and complaint summary and state enforcement fine data:
https://health.data.ny.gov/Health/Nursing-Home-Profile/dypu-nabu

Physical Health Care Practitioners

The NYS DOH provides the NYS Health Profiles site to help individuals find and compare health care providers, this includes information on hospitals by region/county and service: https://profiles.health.ny.gov/hospital/index#5.79/42.868/-76.809

Additionally, the NYS DOH provides the DSRIP Managed Care Provider Network Data which includes information about physicians, hospitals, labs, home health agencies, durable medical equipment providers, etc., for all types of Managed Care plans in NYS.
https://www.health.ny.gov/health_care/medicaid/redesign/providernetwork/

The NYS Provider & Health Plan Look-Up tool can be used for findings providers. The tool is updated with information sent to New York State directly by health plans:
https://pndslookup.health.ny.gov/

To understand shortages, you can refer to the Health Professional Shortage Area (HPSA) Find tool which displays data on the geographic, population, and facility HPSA designations throughout the US: https://data.hrsa.gov/tools/shortage-area/hpsa-find

Inpatient Behavioral Health Care Facilities and Programs & Outpatient Behavioral Health Care Services

The Health Facility General Information dataset provided by the NYS DOH can be found here: https://health.data.ny.gov/Health/Health-Facility-General-Information/vn5v-hh5r

The NYS OMH prepares the County Planning Profiles Tableau Visualizations which provides information about Medicaid Utilization, Mental Health Inpatient Use, Mental Health Outpatient and Housing Program Capacity, and Psychiatric Inpatient Readmissions: https://omh.ny.gov/omhweb/tableau/county-profiles.html

The NYS OASAS provides the Provider and Program Search where you can search for any chemical dependence treatment program, chemical dependence prevention program, providers of clinical screening and assessment services for impaired driving offenders, or problem gambling treatment and prevention. The NYS OASAS provides the Provider and Program Search can be found here:
https://webapps.oasas.ny.gov/providerDirectory/

Care Coordination

To find a list of the NYS DOH designated Health Homes (HH) serving adults and/or children each county and region, please use the following resource:
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_map/index.htm

Behavioral Health Care Practitioners

The NYS Provider & Health Plan Look-Up tool can be used for findings providers. The tool is updated with information sent to New York State directly by health plans and can be found here: https://pndslookup.health.ny.gov/

Section III: Health Status

Section III describes the health status of the population being served. This includes data on disease prevalence, health behaviors and risk factors, mortality, and morbidity.

Disease Prevalence, Hospitalization Rates by Disease or Cause & Mortality Rates

The New York State Community Health Indicator Reports (CHIRS) were developed in 2012 and are updated annually to consolidate and improve data linkages for the health indicators included in the County Health Assessment Indicators (CHAI) for all communities in NYS. The CHIRS present data for more than 300 health indicators that are organized by 15 different health topics. Data tables are provided for all 62 NYS counties, 11 regions (including New York City), the State excluding New York City, and NYS. Data can be found here: https://health.data.ny.gov/Health/Community-Health-Indicator-Reports-CHIRS-Latest-Da/54ci-sdfi

The NYS DOH also provides a dataset on Age-Sex Adjusted Death Rates for Selected Causes of Death by Resident County, which can be found here: https://www.health.ny.gov/statistics/vital_statistics/2019/table40.htm

Health Behaviors and Risk Factors

Data from the 2013-2014 New York Expanded Behavioral Risk Factor Surveillance System (eBRFSS) Survey and the 2016 and 2018 Behavioral Risk Factor Surveillance System can be used to generate percentages of non-institutionalized adult (18+) NYS residents by various health indicators. The eBRFSS data can be found here: https://health.data.ny.gov/Health/Behavioral-Risk-Factor-Surveillance-System-BRFSS-H/jsy7-eb4n?_sm_au_=iVVnMrPRnsfs8P5M

Patients in the Public Mental Health System

The NYS OMH collects data through the Patient Characteristics Survey (PCS). This survey provides a snapshot of people served by the NYS public mental health system. The NYS OMH created a set of Tableau reports to show demographic, clinical, and service data in specific geographic areas compared to nearby areas and the rest of NYS. The PCS Tableau report can be found here: https://omh.ny.gov/omhweb/tableau/pcs.html

Section IV: Behavioral Health Care Utilization

Section IV describes behavioral health care inpatient and emergency room utilization with a focus on Medicaid beneficiaries.

Medicaid Beneficiaries with Mental Health Diagnosis & Substance Use Diagnosis

The NYS OMH PSYCKES application is used for sharing Medicaid billing claims and encounter data, other state health administrative data, as well as data and documents entered by providers and patients. PSYCKES includes data about individuals in the behavioral health population defined as those with any history of psychiatric or substance use service, current psychiatric or substance use diagnosis, or psychotropic medication. The PSYCKES application information and login can be found here: https://omh.ny.gov/omhweb/psyckes_medicaid/

Medicaid Beneficiary Hospital Inpatient Admissions & Emergency Room Visits

The NYS OMH prepares the County Planning Profiles Tableau Visualizations which provides information about Medicaid utilization, mental health inpatient use, mental health outpatient and housing program capacity, and psychiatric inpatient readmissions: https://omh.ny.gov/omhweb/tableau/county-profiles.html

Section V: Unmet Service Needs

Section V describes unmet needs by identifying gaps in behavioral health treatment services and potentially avoidable hospitalizations and emergency room visits.

Behavioral Health Treatment

The NYS OMH PSYCKES application is used for sharing Medicaid billing claims and encounter data, other state health administrative data, data and documents entered by providers and patients. PSYCKES includes data about individuals in the behavioral health population defined as those with any history of psychiatric or substance use service, current psychiatric or substance use diagnosis, or psychotropic medication. The PSYCKES application information and login can be found here: https://omh.ny.gov/omhweb/psyckes_medicaid/

Potentially Avoidable Hospitalizations

The NYS DOH prepares a dataset which leverages the Agency for Healthcare Research and Quality Prevention Quality Indicators, which are a set of population-based measures that can be used with hospital inpatient discharge data to identify ambulatory care sensitive conditions. The rates were calculated using Statewide Planning and Research Cooperative System (SPARCS) inpatient data and Claritas population information. The dataset can be found here: https://health.data.ny.gov/Health/Hospital-Inpatient-Prevention-Quality-Indicators-P/iqp6-vdi4/data

Potentially Avoidable Emergency Room Visits

The NYS DOH prepares a dataset which contains Potentially Preventable Visit (PPV) observed, expected, and risk-adjusted rates for all payer beneficiaries by patient county and patient zip code beginning in 2011. The rates were calculated using Statewide Planning and Research Cooperative System (SPARCS) inpatient and outpatient data and Claritas population information. Dataset can be found here:

https://health.data.ny.gov/Health/All-Payer-Potentially-Preventable-Emergency-Visit-/f8ue-xzy3/data

Section VI: Consumer Input

OMH collects consumer, family, and youth input on perception of care received in the public mental health system on an annual basis.

