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

2019 Local Services Plan Guidelines for Mental Hygiene Services

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CHAPTER 1: Introduction

A. Integrated Local Mental Hygiene Planning

New York State Mental Hygiene Law (§ 41.16) requires the Office of Alcoholism and Substance Abuse Services (OASAS), the Office of Mental Health (OMH) and the Office for People With Developmental Disabilities (OPWDD) to guide and facilitate the local planning process. As part of the local planning process, Local Governmental Units (LGUs) develop and annually submit a combined Local Services Plan (LSP) to all three Mental Hygiene agencies through the Mental Hygiene County Planning System (CPS). There are 57 LGUs in New York, with one LGU representing each county except for a combined LGU for the five counties encompassing New York City and a combined LGU for Warren and Washington counties.

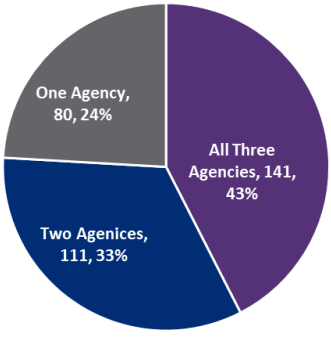
The LSP must establish long-range goals and objectives that are consistent with statewide goals and objectives (§41.16(b) (1)). Mental Hygiene law also requires that each agency's statewide comprehensive plan shall be based upon an analysis of local services plans developed by each LGU.

For many years, each state agency conducted its own local planning process which required LGUs to comply with three different sets of planning requirements. To streamline the local planning process and strengthen the state and local partnership, the three state agencies began collaborating with LGUs through the Conference of Local Mental Hygiene Directors (CLMHD) in 2008 on an integrated and uniform local planning process with a single set of plan guidelines. A statewide Mental Hygiene Planning Committee was established which included representation from OASAS, OMH, OPWDD, and LGUs. For the first time, LGUs could complete a single integrated local services plan for mental hygiene services that was submitted to all three state agencies.

The Goals and Objectives Form is the primary document that LGUs use, as part of local services planning, to communicate and identify their local needs and their goals, objectives, and strategies to address those needs. On the 2018 Goals and Objectives Form, LGUs selected from specific categories to indicate the nature of the unmet mental hygiene needs in their counties. If a need category, such as housing, applied to multiple Mental Hygiene agencies, LGUs had the option of matching it to one, two, or all three agencies. Some need categories are applicable to only one or two agencies.

The results from the 2018 Goals and Objectives Form, illustrated in Figure 1.1, show local mental hygiene needs often occur across agencies and populations. Of the ten need categories applicable to two or more agencies, LGUs indicated a total of 332 needs. Of these 332 needs identified by LGUs, the vast majority (76 percent) were associated with more than one State agency, including more than 40 percent that were associated with all three State agencies.

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



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

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

B. Mental Hygiene Planning Committee

In 2007 OASAS, OMH, OPWDD, worked with the CLMHD to form the Mental Hygiene Planning Committee (MHPC) to explore opportunities for integrated mental hygiene services planning. The MHPC assists in coordinating the integrated local planning process of the three mental hygiene agencies and each LGU. To ensure that the planning process meets the needs of each state agency and is relevant to each county, membership of the MHPC includes planning staff from the three state agencies and several county mental hygiene agencies.

Because of significant reforms in the primary health and mental hygiene services systems, a principal focus of the planning committee is to ensure that the LGUs continue to provide effective oversight of local mental hygiene services for their populations. The MHPC supports LGUs in providing timely and informed input into state, regional and local policy decision-making regarding healthcare delivery and payment reforms.

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

C. The Mental Hygiene County Planning System (CPS)

https://cps.oasas.ny.gov

The Mental Hygiene County Planning System (CPS) is a web-based application developed by OASAS to enable counties and their service providers to complete and submit required local planning forms to the state electronically. There are nearly 2,000 individuals with a CPS user account. Through CPS counties can:

- access relevant and timely data resources for conducting their needs assessment and planning activities;
- complete required planning forms; and
- submit the entire mental hygiene services plan to all three State agencies.

Several report features were built into CPS that allow state agency and county staff to query all completed plans on selected information and generate specific reports in a quick and efficient manner. These reports result in more timely and accurate summary analyses that inform each state agency's statewide planning process and assists in county dissemination of plan results.

Other tools were developed to help counties manage their agency's presence in CPS, including the ability to communicate directly with their addiction service providers and manage the completion and certification of all required planning forms. OASAS prevention and treatment providers also can manage their presence in CPS by approving user accounts for staff that need to complete planning surveys for OASAS or to access county plans and the data resources available to them in CPS.

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

Planning Data Resources added to CPS

Since March 2017, the State mental hygiene agencies have added or updated several data resources to CPS to assist county planners in their needs assessment and services planning activities. These resources are available by selecting "Planning Resources" from the CPS menu:

- OPWDD County Profiles 2017
  This profile contains county-level planning data covering the following five categories: Summary of Enrollments, County of Preference, Fiscal data from FY 15/16, Number of Individuals Requesting an Out-of-Home Residential Service, Autism and Dual Diagnosis by Age Group (Updated July 2017).

- 2016 OASAS Primary Substance at Admission by County of Residence and Service Type
  The data in this file show the primary substance at admission to OASAS-certified chemical dependence treatment programs grouped by the county of residence of the client, during calendar year 2016. This file is based on an extract from the OASAS Client Data System (CDS). Included are the total number of admissions for the year in each of five service categories- crisis, inpatient rehabilitation, residential, outpatient, and opioid treatment program (methadone) grouped by six substance categories - heroin, other opioids, alcohol, crack/cocaine, marijuana, and other substance (examples of drugs in the "other substance" category include: PCP, methamphetamine, benzodiazepine, ketamine, and ecstasy) (Updated November 2017).

- Participants in OASAS Funded Prevention Service Approaches, by County and Approach Type 2016-17
  This file displays the number of participants in OASAS funded prevention service approaches for Prevention Year 2016-17. The data are grouped by county and approach type (Updated November 2017).

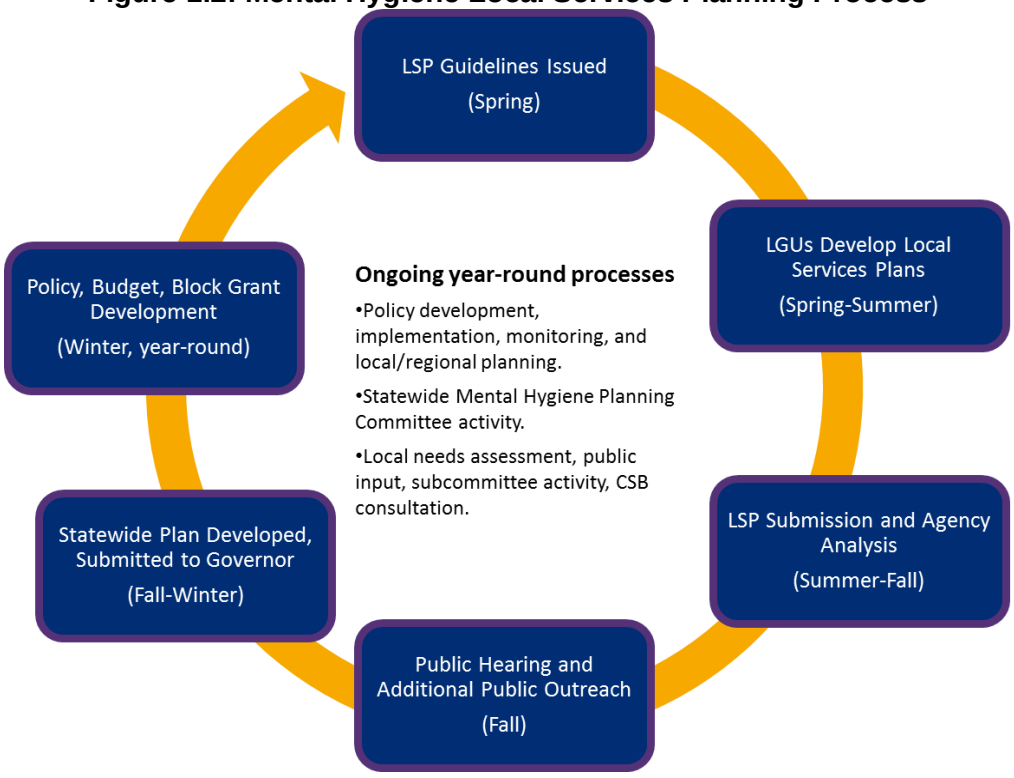
- 2016 OASAS Admissions by Type and County
  The data in this file show admissions to OASAS-certified chemical dependence treatment during calendar year 2016 based on an extract from OASAS CDS. Included are the total number of admissions for the year and what percentage were in the county of residence of the client. The service types included are crisis, opioid treatment program (methadone), inpatient rehabilitation, residential, and outpatient (Updated November 2017).

D. The Mental Hygiene Local Services Planning Process

When the mental hygiene local services planning process became integrated, a fixed planning cycle was established so that the local planning process could be conducted in an efficient and predictable manner each year. As Figure 1.2 shows, the annual process begins with the distribution of plan guidelines in March. LGUs have 90 days to complete their plan and enter it into CPS. Since planning is an ongoing activity that is carried out throughout the year, completing the plan should reflect the results of that year-long activity. Local Services Plans are analyzed and reports are generated to support the work of various state agency activities, including informing each agency's statewide planning process.

OASAS routinely uses the local planning process to survey Substance Use Disorder (SUD) providers on a variety of topics that help to inform the work of the agency. Surveys are brief and specific, and providers are given 30 days to complete them in CPS. In recent years, this process and the management tools built into CPS have resulted in an average survey response rate of 95 percent, which has dramatically increased the value and reliability of the data collected. Consistent with State Mental Hygiene Law, the statewide plan then serves as an important source of guidance for the subsequent local services planning process, which begins again the following March.

Figure 1.2: Mental Hygiene Local Services Planning Process



Mental Hygiene Local Services Planning Timeline

The timeline shown in Table 1.3 highlights the major dates in the local services planning process and is intended to provide continuity in planning expectations from year to year.

Table 1.3: 2019 Local Services Planning Process Timeline

Process Step	Date
Ongoing planning and needs assessment conducted by counties and the Mental Hygiene Planning Committee	Year round
LGU LSP Forms and OASAS Provider and Program Surveys available on CPS	March 2018
Due date for completed OASAS provider planning surveys in CPS	**Monday, April 2, 2018**
Due date for completed LGU Plans in CPS	**Friday, June 1, 2018**

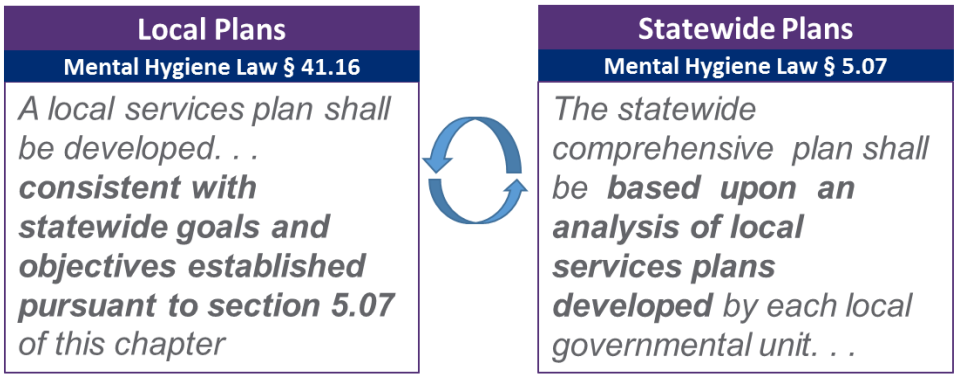
E. Informing Statewide Planning

Section 5.07 of Mental Hygiene Law requires OMH, OASAS and OPWDD to develop a Statewide Comprehensive Plan for the provision of State and local services to individuals with mental illness, substance abuse disorders and developmental disabilities. Purposes of the Comprehensive Plan include:

- identifying statewide priorities and measurable goals to achieve those priorities;
- proposing strategies to obtain goals,
- identifying specific services and supports to promote behavioral health wellness;
- analyzing service utilization trends across levels of care; and
- promoting recovery-oriented state-local service development.

Figure 1.4 shows the statutory relationship between local planning and State planning. As Figure 1.4 illustrates, analyses of the Local Services Plans are a key component of the Statewide Comprehensive Plan.

Figure 1.4: Relationship between Statewide and Local Plans



State agencies conduct extensive reviews of information submitted in the LSPs. For the 2018 Plan Cycle, OASAS published the following written analyses of Plan forms and surveys (available by selecting "Planning Resources" in CPS and then following the link for "2018 Plan Analyses"):

- 2018 Prevention Provider Professional Workforce Survey Summary Analysis
- 2018 Treatment Talent Management Survey Analysis

The local services planning process and the priorities identified in county plans, particularly the cross-system priorities, inform each State agency's policy, programming and budgeting decisions in a way that is more timely and comprehensive than previously possible. To help ensure that policies supporting people with mental illness, developmental disabilities and/or addictions are planned, developed and implemented comprehensively, OASAS, OMH, and OPWDD will continue to rely on the local services planning process and the annual plan submissions as important sources of input.

CHAPTER 2: Planning for Mental Hygiene Services

A. Behavioral and Physical Health Care Reform

While each mental hygiene system of care continues to provide quality, individualized services, the State Department of Mental Hygiene agencies recognize the transformational changes that are occurring in the health care system. As the public healthcare and the mental hygiene services systems continue to transition and integrate, OASAS, OMH and OPWDD are working with their State and local partners to implement a more coordinated system of care that addresses the needs of all individuals.