Youth and Family Assessment of Care Survey (YACS/FACS)

The Youth and Family Assessment of Care Survey (YACS/FACS) Tableau displays results from NYS OMH Youth and Family Assessment of Care satisfaction surveys. This visualization shows the percent positive of responses to various questions about a child's service.
Tableau visualization can be found here: https://omh.ny.gov/omhweb/tableau/yac-facs.html

Consumer Assessment of Care Survey (CACS)

The CACS Report Tableau includes data collected annually from adults in state-operated outpatient, non-residential programs. These reports provide an assessment of consumer perceptions of various dimensions of care and quality of life.
Tableau visualization can be found here: https://omh.ny.gov/omhweb/tableau/

Appendix I: Domains & Data Sources

Domains	Subdomains	Data Source Name	Data Source Link
I. Description of Communities to Be Served	Gender, Race, Ethnicity, Age	US Census American Community Survey (ACS)	https://data.census.gov/cedsci/all?g=0400000US36%240500000
	Income, Education, Unemployment, Poverty	US Census American Community Survey (ACS)	https://data.census.gov/cedsci/all?g=0400000US36%240500000
	Health Insurance Status	US Census American Community Survey (ACS)	https://data.census.gov/cedsci/all?g=0400000US36%240500000
	Special Population, Foreign Born, Primary Language	US Census American Community Survey (ACS)	https://data.census.gov/cedsci/all?g=0400000US36%240500000
		New York State (NYS) Open Data	https://data.ny.gov/Human-Services/Children-in-Foster-Care-Annually-Beginning-1994/hfc5-3hsu
		New York State (NYS) Open Data	https://data.ny.gov/Public-Safety/Jail-Population-By-County-Beginning-1997/nymx-kgkn
II. Physical and Behavioral	Inpatient Physical Health Care	New York State (NYS) Open Data	https://health.data.ny.gov/Health/Health-Facility-General-Information/vn5v-hh5r

Health Care Resources	Facilities & Outpatient Physical Health Care Facilities	New York State (NYS) Open Data	https://health.data.ny.gov/Health/Nursing-Home-Profile/dypu-nabu
		New York State (NYS) Open Data	https://www.health.ny.gov/regulations/hcra/provider/provamb.htm
	Physical Health Care Practitioners	New York State (NYS) Open Data	https://profiles.health.ny.gov/hospital/index#5.79/42.868/-76.809
		New York State (NYS) Open Data	https://www.health.ny.gov/health_care/medicaid/redesign/providernetwork/
		NYS Provider & Health Plan Look-Up Tool	https://pndslookup.health.ny.gov/
		Health Professional Shortage Area (HPSA) Find Tool	https://data.hrsa.gov/tools/shortage-area/hpsa-find
	Inpatient Behavioral Health Care Facilities and Programs & Outpatient Behavioral Health Care Services	New York State (NYS) Open Data	https://health.data.ny.gov/Health/Health-Facility-General-Information/vn5v-hh5r
		Office of Mental Health (OMH) Tableau Report	https://omh.ny.gov/omhweb/tableau/county-profiles.html
		OASAS Provider and Program Search	https://webapps.oasas.ny.gov/providerDirectory/
	Care Coordination	New York State (NYS) Open Data	https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_map/index.htm

	Behavioral Health Care Practitioners	NYS Provider & Health Plan Look-Up Tool	https://pndslookup.health.ny.gov/
III. Health Status	Disease Prevalence, Hospitalization Rate by Disease or Cause & Mortality Rates	New York State (NYS) Open Data	https://health.data.ny.gov/Health/Community-Health-Indicator-Reports-CHIRS-Latest-Da/54ci-sdfi
		New York State (NYS) Open Data	https://www.health.ny.gov/statistics/vital_statistics/2019/table40.htm
	Health Behaviors and Risk Factors	New York Expanded Behavioral Risk Factor Surveillance System (eBRFSS)	https://health.data.ny.gov/Health/Behavioral-Risk-Factor-Surveillance-System-BRFSS-H/jsy7-eb4n?_sm_au_=iVVnMrPRnsfs8P5M
	Patients in the Public Mental Health System	Office of Mental Health (OMH) Tableau Report	https://omh.ny.gov/omhweb/tableau/pcs.html
IV. Medicaid Beneficiaries with Mental Health Diagnosis	Medicaid Beneficiaries with Mental Health Diagnosis	OMH PSYCKES application	https://omh.ny.gov/omhweb/psyckes_medicaid/
	Medicaid Beneficiaries with Substance Use Disorders	OMH PSYCKES application	https://omh.ny.gov/omhweb/psyckes_medicaid/
	Medicaid Beneficiary Hospital	Office of Mental Health (OMH) Tableau Report	https://omh.ny.gov/omhweb/tableau/county-profiles.html

	Inpatient Admissions and Emergency Room Visits		
V. Unmet Service Needs	Behavioral Health Treatment	OMH PSYCKES application	https://omh.ny.gov/omhweb/psyckes_medicaid/
	Potentially Avoidable Hospitalizations	New York State (NYS) Open Data	https://health.data.ny.gov/Health/Hospital-Inpatient-Prevention-Quality-Indicators-P/iqp6-vdi4/data
	Potentially Avoidable Emergency Room Visits	New York State (NYS) Open Data	https://health.data.ny.gov/Health/All-Payer-Potentially-Preventable-Emergency-Visit-/f8ue-xzy3/data
VI. Consumer Input	Service Utilization, Perceived Service Needs, Barriers to Access	Self-Reported Surveys	Consumer and Family input available for current CCBHCs from self-report surveys.
	Scope of Services in Treatment	Self-Reported Surveys	Consumer and Family input available for current CCBHCs from self-report surveys.