While OASAS, OMH and OPWDD face unique challenges in overseeing their respective service systems, several federal and State regulations and policies influence current operating environments and strategic directions across these agencies. Understanding the factors that influence the State's mental hygiene service system empowers LGUs to align their strategic direction with statewide goals and objectives. Included in this chapter is a summary of the federal and statewide initiatives taking place and how local services interact with those initiatives.

Since Governor Cuomo established the Medicaid Redesign Team (MRT) in 2011, several large-scale initiatives have been implemented, however the broader healthcare transformation process continues through this year. The service system redesign across mental hygiene agency settings are advancing care from a fee-for-service chronic care model to community-based, comprehensively managed, and value-driven delivery systems. Under this churning environment, all systems are realigning to achieve the Triple Aim of better care, population health, and lower costs.

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

Medicaid Managed Care

The centerpiece of the MRT vision is the expansion and redesign of the State's behavioral health Medicaid program through a broader managed care strategy and "carving in" previously managed care exempt Medicaid services and beneficiaries into a managed, coordinated benefit package.

Adults in Managed Care

For adults aged 21 and older, the integration of all Medicaid behavioral health and physical health benefits under managed care are delivered through two behavioral health managed care models:

- **Qualified Mainstream Managed Care Organizations (MCOs):** For all adults served in mainstream MCOs throughout the State, qualified MCOs integrate all Medicaid State Plan covered services for mental illness, substance use disorders and physical health conditions.

- **Health and Recovery Plans (HARPs)**: HARPs manage care for adults with significant behavioral health needs. These specialized Plans will facilitate the integration of physical health, mental health and substance use disorder services for individuals requiring specialized expertise, tools and protocols which are not consistently found within most medical plans. In addition to the State Plan Medicaid services offered by mainstream MCOs, qualified HARPs offer access to an enhanced benefit package comprised of Behavioral Health Home and Community Based Services (BH HCBS) designed to provide the individual with a specialized scope of support services not currently covered under the State Plan. BH HCBS will be available to beneficiaries based on their detailed plan of care, which will be informed by a full functional assessment. To qualify as HARPs, Plans were required to demonstrate that they have the organizational capacity and culture to ensure the effective management of behavioral health care and facilitate system transformation.

HARP Behavioral Health Home and Community Based Services (Adult BH HCBS)

The Centers for Medicare and Medicaid Services (CMS) authorized various BH HCBS under Medicaid waiver authority. BH HCBS are designed to help adults (21 and over) with serious mental illness and/or substance use disorders remain and recover in the community, and reduce preventable admissions to hospitals, nursing homes, or other institutions.

BH HCBS address isolation and promote integration by providing a means by which individuals may gain the motivation, functional skills, and personal improvement to be fully integrated into the community and achieve life goals. The goal of integrating BH HCBS into the managed care environment is to promote significant improvements in the behavioral health system of care and move toward a recovery-based managed care delivery model. The recovery model of care, as envisioned in the HARP and HIV Special Needs Plan (SNP) models, emphasizes and supports an individual's recovery by optimizing quality of life and reducing symptoms of mental illness and substance use disorders through empowerment, choice, treatment, education, employment, housing, and health and well-being.

HARPs and HIV SNPs provide BH HCBS as a covered benefit for qualified members. HARPs and HIV SNPs must create an environment where the plan, service providers, plan members, families and other significant supporters, and government partner to assist members in prevention, management, and treatment of physical and behavioral health conditions, including serious mental illness and Substance Use Disorders.

The following BH HCBS are included in the HIV SNP and HARP benefit package:

- Psychosocial Rehabilitation
- Community Psychiatric Support and Treatment
- Habilitation
- Family Support and Training
- Short-term Crisis Respite
- Intensive Crisis Respite
- Education Support Services
- Empowerment Services - Peer Supports
- Pre-vocational Services
- Transitional Employment
- Intensive Supported Employment
- Ongoing Supported Employment
- Non-Medical Transportation[i]

Children in Managed Care:

The MRT Children's Health and Behavioral Health Team has designed a separate framework for children's integrated health and behavioral health services under managed care. The separate framework is due to recognition of gaps in the current service system, the complexity of multi-systems involvement by children and families, and the fluidity of children's needs and challenges as they develop.

The Children's BH MRT Subcommittee made a recommendation in 2011 that the children's system needed improvement with respect to service access, funding and earlier intervention for children and families. Since then, the Children's Medicaid Redesign Leadership team, with representation from OMH, Office of Children and Family Services (OCFS), OASAS, and DOH, has been using the transition of behavioral health services to Medicaid Managed Care to achieve significant reforms in the children's behavioral healthcare system. There is a recognition that, generally, the children's system in its current form fails to identify children with behavioral health needs soon enough to consistently apply effective intervention. Early identification, accurate diagnosis, and effective intervention of behavioral health problems can help keep children and youth on track developmentally, which in turn prevents expensive, ancillary problems from developing, such as school dropout or involvement in the juvenile justice system. While a continuum of behavioral health services exists, there are significant gaps in our children's service delivery system, particularly in home and community-based preventive and step-down services.

The leadership team has put together a proposed benefit package, which will address these gaps and weaknesses. This package, once approved and implemented, will enable New York State to serve more children and to prevent the need for more restrictive, more expensive services. The design will also break down some of the systems walls we have historically built up around our services, particularly in the Home and Community Based Services (HCBS) that three State agencies offer through 1915c waivers. We envision building a service delivery system in which children and families can access the services they need, when they need them, and in the right amount, regardless of the door through which they have entered.

Many opportunities are missed early in a child's trajectory of challenges that could prevent a costly path for the child and their family's future. Children and their families, in many cases, must fail through a variety of programs, services and interventions before being determined eligible for an HCBS Waiver. By that time, they have likely developed a more complex array of challenges which, if addressed earlier, may not have occurred.

The shortcomings of the current systems, combined with the vision of earlier intervention, led to a decision to develop a new set of State Plan Medicaid (SPA) Services. This new set of services will enable providers to focus on prevention and wellness, allow for better integration of behavioral health services and early pediatric care, and creates improved opportunity for the delivery of evidence-based practices statewide. The proposed services will be available for all children on Medicaid under the age of 21 who meet medical necessity criteria. Delivery of the new services may take place in natural settings where children live and go to school. The six proposed services are:

- Crisis Intervention,
- Community Psychiatric Support and Treatment,
- Psychosocial Rehabilitation Services,
- Other Licensed Practitioner Services,
- Family Peer Support Services, and
- Youth Peer Training and Support Services.

In addition to adding State Plan services, the State plans to align and transition the existing 1915c Waiver services into one array of HCBS available for children with measurable functional impairment. This includes all existing children's waivers – OMH HCBS Waiver, Office of Children and Family Services (OCFS), Bridges to Health, and DOH Care At Home.