Appendix II: PSYCKES Measures & Definitions

Set	Measure	Description
Readmission Post-Discharge from any Hospital	Readmission (30d) from any Hosp: BH to All Cause	The percentage of individuals with a BH (Behavioral Health: MH and/or SUD) hospitalization who had one or more any cause re-hospitalizations within 30 days of discharge, in the past 12 months.
	Readmission (30d) from any Hosp: All Cause to All Cause	The percentage of individuals with any hospitalization who had one or more any cause re-hospitalizations within 30 days of discharge, in the past 12 months.
Treatment Engagement	Discontinuation - Antidepressant <12 weeks (MDE)	The percentage of recipients 0-64 years with a diagnosis of major depression who were started on an antidepressant medication but did not remain on any antidepressant for a minimum of 12 weeks in the past 12 months.
	Adherence - Antipsychotic (Schiz)	The percentage of recipients 18-64 years with a diagnosis of schizophrenia or schizoaffective who had an antipsychotic medication available to them less than 80 percent of the time from the first observed antipsychotic medication to the report date, in the past 12 months.
	Adherence - Mood Stabilizer (Bipolar)	The percentage of recipients 0-64 years with a diagnosis of bipolar who had an antipsychotic or mood stabilizer medication available to them less than 80 percent of the time (based on prescriptions filled in the past 12 months, from the first antipsychotic or mood stabilizer prescription filled to the report date).
Substance Use Disorders	Substance Use Disorders Summary	A summary measure indicating the number of unique individuals who meet the criteria for any of the Substance Use Disorders indicators. Provider agency users will only be able to see a list of recipients from this indicator for whom consent was obtained because substance use information has special protections.

Health and Recovery Plan (HARP)	HARP Enrolled - Not Health Home Enrolled	The percentage of currently Medicaid-eligible adults 21 and over who are enrolled in a Managed Care Health and Recovery Plan (HARP) but are not enrolled in a Health Home.
	HARP-Enrolled - No Assessment for HCBS	The percentage of currently Medicaid-eligible adults 21 and over who are enrolled in a Managed Care Health and Recovery Plan (HARP) but have not had an assessment completed to determine eligibility for Home and Community Based Services (HCBS).
Health Promotion and Coordination	Prevent Hosp Dehydration	The percentage of adults with one or more preventable hospitalization due to dehydration in the past 12 months.
	4+ Inpatient/ER - Med	The percentage of individuals with 4+ or more medical inpatient/ER stays in the past 12 months.
High Utilization - Inpt/ER	4+ Inpatient/ER - All	The percentage of individuals with 4+ or more inpatient/ER stays in the past 12 months.
	4+ Inpatient/ER - BH	The percentage of individuals with 4+ or more psychiatric inpatient/ER stays in the past 12 months.
	4+ Inpatient/ER - Med	The percentage of individuals with 4+ or more medical inpatient/ER stays in the past 12 months.
Polypharmacy	Antipsychotic Two Plus	The percentage of individuals who were prescribed two or more antipsychotic medications among patients prescribed any antipsychotic medication.
	Antidepressant Two Plus - SC	The percentage of individuals who were prescribed two or more antidepressant medications in the same subclass among patients prescribed any antidepressant medication.
	Antidepressant Three Plus	The percentage of individuals who were prescribed three or more antidepressant medications among patients prescribed any antidepressant medication.
	Antipsychotic Three Plus	The percentage of individuals who were prescribed three or more antipsychotic medications among patients prescribed any antipsychotic medication.

	Psychotropics Three Plus	The percentage of individuals younger than 18 years old who were prescribed three or more psychotropic medications among those younger than 18 years old prescribed any psychotropic medication.
	Psychotropics Four Plus	The percentage of individuals 18 years and older who were prescribed four or more psychotropic medications among those 18 years old and older prescribed any psychotropic medication.
	Summary	A summary measure indicating the number of unique individuals who meet the criteria for any of the polypharmacy indicators.
Preventable Hospitalization	Prevent Hosp Diabetes	The percentage of adults with one or more preventable hospitalization due to Diabetes in the past 12 months.
	Prevent Hosp Summary	The percentage of served adults with one or more preventable hospitalization in the past 12 months.
	Prevent Hosp Asthma	The percentage of adults with one or more preventable hospitalization due to Asthma in the past 12 months.
	Prevent Hosp Dehydration	The percentage of adults with one or more preventable hospitalization due to dehydration in the past 12 months.
Readmission	Readmission - Hosp BH d/c 45 day	The percentage of individuals with a BH hospitalization at this facility who had one or more BH re-hospitalizations within 45 days of discharge from this facility's BH inpatient service, in the past 12 months.
	Readmission - All BH 30 day	The percentage of individuals with a BH hospitalization who had one or more BH re-hospitalizations within 30 days of discharge, in the past 12 months.
	Readmission - Hosp BH d/c 15 day	The percentage of individuals with a BH hospitalization at this facility who had one or more BH re-hospitalizations within 15 days of discharge from this facility's BH inpatient service, in the past 12 months
	Readmission - Hosp BH d/c 30 day	The percentage of individuals with a BH hospitalization at this facility who had one or more BH re-hospitalizations

		within 30 days of discharge from this facility's BH inpatient service, in the past 12 months
	Readmission - All BH 7 day	The percentage of individuals with a BH hospitalization who had one or more BH re-hospitalizations within 7 days of discharge, in the past 12 months.
	Readmission - All BH 45 day	The percentage of individuals with a BH hospitalization who had one or more BH re-hospitalizations within 45 days of discharge, in the past 12 months.
Youth Indicator	Youth - BH Med <6yrs old	The percentage of youth younger than 6 years old who were prescribed any psychotropic medications among youth younger than 18 years old prescribed any psychotropic medication.
	Summary	A summary measure indicating the number of unique individuals who meet criteria for any of the youth indicators.
	Youth - 3+ Polypharmacy	The percentage of individuals younger than 18 years old who were prescribed three or more psychotropic medications among those younger than 18 years old prescribed any psychotropic medication.
	Youth - High Dose	The percentage of youth prescribed psychotropic medications at higher than recommended dosages.
BH Care Coordination	Discontinuation - Antidepressant <12 weeks (MDE)	The percentage of recipients 0-64 years with a diagnosis of major depression who were started on an antidepressant medication but did not remain on any antidepressant for a minimum of 12 weeks in the past 12 months.
	Adherence - Antipsychotic (Schiz)	The percentage of recipients 0-64 years with a diagnosis of schizophrenia ('295' and '29599') who had an antipsychotic medication available to them less than 80 percent of the time from the first observed antipsychotic medication to the report date, in the past 12 months.
	Adherence - Mood Stabilizer (Bipolar)	The percentage of recipients 0-64 years with a diagnosis of bipolar ('296' and '2968') who had a mood stabilizer or antipsychotic medication available to them less than 80 percent of the time from the first observed mood stabilizer or