Unlike the proposed State Plan services, which will be universally available to all children with Medicaid who meet medical necessity, the proposed array of HCBS will be available to children eligible for Medicaid who meet specific target population and functional limitations criteria. The proposed HCBS array was developed by aligning all the services currently offered to children enrolled in the existing 1915c Waivers – services which produce good outcomes, keep children out of long term institutional care, and provide the supports that families need to recover and become more resilient.

New York's vision for the children's system of care integrates physical and behavioral health services within mainstream Medicaid Managed Care Plans. There will be no HARPS for children. When the transition is implemented, services that were previously carved out of managed care and paid on a fee-for-service basis will be included in the Medicaid managed care benefit available to children.

Consistent with the Medicaid Redesign Team's "Care Management for All" goal, every child that receives Medicaid will be enrolled in a high-quality, fully integrated care management program. Care management will be provided by a range of care management models including Plans, Patient Centered Medical Homes and Health Homes. Children with the highest level of need, who meet the criteria, will be enrolled in Health Homes. To best integrate all care and services, Plans will be required to contract with behavioral health, foster care agencies, and specific community-based providers, as well as pediatric health care and specialty health care providers already in network.

Children and their families are involved in a variety of systems and to ensure that all care is coordinated, Plans will be required to develop and maintain working relationships with school districts, non-Medicaid funded

community services and supports, Regional Planning Consortiums, and local government. This entire design and plan has been created, discussed, and moved forward under the collaboration of the four agencies and in partnership with the Children's Health & Behavioral Health MRT Subcommittee.

Delivery System Reform Incentive Payment (DSRIP) Program

The Delivery System Reform Incentive Payment (DSRIP) program is the main mechanism by which New York State is implementing the MRT Waiver Amendment. DSRIP´s purpose is to fundamentally restructure the health care delivery system by reinvesting in the Medicaid program, with the primary goal of reducing avoidable hospital use by 25 percent over five years.

Performing Provider Systems (PPS) are providers that form partnerships and collaborate in a DSRIP Project Plan. A DSRIP Project Plan is the overall plan that a Performing Provider System submits to the State. The Project Plan is composed of at least five projects, but no more than eleven projects, based upon projects chosen from a predetermined list. There are four Domains in DSRIP that represent groupings of project milestones and associated metrics. The Domains have strategy sub lists identifying specific strategies. Mental health and substance use disorder (SUD) projects generally fall under one of two Domain sub lists:

- Domain 3: Clinical Improvement Projects, and
- Domain 4: Population-wide Projects: New York's Prevention Agenda

There are 25 PPSs in the state. Table 2 illustrates the number of PPSs that have chosen a behavioral health project from domains 3.A or 4.A.

Table 2.1: PPS Behavioral Health Project Selections

Domain 3: Clinical Improvement Projects		
A. Behavioral Health	**# of PPSs**	**% of PPSs**
3.a.i Integration of primary care and behavioral health services	**25**	**100%**
3.a.ii Behavioral health community crisis stabilization services	**11**	**44%**
3.a.iii Implementation of evidence-based medication adherence programs (MAP) in community based sites for behavioral health medication compliance	**2**	**8%**
3.a.iv Development of Withdrawal Management (e.g., ambulatory detoxification, ancillary withdrawal services) capabilities and appropriate enhanced abstinence services within community-based addiction treatment programs	**4**	**16%**
3.a.v Behavioral Interventions Paradigm (BIP) in Nursing Homes	**1**	**4%**
Domain 4: Population-wide Projects: New York's Prevention Agenda		
A. Promote Mental Health and Prevent Substance Abuse	**# of PPSs**	**% of PPSs**
4.a.i Promote mental, emotional and behavioral (MEB) well-being in communities	**2**	**8%**
4.a.ii Prevent Substance Abuse and other Mental Emotional Behavioral Disorders	**1**	**4%**
4.a.iii Strengthen Mental Health and Substance Abuse Infrastructure across Systems	**13**	**52%**

The Prevention Agenda, Looking Forward

The New York State Prevention Agenda 2013-2018 is DOH's multi-year state health improvement plan. The goal of the Prevention Agenda is for State and local action to improve health status and reduce health disparities in five priority areas:

1. Prevent Chronic Diseases;
2. Promote a Healthy and Safe Environment;
3. Promote Healthy Women, Infants and Children;
4. Promote Mental Health and Prevent Substance Abuse; and
5. Prevent HIV, STDs, Vaccine Preventable Diseases and Healthcare Associated Infections.

The Prevention Agenda establishes goals for each priority area and defines indicators to measure progress toward achieving these goals, including reductions in health disparities among racial, ethnic, and socioeconomic groups and persons with disabilities across the lifespan. The Prevention Agenda also identifies interventions and offers guidance on related intermediate measures shown to be effective to reach each goal.

The Prevention Agenda promotes stakeholder collaboration at the community level to assess health status and needs, identify local health priorities and plan and implement strategies for local health improvement, and serves as a guide to local health departments (LHDs) and hospitals as they work together with their community to develop and implement Community Health Assessments, including Community Health Improvement Plans, required of LHDs, and Community Service Plans required of hospitals.

With the current cycle of the Prevention Agenda ending in 2018, a new six-year period is set to begin in January 2019. The New York State Public Health and Health Planning Council's Public Health Committee will lead the development of the Prevention Agenda 2019-2024, and will be establishing cross-sectoral workgroups to develop the priority-specific action plans. Workgroup members will solicit community feedback, refine goals, identify best practices and ways to measure progress in each of the five priority areas of the Prevention Agenda for this next cycle

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

B. Integrating Care for Earlier Identification and Treatment of Behavioral and Physical Health Conditions

Since the passage of the federal Affordable Care Act, and the creation of the New York State Medicaid Redesign Team (MRT) shortly thereafter, there has been increasing recognition of the value of integrated behavioral and primary/physical healthcare treatment. This section outlines three of the most significant efforts underway in New York State to build more behavioral health capacity for primary care, and to build primary care capacity for behavioral health. They include Integrated Outpatient Services regulations, DSRIP integration projects, and Collaborative Care.

Integrated Outpatient Clinic Services

On January 1, 2015, New York witnessed the culmination of a four-year effort to further the integration of physical and behavioral health services in clinic settings across state. The new authorization establishes the licensure category "Integrated Outpatient Services" (IOS) and appears identically within regulations for OMH-licensed providers (14 NYCRR Part 598), OASAS-certified programs (14 NYCRR Part 825), and DOH-licensed providers (10 NYCRR Part 404).

Over the past five years, OMH, OASAS, and DOH have partnered in the development, implementation and oversight of the "Integrated Licensure Project." This collaboration resulted in the development of clinical and physical plant standards, staffing requirements, and a single application and review process – all with the goal to reduce the administrative burden on providers and to improve the quality of care provided to consumers with multiple needs by improving the overall coordination and accessibility of care.