		antipsychotic medication to the report date, in the past 12 months.
	4+ Inpatient/ER - BH	The percentage of individuals with 4+ or more psychiatric inpatient/ER stays in the past 12 months.
	3+ ER- BH	The percentage of individuals with 3 or more BH ER visits in the past 12 months.
	3+ Inpatient - BH	The percentage of individuals with 3 or more BH ER visits in the past 12 months.
	Summary	A summary measure indicating the number of unique individuals who meet the criteria for any of the BH Care Coordination indicators.
	Readmission - All BH 45 day	The percentage of individuals with a BH hospitalization who had one or more BH re-hospitalizations within 45 days of discharge, in the past 12 months.
BHO	High Need - Ineffectively Engaged	'Individuals with multiple MH Inpatient or ER admissions or a prior AOT order or forensic MH service use who also have no current connection to TCM (ICM/SCM/BCM) and limited outpatient MH service use (4 or FEWER visits in prior 6 months)
Cardiometabolic	AP + Diabetes Risk	The percentage of individuals who were diagnosed with diabetes (or pre-diabetes) or received a medication for diabetes (or pre-diabetes) during the previous five years and who have been prescribed an antipsychotic medication with a moderate- to high-risk for cardiometabolic disorders during the previous 35 days.
	AP + Hypertension Risk	The percentage of individuals who were diagnosed with hypertension (HTN) during the previous five years and were prescribed an antipsychotic medication with a moderate- to high-risk for cardiometabolic disorders during the previous 35 days.

	AP + Hyperlipidemia Risk	The percentage of individuals who were diagnosed with hyperlipidemia or received a medication for hyperlipidemia during the previous five years and who were prescribed an antipsychotic medication with a moderate- to high-risk for cardiometabolic disorders during the previous 35 days.
	AP + Cardiovascular Disease Risk	The percentage of individuals who were discharged alive for coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) during the previous five years or who were diagnosed with ischemic vascular disease (IVD) or AMI during the previous five years and who have been prescribed an antipsychotic medication with a moderate- to high-risk for cardiometabolic disorders during the previous 35 days.
	Summary	A summary measure indicating the number of unique individuals who meet criteria for any of the cardiometabolic indicators.
	AP + Obesity Risk	The percentage of patients of all ages who were diagnosed with obesity or received a medication for obesity during the previous five years and who were prescribed an antipsychotic medication with a moderate- to high-risk for cardiometabolic disorders during the previous 35 days.
Care Monitoring	Care Monitoring Interim-2+ BH ER/Inpt	This quality flag identifies individuals who belong to a vulnerable population and had two or more behavioral health (BH) ER and/or Inpatient services in the previous four months, as of the report date.
Dose	Dose - Antipsychotic > 1x	The percentage of individuals with antipsychotic medication(s) who have a dose exceeding the recommended maximum.
	Dose - Antidepressant > 1x	The percentage of individuals with antidepressant medication(s) who have a dose exceeding the recommended maximum.

	Dose - Mood Stabilizer > 1x	The percentage of individuals with mood stabilizer medication(s) who have a dose exceeding the recommended maximum.
	Dose - ADHD Meds > 1x	The percentage of individuals with ADHD medication(s) who have a dose exceeding the recommended maximum.
	Summary	The percentage of individuals with psychotropic medication(s) who have a dose exceeding the recommended maximum.
	Dose - Anxiolytic/Hypnotic > 1x	The percentage of individuals with anxiolytic medication(s) who have a dose exceeding the recommended maximum.
Health Promotion and Coordination	Summary	A summary measure indicating the number of unique individuals who meet the criteria for any of the HPC indicators.
	Diabetes Monitoring-No HbA1c >1 Yr	The percentage of clients with diabetes without a monitoring test (HbA1c) in the past 12 months.
	No Outpatient Medical Visit >1 Yr	The percentage of clients without any outpatient medical visits (office visit (non-BH), home service (non-BH), preventive service, medical exam, ob/gyn or prostate screening) in the past 12 months.
	No Diabetes Screening- On Antipsychotic	The percentage of clients on any antipsychotic without a diabetes screening test (Glucose/HbA1c test) in the past 12 months.
	Prevent Hosp Asthma	The percentage of adults with one or more preventable hospitalization due to Asthma in the past 12 months.
	Prevent Hosp Diabetes	The percentage of adults with one or more preventable hospitalization due to Diabetes in the past 12 months.
AP Adult Set	Adherence - Antipsychotic (Schiz)	The percentage of recipients 18-64 years with a diagnosis of schizophrenia who had an antipsychotic medication available to them less than 80 percent of the time from the first observed antipsychotic medication to the report date, in the past 12 months.

	No Diabetes Screening Adults on Antipsychotic	
	Antipsychotic Two Plus	The percentage of adults who were prescribed two or more antipsychotic medications among patients prescribed any antipsychotic medication.
Kids AP Set	No Metabolic Monitoring Children on Antipsychotic	
	No Diabetes Screening Children (Schiz or Bipolar) on Antipsychotic	
	Antipsychotic Two Plus	The percentage of children who were prescribed two or more antipsychotic medications among patients prescribed any antipsychotic medication.
General Medical Health	No Diabetes Screening (Gluc/HbA1c) Schiz or Bipolar on Antipsychotic	The percentage of adults 18-64 years with a diagnosis of schizophrenia or bipolar disorder with any oral or injectable antipsychotic medication during the previous 12 months, who did not have either an HbA1c or blood glucose test in the past 12 months.
	Diabetes Monitoring-No HbA1c >1 Yr	The percentage of clients with diabetes without a monitoring test (HbA1c) in the past 12 months.
	No Outpatient Medical Visit >1 Yr	The percentage of clients without any outpatient medical visits (office visit (non-BH), home service (non-BH), preventive service, medical exam, ob/gyn or prostate screening) in the past 12 months.
	No Metabolic Monitoring (Gluc/HbA1c and LDL-C) on Antipsychotic	The percentage of adults 18-64 with at least two prescriptions for an antipsychotic medication at any time during the past 12 months who did not have both a blood lipid test (LDL-C or cholesterol test) and an HbA1c or blood glucose test, in the past 12 months.
	Prevent Hosp Summary	The percentage of served adults with one or more preventable hospitalization in the past 12 months.
	General Medical Health Summary	A summary measure indicating the number of unique individuals who meet the criteria for any of the General Medical Health indicators.

High Utilization - Inpt/ER	2+ Inpatient - BH	The percentage of individuals with 2 or more BH (Behavioral Health: MH and/or SUD) inpatient stays in the past 12 months.
	2+ Inpatient - MH	The percentage of individuals with 2 or more MH (Mental Health) inpatient stays in the past 12 months.
	2+ Inpatient - Medical	The percentage of individuals with 2 or more Medical inpatient stays in the past 12 months.
	2+ ER - BH	The percentage of individuals with 2 or more BH (Behavioral Health: MH and/or SUD) ER visits in the past 12 months.
BH QARR - Improvement Measure	6. No Diabetes Monitoring (HbA1C and LDL-C) Diabetes and Schiz	The percentage of adults 18-64 years diagnosed with both schizophrenia and diabetes who did not have both an HbA1c and an LDL-C test in the past 12 months.
Health and Recovery Plan (HARP)	HARP Enrolled - Not Health Home Enrolled	The percentage of currently Medicaid-eligible adults 21 and over who are enrolled in a Managed Care Health and Recovery Plan (HARP) but are not enrolled in a Health Home.
	Health Home Care Management - Adult Summary	A summary measure indicating the number of unique individuals who meet criteria for any of the PSYCKES Health Home Care Management - Adult indicators.
BH QARR - Improvement Measure	7. Readmission (30d) from any Hosp: MH to MH	The percentage of individuals with a MH (Mental Health) hospitalization who had one or more MH re-hospitalizations within 30 days of discharge, in the past 12 months.
High Utilization - Inpt/ER	Clozapine Candidate with 4+ Inpatient/ER - MH	The percentage of individuals diagnosed with schizophrenia who had 4 or more emergency room visits or inpatient stays for mental health cause and who did not have any evidence of Clozapine in the past year. Excludes individuals with the following medical conditions in the past year: leukopenia agranulocytosis, neutrophil disorders, myocarditis, narrow angle glaucoma, malignant neoplasms, seizure disorders, Alzheimer's or other degenerative brain disorders.
	4+ Inpatient/ER - MH	The percentage of individuals with 4+ or more mental health inpatient/ER stays in the past 12 months.

Treatment Engagement	Treatment Engagement - Summary	A summary measure indicating the number of unique individuals who meet the criteria for any of the treatment engagement indicators.
Substance Use Disorders	No Continuity of Care after Detox to Lower Level of Care	The percentage of individuals ages 13 and older discharged from inpatient detox who did not have follow up treatment in a lower level of care setting within 14 days. Provider agency users will only be able to see a list of recipients from this indicator for whom consent was obtained because substance use information has special protections.
	No Continuity of Care after Rehab to Lower Level of Care	The percentage of individuals ages 13 years and older discharged from inpatient rehabilitation who did not have follow up treatment in a lower level of care setting within 14 days. Provider agency users will only be able to see a list of recipients from this indicator for whom consent was obtained because substance use information has special protections.
	No Initiation of Medication Assisted Treatment (MAT) for New Episode of Opioid Use Disorder (OUD)	The percentage of individuals ages 13 and older newly diagnosed with Opioid Use Disorder (OUD) who did not initiate Medication Assisted Treatment (MAT) within 30 days of the new OUD diagnosis index visit. Provider agency users will only be able to see a list of recipients from this indicator for whom consent was obtained because substance use information has special protections.
	No Utilization of Medication Assisted Treatment (MAT) for Opioid Use Disorder (OUD)	The percentage of individuals ages 13 and older with Opioid Use Disorder (OUD) who did not initiate Medication Assisted Treatment (MAT) at any time during measurement year. Provider agency users will only be able to see a list of recipients from this indicator for whom consent was obtained because substance use information has special protections.
	No Initiation of SUD Treatment	The percentage of individuals ages 13 and older with a new diagnosis of alcohol or other substance use disorder (SUD) who did not initiate SUD treatment within 14 days of diagnosis. Provider agency users will only be able to see a list of recipients from this indicator for whom consent was

		obtained because substance use information has special protections.
	No Engagement in Opioid Use Disorder (OUD) Treatment	The percentage of individuals ages 13 and older with a new episode of Opioid Use Disorder (OUD) who did not engage in 2 or more visits of OUD treatment within 30 days of initiation visit. Provider agency users will only be able to see a list of recipients from this indicator for whom consent was obtained because substance use information has special protections.
	No Engagement in SUD Treatment	The percentage of individuals ages 13 and older with a new diagnosis of alcohol or other substance use disorder (SUD) who did not engage in SUD treatment as evidence by initiation of SUD treatment within 14 days of diagnosis and followed up by 2 or more additional visits for SUD treatment within 30 days of initiation visit. Provider agency users will only be able to see a list of recipients from this indicator for whom consent was obtained because substance use information has special protections.
	No Follow Up after SUD ER Visit (7 days)	The percentage of individuals ages 13 and older discharged from an emergency room for alcohol or other substance use disorder (SUD) and not seen on an ambulatory basis for treatment within 7 days of discharge. Provider agency users will only be able to see a list of recipients from this indicator for whom consent was obtained because substance use information has special protections.
High Utilization - Inpt/ER	POP : High User	The percentage of individuals enrolled in a Performance Opportunity Project (POP)-participating Managed Care plan with 3 or more mental health Inpatient visits OR 4 or more mental health ER visits OR a diagnosis of schizophrenia or bipolar and 3 or more medical Inpatient visits in the past in 12 months.