Participating facilities in the Project have been overseen by a single State ("host") agency, which monitors for compliance with standards at the single site. Therefore, though an agency may have multiple licenses, they are only subject to one survey. Further, the Project has promoted the use of an integrated physical and behavioral health record for recipients.

The now-established IOS regulations further the core principles of the Project, which are:

1. Allowing a provider to deliver the desired range of cross-agency clinic services at a single site under a single license;

2. Requiring the provider to possess licenses within their network from at least 2 of the 3 participating State agencies;
3. Allowing the site's current license to serve as the "host"; and
4. Facilitating the expansion of "add-on" services through a request to the State agency that is principally responsible for oversight of such services.

Applicable Sites for Integrated Outpatient Services

Providers eligible to become IOS providers under the uniform regulations must already possess licenses within their network from at least 2 of the 3 participating State agencies, as indicated above. In addition, the provider must be in "good standing" with the agencies for whom it will be operating integrated services, and must be affiliated with a Health Home (DSRIP Performing Provider System network status is not a sufficient substitute for Health Home affiliation).

Integrated outpatient clinics fall into three main categories that are organized under "host" models. The host model refers to the lead agency which oversees and is the primary point of contact for all of the integrated services:

1. Primary Care Host Model: The State Department of Health is the lead oversight agency, and behavioral health services (substance use disorder (SUD) and/or mental health (MH)) are provided in addition to primary health care.
2. Mental Health Behavioral Care Host Model: The State Office of Mental Health is the lead oversight agency, and primary health care and/or substance use disorder services are provided in addition to mental health care.
3. Substance Use Disorder Behavioral Care Host Model: The State Office of Alcoholism and Substance Abuse Services is the lead oversight agency, and primary health care and/or mental health services are provided in addition to substance use disorder care.

Applications to become an IOS provider are made on a clinic-specific basis, and therefore the agency under which the applicant clinic is originally licensed determines the host site status. For example, an Article 31 mental health clinic applying to become an IOS clinic providing substance use disorder services in addition to those on its original license, will have the State Office of Mental Health as its primary State oversight agency and point of contact.

Services Provided by Integrated Outpatient Clinics

Any clinic that operates as an IOS provider must continue to offer those services required under their host model agency regulations, in addition to those services required under the regulations of the secondary and tertiary licensing agencies.

Any behavioral health care host model must also complete treatment plans for clinic enrollees, which must include physical health, behavioral health, and social service needs. Treatment plans must be completed within 30 days of admission to the clinic. Primary care host models must complete treatment plans for behavioral health services only after a patient has been advanced beyond assessment and pre-admission services. In such cases, a treatment plan is required within 30 days after a decision has been made to begin post-admission behavioral health services.

Adoption of Integrated Outpatient Services by Clinics Statewide

Since the final adoption of the IOS regulations on January 1, 2015, those clinics that were included in the pilot project for integrated outpatient services have continued providing integrated services consistent with the regulations. Additional providers that were not included in the pilot have also since received approval to provide integrated services. The following statistics reflect the number of IOS sites by type, including both grandfathered sites and those approved under the new IOS regulations (as of December 2017):

50 OMH host sites total

- 40 with SUD
- 7 with primary care

- 3 with both

22 OASAS host sites total
- 19 with MH
- 2 with primary care
- 1 with both

5 DOH host sites total (with 6 additional under review as of 12/2017)
- 4 with MH
- 0 with SUD
- 1 with both

Integration of Primary and Behavioral Health Care under DSRIP: Project 3.a.i.

In addition to the opportunity to provide integrated behavioral health and primary care services under the IOS regulations, the DSRIP Program has provided another avenue for clinics within Performing Provider Systems to integrate care under DSRIP Project 3.a.i.

OMH, OASAS, and DOH collectively agreed to raise the current licensure thresholds associated with clinics to allow a greater number of secondary and tertiary services at existing sites, for those clinics that are part of a DSRIP Project 3.a.i. (which was chosen by all 25 PPSs). However, it is important to note that any clinic providers operating within the existing licensure thresholds or the DSRIP Project 3.a.i. licensure thresholds must also meet certain regulatory requirements outlined by the host model.[ii]

Approved DSRIP 3.a.i. integrated clinic sites (as of December 2016):

22 OMH host sites total
- 12 with SUD
- 8 with primary care
- 2 with both

10 OASAS host sites total
- 1 with MH
- 3 with primary care
- 6 with both

1 DOH host sites total
- 0 with MH
- 0 with SUD
- 1 with both

Table 2.2 Licensure Threshold Crosswalk for DSRIP Project 3.a.i. Clinics[iii]

Existing Licensure Thresholds	DSRIP Project 3.a.i Licensure Thresholds
A PHL Article 28 provider that has more than 2,000 total visits per year must be licensed by OMH if it has more than 10,000 annual visits for mental health services or more than 30 percent of its total annual visits are for mental health services.	A PHL Article 28 provider that has more than 2,000 total visits per year must be licensed by OMH if more than 49 percent of its total annual visits are for mental health services.
No existing Licensure Threshold. A PHL Article 28 provider may not provide substance use disorder services without being certified by OASAS pursuant to MHL Article 32.	A PHL Article 28 provider must be certified by OASAS if more than 49 percent of its total annual visits are for substance use disorder services.

A MHL Article 31 provider or MHL Article 32 must be licensed by DOH if more than 5 percent of its total annual visits are for primary care services or if any visits are for dental services.	A MHL Article 31 provider or MHL Article 32 must be licensed by DOH if more than 49 percent of its total annual visits are for primary care services or if any visits are for dental services.
No existing Licensure Threshold. A MHL Article 31 provider or MHL Article 32 is able to integrate mental health and substance use disorder services pursuant to a Memorandum of Agreement between OMH and OASAS.	A MHL Article 31 provider must be certified by OASAS if more than 49 percent of its total annual visits are for substance use disorder services. A MHL Article 32 provider must be certified by OMH if more that 49 percent of its total annual visits are for mental health services.

Collaborative Care Medicaid Program

Behavioral health disorders such as depression, anxiety, and substance use disorders are major drivers of disability and health care costs, but only three in 10 adults living with a mental health or substance use disorder currently receive care from a mental health specialist.[1] At a time when policy makers and payers are tasked with quickly moving from volume to value-based purchasing of healthcare, there is strong evidence that effectively integrated behavioral health services can help achieve the health care Triple Aim for better care, better outcomes, and lower costs.

Among models of behavioral health integration, Collaborative Care (also known as the IMPACT model) stands apart through a large evidence base, and a significant potential impact on population health. This model of care brings the individual together with the primary care provider, a care manager, and a consulting psychiatrist to treat depression and other common mental health diagnoses in the primary care environment. An electronic registry is used to track each individual's progress and to monitor outcomes on the whole patient population. Collaborative Care helps a practice build the capacity in-house to treat behavioral health conditions, and enhances the ability to manage co-morbid chronic diseases, such as diabetes or hypertension, by addressing some of the behavioral factors impacting physical health outcomes.

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

With a legislative allocation of at least $10 million annually to support the New York State Collaborative Care Medicaid Program (CCMP), more than 3,300 Medicaid patients have benefited from receiving treatment for their depression in primary care since the program began in 2015. There are now more than 50 primary care practices participating across the State, including hospital-affiliated clinics, federally qualified health centers and independent provider practices. CCMP continues to provide technical assistance and training to participating practices to help them continue to grow and sustain their programs.

In addition to the training and support practices receive, New York State has designed an innovative payment model to advance sustainability for practices in CCMP.

Reimbursement is one of the principal barriers to adoption of the Collaborative Care model, since it does not fit in a typical fee-for-service structure. New York State has developed a value-based formula that uses a monthly case-rate payment. This allows practices to provide necessary services flexibly, without being limited by fee-for-service billing. The monthly payment also helps to support crucial infrastructure, such as the addition of

[1]Wang, P.S., Lane, M., Olfson, M., et al. (2005). Twelve-month use of mental health services in the United States: Results from the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62* (6) 629-40.

behavioral health care management staff to provide counseling and care coordination as well as maintenance of a population-health registry system that allows for tracking of patient progress.

The value-based payment model emphasizes frequent telephonic contacts with the patient, recurring in-person sessions, and virtual consultation with an off-site psychiatrist for caseload support focused on patients who are not improving. In order to receive the monthly payment, the practice needs to have had contact with patients and completed a PHQ-9 depression screening to track patients' depression symptoms.[2] 25 percent of the payment is withheld each month, and can be paid retroactively after six months if the practice can attest that the patient has improved, or that they have intervened and made adjustments to the patient's treatment plan to address the lack of improvement. Participating sites report process and outcomes data on a quarterly basis. These measures hold providers accountable so that patients do not remain in ineffective treatment for too long.

The combination of financial and training support has resulted in positive outcomes for participating sites. As of June 2016, 53 percent of patients being treated for depression in CCMP sites have shown improvement after 10 weeks or more of treatment. CCMP sites are screening an average of 80 percent of their patients for depression. Sites have also seen an increase in the number of patients who are not improving that have had changes made to their treatment plan and/or their case reviewed by the psychiatric consultant -- which indicates practices are intervening earlier to improve outcomes.

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

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

The mission of the New York State Office of Alcoholism and Substance Abuse Services (OASAS) is to improve the lives of all New Yorkers by leading a comprehensive premier system of addiction services for prevention, treatment, and recovery.

OASAS oversees an SUD and problem gambling service system that provides a full array of services to a large and culturally diverse population. OASAS funds, certifies and regulates the State's system of SUD and problem gambling treatment and prevention services, including the direct operation of 12 Addiction Treatment Centers (ATCs) statewide. The OASAS treatment provider system serves about 232,000 people each year, with an average daily enrollment of 98,000 across more than 900 certified programs. During the 2016-17 school year, approximately 4,604,000 residents were reached by a one-time, population-based prevention service and 406,000 youth received a direct prevention service.

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

- Enhancing Access to Treatment and Recovery;
- Increasing SUD Treatment System Efficiency through Healthcare System Transformation; and
- Improving the Effectiveness and Quality of Prevention, Treatment, and Recovery Services and Supports.

In addition to the information found in this chapter, more details on OASAS initiatives is found in the Agency's Statewide Comprehensive Plan, available at https://www.oasas.ny.gov/pio/commissioner/5yrplan.cfm.

Enhancing Access to Treatment and Recovery

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

Heroin and Opioid Legislation Treatment Initiatives

Since 2014, New York Governor Andrew M. Cuomo has implemented a series of aggressive reforms to combat heroin and opioid addiction, including signing historic Combat Heroin Legislation that year; expanding insurance coverage for substance use disorder treatment; increasing access and enhancing treatment capacity across the state, including a major expansion of opioid treatment and recovery services.

On June 22, 2016, Governor Cuomo again signed legislation to combat the heroin and opioid crisis in New York State. The comprehensive package of bills was passed as part of the 2016 Legislative Session and marks a major step forward in the fight to increase access to treatment, expand community prevention strategies, and limit the over-prescription of opioids in New York. The legislation included several best practices and recommendations identified by the Governor's Heroin and Opioid Task Force, and builds on the state's aggressive efforts to break the cycle of heroin and opioid addiction and protect public health and safety.

Opioid State Targeted Response Grant Program Treatment System Enhancements

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

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

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

Additional OUD Treatment Expansion Through Federal Grants

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

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

Expanding Treatment of Persons Released from Incarceration

In 2016, a partnership between OASAS and the State Department of Corrections and Community Supervision

(DOCCS) initiated an injectable Naltrexone program at the Edgecombe Correctional Facility. This unique collaboration takes technical parole violators and remands them for 45 days to the Edgecombe Treatment Facility. While in custody, parolees participate in an intense 45-day SUD treatment program provided by a community treatment agency. With the increase in heroin and other opioid use, the State negotiated an agreement to provide a dose of the medication to willing parolees. Upon release, the parolees are refereed to an OASAS certified-treatment program where they can receive psychosocial counseling and subsequent injections of naltrexone. The first dose is delivered at the correctional facility at no cost to the inmate.

A similar program to Edgecombe now exists at 17 local correctional facilities in the State.

Other SUD Treatment Initiatives

- *Open Access Centers*
  In his 2017 State of the State briefing, Governor Cuomo identified the creation of Open Access Centers to provide immediate engagement and linkage to treatment for individuals with a SUD as a priority for the state. Open Access Centers will be available 24/7 to provide immediate engagement, assessment and referral for all SUD services and interventions.
- *OASAS Treatment Availability Dashboard*
  The OASAS Treatment Availability Dashboard application, http://findaddictiontreatment.ny.gov, allows New Yorkers to access any service in the OASAS continuum of care, including crisis, residential, inpatient, outpatient, and opioid treatment programs.
- *Screening, Brief Intervention and Referral to Treatment*
  Screening, Brief Intervention and Referral to Treatment (SBIRT) is an evidence-based approach to identifying patients who use alcohol and other drugs at risky levels with the goal of reducing and preventing related health consequences, disease, accidents and injuries. OASAS works closely with DOH and OMH to bring SBIRT to physical and behavioral healthcare settings.