	POP : Potential Clozapine Candidate	High User client enrolled in a POP-participating MC plan with a diagnosis of schizophrenia and no evidence of clozapine in past 6 months
Health and Recovery Plan (HARP)	HARP-Enrolled - No Assessment for HCBS	The percentage of currently Medicaid-eligible adults 21 and over who are enrolled in a Managed Care Health and Recovery Plan (HARP) but have not had an assessment completed to determine eligibility for Home and Community Based Services (HCBS).
BH QARR - DOH Performance Tracking Measure	1. No Follow Up for Child on ADHD Med - Initiation	The percentage of children ages 6 to 12 years newly prescribed ADHD medication without a follow-up visit with a prescribing practitioner within 30 days after starting the medication.
	2. No Follow Up for Child on ADHD Med - Continuation	The percentage of children ages 6 to 12 years newly prescribed ADHD medication who remained on the medication for 7 months but did not have at least 2 follow-up visits with a prescribing practitioner in the 9 months following the first follow-up visit.
	3. Antidepressant Medication Discontinued - Acute Phase	The percentage of adults ages 18 to 64 with a diagnosis of major depression and newly started on an antidepressant medication who had less than 12 weeks of continuous treatment with the antidepressant.
	4. Antidepressant Medication Discontinued - Recovery Phase	The percentage of adults ages 18 to 64 with a diagnosis of major depression and newly started on an antidepressant medication who had less than 6 months of continuous treatment with the antidepressant following the first 12 week acute phase treatment period.
	15. Multiple Concurrent Antipsychotics - Child & Adol	The percentage or children and adolescents 1-17 years of age who were on two or more concurrent antipsychotic medications for at least 90 consecutive days during the measurement year.
	17. No Psychosocial Care - Child & Adol on Antipsychotic	The percentage of children and adolescents ages 1 to 17 years newly prescribed an antipsychotic medication who do not have documentation of psychosocial care in the 121 day

		period surrounding the Index Prescription Start Date (IPSD) (90 days prior through 30 days after IPSD).
	6. No Follow Up after MH Inpatient - 7 Days	The percentage of individuals ages 6 years and older discharged from a hospital for mental health treatment and not seen on an ambulatory basis or for intermediate treatment with a mental health provider within 7 days of discharge.
	15. No Follow Up after MH Inpatient - 30 Days	The percentage of individuals ages 6 years and older discharged from a hospital for mental health treatment and not seen on an ambulatory basis or for intermediate treatment with a mental health provider within 30 days of discharge.
	9. No Initiation of SUD Treatment	The percentage of individuals ages 13 and older with a new diagnosis of alcohol or other substance use disorder (SUD) who did not initiate SUD treatment within 14 days of diagnosis. Provider agency users will only be able to see a list of recipients from this indicator for whom consent was obtained because substance use information has special protections.
	8. No Engagement in SUD Treatment	The percentage of individuals ages 13 and older with a new diagnosis of alcohol or other substance use disorder (SUD) who did not engage in SUD treatment as evidence by initiation of SUD treatment within 14 days of diagnosis and followed up by 2 or more additional visits for SUD treatment within 30 days of initiation visit. Provider agency users will only be able to see a list of recipients from this indicator for whom consent was obtained because substance use information has special protections.
High Utilization - Inpt/ER	2+ ER - MH	The percentage of individuals with 2 or more MH (Mental Health) ER visits in the past 12 months.
	2+ ER - Medical	The percentage of individuals with 2 or more Medical ER visits in the past 12 months.

	2+ Inpatient / 2+ ER - Summary	A summary measure indicating the number of unique individuals who meet the criteria for any of the Utilization indicators.
BH QARR - Improvement Measure	1. Adherence - Antipsychotic (Schiz)	The percentage of adults 18-64 years with a diagnosis of schizophrenia who had an antipsychotic medication available to them less than 80 percent of the time (based on prescriptions filled in the past 12 months, from the first antipsychotic prescription filled to the report date).
	2. Discontinuation - Antidepressant <12 weeks (MDE)	The percentage of adults 18-64 years with a diagnosis of major depression who were started on an antidepressant medication but did not remain on any antidepressant for a minimum of 12 weeks in the past 12 months.
	5. Antipsychotic Polypharmacy (2+ >90days) Children	The percentage of children 1-17 years who were prescribed two or more different antipsychotic medications concurrently for >90 days, among children prescribed any antipsychotic medication for >90 days.
	4. No Diabetes Screening (Gluc/HbA1c) Schiz or Bipolar on Antipsychotic	The percentage of adults 18-64 years with a diagnosis of schizophrenia or Bipolar Disorder with any oral or injectable antipsychotic medication during the previous 12 months, who did not have either an HbA1c or blood glucose test in the past 12 months.
	BH QARR - 2020 Quality Incentive Subset Summary (1-4)	A summary measure indicating the number of unique individuals who meet the criteria for the adherence and/or the diabetes monitoring for individuals with schizophrenia and diabetes QARR indicators.
	3. No Metabolic Monitoring (Gluc/HbA1c and LDL-C) on Antipsychotic	The percentage of children 0-17 with at least two prescriptions for an antipsychotic medication at any time during the past 12 months who did not have both a blood lipid test (LDL-C or cholesterol test) and an HbA1c or blood glucose test, in the past 12 months.
	BH QARR - 2020 Total Indicator Summary (1-7)	A summary measure indicating the number of unique individuals who meet the criteria for any of the QARR indicators.

	No Metabolic Monitoring (Gluc/HbA1c) on Antipsychotic	Enrollee with at least two prescriptions for an antipsychotic medication at any time during the past 12 months who did not have an HbA1c or blood glucose test, in the past 12 months.
	No Metabolic Monitoring (LDL-C) on Antipsychotic	Enrollee with at least two prescriptions for an antipsychotic medication at any time during the past 12 months who did not have a blood lipid test (LDL-C or cholesterol test) , in the past 12 months.
Readmission Post-Discharge from this Hospital	Readmission (30d) from this Hosp: MH to MH	The percentage of individuals with a MH (Mental Health) hospitalization at this facility who had one or more MH re-hospitalizations within 30 days of discharge from this facility's MH inpatient service, in the past 12 months.
	Readmission (30d) from this Hosp: BH to BH	The percentage of individuals with a BH (Behavioral Health: MH and/or SUD) hospitalization at this facility who had one or more BH re-hospitalizations within 30 days of discharge from this facility's BH inpatient service, in the past 12 months.
	Readmission (30d) from this Hosp: Medical to Medical	The percentage of individuals with a Medical hospitalization at this facility who had one or more Medical re-hospitalizations within 30 days of discharge from this facility's Medical inpatient service, in the past 12 months.
	Readmission (30d) from this Hosp: Medical to All Cause	The percentage of individuals with a Medical hospitalization at this facility who had one or more any cause re-hospitalizations within 30 days of discharge from this facility's Medical inpatient service, in the past 12 months.
	Readmission (30d) from this Hosp: MH to All Cause	The percentage of individuals with a Mental Health (MH) hospitalization at this facility who had one or more any cause re-hospitalizations within 30 days of discharge from this facility's MH inpatient service, in the past 12 months.
	Readmission (30d) from this Hosp: BH to All Cause	The percentage of individuals with a BH (Behavioral Health: MH and/or SUD) hospitalization at this facility who had one or more any cause re-hospitalizations within 30 days of