New Recovery Services

OASAS is rapidly increasing the availability of recovery services throughout the State. These new, innovative services include:

- Peer Engagement Specialists;
- Family Support Navigators;
- Youth Clubhouses;
- Recovery Centers;
- Certified Recovery Peer Advocates (CRPAs); and
- Regional Addiction Resource Centers

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

Expanded Problem Gambling Treatment through ATCs

In January 2017, OASAS announced the availability of inpatient care for New Yorkers suffering from gambling addiction at six OASAS ATCs. The ATCs were granted waivers allowing them to admit and treat individuals with problem gambling as their primary diagnosis. The ATCs now have qualified problem gambling clinicians on staff to provide these inpatient services.

Increasing SUD Treatment System Efficiency through Healthcare System Transformation

New York State's vision for public healthcare reform is to achieve the "Triple Aim" of improved health outcomes, decreased costs, and increased consumer satisfaction. The Medicaid Redesign Team (MRT), convened by Governor Andrew Cuomo in 2011, set forth recommendations for achieving the Triple Aim, including integration of the physical health and behavioral health (mental health and substance use disorder) delivery systems. Healthcare system transformation activities in which OASAS and its providers are involved include:

- Behavioral Health Managed Care,
- Delivery System Reform Incentive Payment (DSRIP) Program; and
- Regional Planning Consortiums (RPCs).

Detailed information on these initiatives is found in Sections A and B of this chapter.

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

Statewide Prevention Media Campaigns

- *Combat Heroin*
  The Combat Heroin campaign informs and educates New Yorkers about the risks of heroin and prescription opioid use, the signs of addiction, and the resources available to help.
- *Combat Addiction*
  The statewide Combat Addiction campaign emphasizes the far-reaching effects of addiction and connects New Yorkers with information and support services through social media, bilingual public service announcements, and print ads. As part of the Combat Addiction campaign OASAS, in collaboration with the New York State Media Service Center, produced Reversing the Stigma- a documentary about addiction and recovery and the stigmas that surround them.
- *Talk2Prevent*
  OASAS developed the Talk2Prevent campaign to give parents the information and tools they need to talk to their children about the risks of underage drinking and drug use.
- *Hidden Fentanyl Kills*
  The Hidden Fentanyl Kills campaign consists of ads and information cards warning New Yorkers about the dangers of fentanyl, providing safety tips on prevention, and offering guidance on how to safely respond to a fentanyl overdose.

Evidence-Based Programs and Strategies (EBPS) for Prevention

OASAS promotes the improvement of the SUD prevention system by using evidence generated by applied scientific prevention services research. Evidence-based programs and strategies (EBPS) are developed using outcome studies to document their effectiveness in preventing substance abuse, violence, delinquency and the risk and protective factors that predict these behaviors. EBPS are a required standard for all service providers and most EBPS provided by OASAS-funded prevention providers are delivered in school settings. OASAS established six Prevention Resource Centers (PRCs) to support local communities' implementation of EBPS. The PRCs disseminate current prevention science, through training and technical assistance, to community coalitions and prevention providers.

As part of the Opioid STR grant OASAS is implementing EBPS in various settings to reduce the likelihood of opioid use and prescription drug abuse among adolescents. Funding from the grant will go to providers throughout the state to deliver evidence-based prevention services for underserved, hard-to-reach youth and other at-risk populations. Furthermore, through the Opioid STR grant, providers will deliver the Strengthening Families Program (SFP) EBP to families residing in New York City shelters and Permanent Supportive Housing (PSH).

Strategic Prevention Framework Partnership for Success (SPF PFS)

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

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

Ten community coalitions were selected in 2015 to implement environmental strategies in their communities. Strategies include information dissemination, social marketing and social norms. Methods to reach communities involve ads on TV and radio, billboards, bus stops and movie theaters as well as prescriber education sessions, drop box installation and working with law enforcement.

Using Level of Care for Alcohol and Drug Treatment Referral (LOCADTR) to Provide Effective Treatment

OASAS, in partnership with The National Center on Addiction and Substance Abuse developed the Level of Care for Alcohol and Drug Treatment Referral (LOCADTR) 3.0. LOCADTR 3.0 is a web-based tool used by treatment programs, Medicaid Managed Care plans, and other referral sources to determine the most appropriate level of care for a client with a substance use disorder. Designed for treatment programs and referral sources working with individuals who experience substance use disorders, LOCADTR guides decision making regarding the appropriate level of care for a client.

D. Planning for Mental Health Services

The forces of change in Medicaid Redesign, mental health parity, managed behavioral health and the Olmstead Plan continue to drive the transformation of the public mental health system in New York State, and it is critical that local stakeholders be informed and engaged in ongoing planning. With so many large scale reforms converging, there are numerous opportunities to serve and support the recovery and resiliency of adults, children, and families impacted by mental illness. Below are a number of recent and ongoing initiatives that will drive, and are driven by local and statewide planning efforts in the public mental health system.

The OMH Transformation Plan for State and Community-Operated Services

The OMH Transformation Plan aims to rebalance the agency's institutional resources by further developing and enhancing community-based mental health services throughout New York State. By doing so, the Plan will strengthen and broaden the public mental health system to enhance the community safety net; allowing more individuals with mental illness to be supported with high quality, cost-effective services within home and community-based settings and avoid costly inpatient psychiatric stays.

Beginning with the State fiscal year (SFY) 2014-15 State Budget and continuing through SFY 2016-17, the OMH Transformation Plan has "pre-invested" $81 million annualized into priority community services and supports, with the goals of reducing State and community-operated facilities' inpatient psychiatric admissions and lengths of stay. An additional $19 million has been reinvested from Article 28 and 31 inpatient facilities to further support the OMH Transformation Plan.

Early Identification and Intervention Strategies

OMH is focused on supporting increased efforts to identify and provide appropriate treatment for mental health conditions before they become more disabling for individuals, and more expensive to treat. Initiatives focused on early identification and intervention include collaborative efforts with the Department of Health on the Prevention Agenda 2013-2018, and initiatives including:

Project TEACH

TEACH is a collaborative model that is committed to strengthening and supporting the ability of primary care providers (PCPs) to provide mental health services to children, adolescents and their families. This statewide program is comprised of three interrelated services for PCPs: rapid access to child and adolescent psychiatric consultation, referral and linkage to assist families and primary care providers to access community mental health and support services and educational based training.

In 2015, the Office of Mental Health re-bid contracts for the Regional Provider services with an increase of funding for Project TEACH by $1.4 million to $2.5 million annually through 2020, and instituted other improvements including an increase of child and adolescent psychiatry staffing from 2.0 to 5.25 full time equivalents statewide.

The increased funding will now enable Project TEACH to triple the number of consultations with pediatric primary care providers provided by child and adolescent psychiatrists, increase trainings for primary care providers, and add staff to provide children and families with linkages and referrals to community supports and services. The increased funding will also support a new site for the program—the seventh site statewide. Additionally, other providers who offer ongoing treatment to children, such as general (non-child) psychiatrists, may now request a consultation – further improving the quality of care available to New York children already engaged with psychiatric treatment providers.