		discharge from this facility's BH inpatient service, in the past 13 months.
	Readmission (30d) from this Hosp: All Cause to All Cause	The percentage of individuals with a hospitalization for any cause from this hospital who had one or more any cause re-hospitalizations within 30 days of discharge, in the past 12 months.
	Readmission (30d) from any Hosp: MH to MH	The percentage of individuals with a MH (Mental Health) hospitalization who had one or more MH re-hospitalizations within 30 days of discharge, in the past 12 months.
	Readmission (30d) from any Hosp: BH to BH	The percentage of individuals with a BH (Behavioral Health: MH and/or SUD) hospitalization who had one or more BH re-hospitalizations within 30 days of discharge, in the past 12 months.
	Readmission (30d) from any Hosp: Medical to Medical	The percentage of individuals with a Medical hospitalization who had one or more Medical re-hospitalizations within 30 days of discharge, in the past 12 months.
	Readmission (30d) from any Hosp: Medical to All Cause	The percentage of individuals with a Medical hospitalization who had one or more any cause re-hospitalizations within 30 days of discharge, in the past 12 months.
	Readmission (30d) from any Hosp: MH to All Cause	The percentage of individuals with a Mental Health (MH) hospitalization who had one or more any cause re-hospitalizations within 30 days of discharge, in the past 12 months.
BH QARR - DOH Performance Tracking Measure	5. Low Antipsychotic Medication Adherence - Schizophrenia	The percentage of adults ages 18 to 64 with a diagnosis of schizophrenia who were dispensed an antipsychotic medication and remained on that antipsychotic medication for less than 80 percent of their treatment time.
	16. No CV Monitoring - CV & Schizophrenia	The percentage of adults ages 18 to 64 diagnosed with both schizophrenia and cardiovascular disease, who did not have a blood lipid test (LDL-C or cholesterol test) during the measurement year.

	14. No Diabetes Monitoring - DM & Schizophrenia	The percentage of adults ages 18 to 64 diagnosed with both schizophrenia and diabetes who did not have both an HbA1c and an LDL-C test during the measurement year.
	BH QARR - DOH 2020 Total Indicator Summary (1-17)	The NYS Department of Health (DOH) calculates the Quality Assurance Reporting Requirements (QARR) Performance Tracking Measure monthly. The measures are calculated monthly after a 6 month data maturation period to allow for services to be invoiced. The measures are calculated for a 12-month period of services. Although the measures are calculated each month for a rolling 12-month period, select reporting periods may be used as the annual performance assessment for different initiatives.
	10. No Diabetes Screening - Schizophrenia/Bipolar on Antipsychotic	The percentage of adults ages 18 to 64 with a diagnosis of schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and did not have a diabetes screening test during the measurement year.
	BH QARR - DOH 2020 Quality Incentive Subset (1-13)	A summary measure indicating the number of unique individuals who meet the criteria for any of the Quality Incentive Subset of the BH QARR Performance indicators.
Health and Recovery Plan (HARP)	Eligible for Health Home Plus - Not Health Home Enrolled	The percentage of Medicaid eligible adults 18 and over who are eligible for Health Home Plus but are not enrolled in a Health Home.
	Eligible for Health Home Plus - No Health Home Plus Service	The percentage of Medicaid eligible adults 18 and over who are eligible for Health Home Plus but did not receive a Health Home Plus service in the past 12 months according to Medicaid billing.
Substance Use Disorders	No Follow Up after SUD ER Visit (30 days)	The percentage of individuals ages 13 and older discharged from an emergency room for alcohol or other substance use disorder (SUD) and not seen on an ambulatory basis for treatment within 30 days of discharge. Provider agency users will only be able to see a list of recipients from this indicator for whom consent was obtained because substance use information has special protections.

	No Initiation of Opioid Use Disorder (OUD) Treatment	The percentage of individuals ages 13 and older with a new episode of Opioid Use Disorder (OUD) who did not initiate OUD treatment within 14 days. Provider agency users will only be able to see a list of recipients from this indicator for whom consent was obtained because substance use information has special protections.
BH QARR - DOH Performance Tracking Measure	11. No Metabolic Monitoring (Gluc/HbA1c and LDL-C) Child & Adol on Antipsychotic	The percentage of children and adolescents ages 1 to 17 years with two or more antipsychotic prescriptions who did not have both a blood lipid test (LDL-C or cholesterol test) and an HbA1c or blood glucose test during the measurement year
	12. No Metabolic Monitoring (Gluc/HbA1c) Child & Adol on Antipsychotic	The percentage of children and adolescents ages 1 to 17 years with two or more antipsychotic prescriptions who did not have an HbA1c or blood glucose test during the measurement year
	13. No Metabolic Monitoring (LDL-C) Child & Adol on Antipsychotic	The percentage of children and adolescents ages 1 to 17 years with two or more antipsychotic prescriptions who did not have a blood lipid test (LDL-C or cholesterol test) test during the measurement year
	7. No Follow Up After MH ED Visit - 7 Days	The percentage of individuals ages 6 years and older discharged from an Emergency Department for mental health treatment and not seen on an ambulatory basis or for intermediate treatment with a mental health provider within 7 days of discharge
High Mental Health Need	High Mental Health Need	

Appendix III: All Data Links

Source	Link
Center for Disease Control (CDC)	https://www.cdc.gov/globalhealth/healthprotection/fetp/training_modules/15/community-needs_pw_final_9252013.pdf
Substance Abuse and Mental Health Services Administration (SAMHSA)	https://www.samhsa.gov/section-223/certification-resource-guides/conduct-needs-assessment
Center for Disease Control (CDC)	https://www.cdc.gov/chinav/index.html
Agency for Healthcare Research and Quality	https://www.ahrq.gov/ncepcr/tools/cultural-competence/planclas.html
US Department of Health and Human Services	https://www.hrsa.gov/sites/default/files/quality/toolbox/508pdfs/readinessassessment.pdf
NYS OPEN Data platform	https://data.ny.gov/
Department of Health	https://www.health.ny.gov/
Office of Mental Health	https://omh.ny.gov/
Office of Addiction Services and Supports	https://oasas.ny.gov/
NYC Office of Health and Mental Health	https://www1.nyc.gov/site/doh/index.page
Adult Housing	https://my.omh.ny.gov/analytics/saw.dll?dashboard&PortalPath=%2Fshared%2FAdult%20Housing%2F_portal%2FAdult%20Housing&nquser=BI_Guest&nqpassword=Public123#reports
Assisted Outpatient Treatment (AOT) Reports	https://my.omh.ny.gov/analytics/saw.dll?dashboard&PortalPath=%2Fshared%2FAOTLP%2F_portal%2FAssisted%20Outpatient%20Treatment%20Reports&nquser=BI_Guest&nqpassword=Public123#reports
Children, Teens and Families Indicators	https://my.omh.ny.gov/analytics/saw.dll?PortalPages&PortalPath=%2Fshared%2FKids%2F_portal%2FKids&Page=Home&nquser=BI_Guest&nqpassword=Public123#reports
Personalized Recovery Oriented Services (PROS)	https://my.omh.ny.gov/analytics/saw.dll?PortalPages&PortalPath=%2Fshared%2FPROS%2F_portal%2FPROS&Page=Home&nquser=BI_Guest&nqpassword=Public123#reports
Assertive Community Treatment (ACT) Reports	https://omh.ny.gov/omhweb/tableau/act.html

Consumer Assessment of Care Survey (CACS)	https://omh.ny.gov/omhweb/tableau/
County Planning Reports	https://omh.ny.gov/omhweb/tableau/county-profiles.html
OMH Medicaid Population Characteristics and Service Utilization Trends	https://omh.ny.gov/omhweb/tableau/service-trend.html
Patient Characteristics Survey (PCS)	https://omh.ny.gov/omhweb/tableau/pcs.html
Profile of Children in NYS Medicaid with Behavioral Health Needs	https://omh.ny.gov/omhweb/tableau/children.html
Youth and Family Assessment of Care Survey (YACS/FACS)	https://omh.ny.gov/omhweb/tableau/yac-facs.html
NYS Office of Mental Health Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) Application Homepage	https://omh.ny.gov/omhweb/psyckes_medicaid/
Helpdesk	https://omh.ny.gov/omhweb/email/compose_mail.php?tid=ITpsyckesHelpdesk
Data	https://omh.ny.gov/omhweb/psyckes_medicaid/about/#data
Utilization Reports User's Guide	https://omh.ny.gov/omhweb/psyckes_medicaid/using_psyckes/utilization-reports.pdf
NYS Office of Addiction Services and Supports (OASAS) Resources	https://apps.oasas.ny.gov/reports_doc/OASAS_reports_course/NYR1_0201/NYR1_0201_0160.html
NYS Department of Health (DOH) Resources	https://health.data.ny.gov/
NYS Health Connector	https://nyshc.health.ny.gov/web/nyapd/home
Hospital emergency room visits by frequency, diagnosis, and by region (at the county level)	https://nyshc.health.ny.gov/web/nyapd/emergency-department-visits-in-new-york
Health plan quality ratings (including Medicaid and Medicare)	https://nyshc.health.ny.gov/web/nyapd/5-star-quality-health-plan
NYS Health Profiles	https://profiles.health.ny.gov/hospital/index#5.79/42.868/-76.809
Census American Community Survey (ACS)	https://data.census.gov/cedsci/all?g=0400000US36%240500000

Children in Foster Care	https://data.ny.gov/Human-Services/Children-in-Foster-Care-Annually-Beginning-1994/hfc5-3hsu
NYS DOH open data dataset: Jail Population	https://data.ny.gov/Public-Safety/Jail-Population-By-County-Beginning-1997/nymx-kgkn
Health Facility General Information dataset	https://health.data.ny.gov/Health/Health-Facility-General-Information/vn5v-hh5r
Ambulatory Surgical Services	https://www.health.ny.gov/regulations/hcra/provider/provamb.htm
Nursing Home dataset	https://health.data.ny.gov/Health/Nursing-Home-Profile/dypu-nabu
DSRIP Managed Care Provider Network Data	https://www.health.ny.gov/health_care/medicaid/redesign/providernetwork/
NYS Provider & Health Plan Look-Up	https://pndslookup.health.ny.gov/
Health Professional Shortage Area (HPSA)	https://data.hrsa.gov/tools/shortage-area/hpsa-find
OASAS Provider and Program Search	https://webapps.oasas.ny.gov/providerDirectory/
Health Homes (HH)	https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_map/index.htm
Community Health Indicator Reports (CHIRS)	https://health.data.ny.gov/Health/Community-Health-Indicator-Reports-CHIRS-Latest-Da/54ci-sdfi
Age-Sex Adjusted Death Rates for Selected Causes of Death	https://www.health.ny.gov/statistics/vital_statistics/2019/table40.htm
New York Expanded Behavioral Risk Factor Surveillance System (eBRFSS) Survey	https://health.data.ny.gov/Health/Behavioral-Risk-Factor-Surveillance-System-BRFSS-H/jsy7-eb4n?_sm_au_=iVVnMrPRnsfs8P5M
Agency for Healthcare Research and Quality Prevention Quality Indicators	https://health.data.ny.gov/Health/Hospital-Inpatient-Prevention-Quality-Indicators-P/iqp6-vdi4/data
All Payer Potentially Preventable Emergency Visit (PPV) Rates	https://health.data.ny.gov/Health/All-Payer-Potentially-Preventable-Emergency-Visit-/f8ue-xzy3/data
Community Health Needs Assessment for Charitable Hospital Organizations - Section 501(r)(3)	https://www.irs.gov/charities-non-profits/community-health-needs-assessment-for-charitable-hospital-organizations-section-501r3
Certified Community Behavioral Health Clinics (CCBHC)	https://omh.ny.gov/omhweb/bho/ccbhc.html