In addition to expansion of the Project TEACH Regional Provider services, OMH has established the Project TEACH Statewide Coordination Center (SCC) to oversee the successful expansion of Project TEACH. The SCC will promote Project TEACH, strengthen the coordination of consultation services to ensure that utilization is at full capacity, expand training on a statewide basis, add specialty consultation for identified areas of need, and oversee the evaluation of services provided by Project TEACH. The SCC will work with other prevention and early identification initiatives, such as suicide prevention and first episode psychosis initiatives (described later in this report) to bring training to pediatric PCPs.

Additionally, the SCC will be a New York State leader in advancing prevention science by serving as a clearinghouse and resource for promising and evidence based practices in promoting children's social-emotional health and preventing and treating disorders, and will support the continued integration of pediatric primary care and behavioral health at a systems level.

After expansion of the program is complete, OMH plans to enroll an additional 3,800 providers and conduct an additional 24,500 consultations over the next five years. For more information about Project TEACH, including information on how primary care providers can take advantage of this program, please visit: http://projectteachny.org.

OnTrackNY

OMH is seeking to improve early identification and treatment for individuals with psychotic disorders such as schizophrenia through the dissemination of first episode psychosis (FEP) models. The ultimate goal of the FEP initiative is to minimize disability so often associated with schizophrenia and to maximize recovery. New York State's *OnTrackNY* initiative for first episode psychosis interventions has expanded statewide with 22 sites as of year-end 2017, and 700 individuals served in the past year alone.

Suicide Prevention

Suicide is a significant public health problem in the United States and New York State. The most recent data available indicates that in 2014, 42,826 persons died by suicide in this country. Over the last decade, the nation witnessed the number of annual suicide deaths surpassing deaths by motor vehicle accidents, homicides, and most recently breast cancer. Since 1999 rates of leading causes of death, such as heart disease, stroke, and cancer, have been decreasing, but according to a recent report by the Centers for Disease Control and Prevention (CDC), the suicide death rate in the US increased by 24%.[iv]

New York State itself has one of the lowest suicide rates in the nation, at 8.6 suicide deaths per 100,000 (vs. 13.4 per 100,000 nationally), however this still reflects an increase of 32% over the past decade, amounting to 1,700 deaths by suicide in 2014.[v]

In consultation with a panel of national and state experts on suicide, public health, and prevention, The New York State Office of Mental Health Suicide Prevention Office (SPO) recently developed a comprehensive suicide prevention plan that addresses the problem at three levels:

1. Implementation of the *Zero Suicide* strategy for preventing suicide for individuals in health and behavioral health care settings;
2. A lifespan prevention approach to foster competent and caring communities; and
3. Suicide surveillance and data-informed suicide prevention.

This chapter provides a brief statistical summary of suicide in New York and nationally, followed by an overview of the Suicide Prevention Office strategic plan to prevent suicide in New York State. The full version of the SPO's Suicide Prevention Plan 2016-17 is available at https://www.omh.ny.gov/omhweb/resources/publications/suicde-prevention-plan.pdf

Early Childhood Initiatives

OMH has developed a number of initiatives that help establish supports for young children's social-emotional development across a wide range of settings. One such initiative is funding for Healthy Steps for Young Children, a program that embeds behavioral health professionals within primary care provider offices to screen children from birth to age five for developmental and behavioral concerns and when necessary, provide support to families and linkages to needed services. There are currently 19 sites statewide, which are estimated to engage 6,650 families across New York State over the next three years.

Additionally, programs such as ParentCorps are also increasing screening services throughout the State. ParentCorps is a culturally-informed, family-centered evidence based, preventive intervention designed to foster healthy development and school success among young children (ages three to six) living in low-income communities.

Through these efforts and others, such as Project TEACH (described above), OMH is better able to align and mobilize resources from various service systems to intervene early and make an important public health impact.

Promotion of Recovery and Resilience in Community Services

An integral component of effective treatment is a recovery-oriented approach to care that supports individuals' capacity to live at home and in their communities with all the needed services and supports. OMH continues to make significant efforts to provide individuals with mental illness the opportunity to participate as complete members of our communities and society as a whole. Efforts underway include:

Peer Workforce Expansion

Given the demand for more information on using peer staff, the OMH Office of Consumer Affairs has provided comprehensive in-person training in all New York State regions for both State and community providers. These trainings help agencies recruit, train, and support peer staff in a variety of program types and roles. They will continue through a series of webinars in 2015 and ongoing technical assistance for LGUs and providers as needed. Local governments, voluntary organizations, and other potential peer employers may also obtain resources on peer workforce development through a free federal resource called the Job Accommodation Network (JAN).

In addition to increasing the size of the peer workforce, New York State has a strong commitment to ensuring a qualified peer workforce that provides evidence-based practices. To ensure continued opportunities for peer services, OMH worked with peer leaders to develop a Peer Specialist Certification process which is currently accepting enrollees. The Academy of Peer Services is a free online training platform for individuals delivering peer support services in New York State. The Academy was developed through the collaboration of peer leaders and the Rutgers University School of Health Related Professions. Enrollment in the Academy can be done on the Academy of Peer Services website.

Family Peer and Youth Support Services

OMH funds and supports a variety of peer-run and peer-oriented services and programs, including peer specialists, family and parent advisors, and youth peer advocates, to help individuals on their journey towards recovery and family members who struggle to access supports and services for children and youth with social and behavioral challenges. In addition, OMH continues to promote the credentialing of Family Peer Advocates (FPAs) and is working with youth peer advocates on the development of a Youth Peer Advocate credential. The standardization of this credentialing process will help build and sustain the integration of peer services into the future.

New York Employment Services System

OMH has led the efforts designed to support competitive employment opportunities and outcomes for people with disabilities through a comprehensive job matching/employment supports coordination and data system known as the New York Employment Services System (NYESS). NYESS serves as a single point of access for all New Yorkers seeking employment and employment supports, regardless of an individual's abilities/disabilities and regardless of the State agency system from which they receive employment services/supports.

Preparing for and Serving our Aging Population

Based on its work with a recent round of partnership innovation projects, OMH has selected eight mental providers to develop community programs that identify adults age 55 or older whose independence or survival in the community is in jeopardy because of a mental health, substance use, or aging-related concern. To effectively serve the aging population, each *Partnership Innovation for Older Adults* program will:

- Create a local "triple partnership" of mental health, substance use disorder, and aging services providers;
- Include the local Office for the Aging as a member of the partnership with partnership responsibilities or as an organization with a key role in carrying out the program;
- Access behavioral health services to meet the needs of older adults in aging services programs who need them;
- Access home and community-based, non-medical, aging support services to meet the needs of older adults in behavioral health services programs who need them;
- Identify at-risk older adults in the community who are not connected to the service delivery system and those who encounter difficulties accessing needed services. Mobile outreach and off-site Services are to be used assess unmet needs for behavioral health and aging services – as well as unmet needs related to areas such as physical health, cognition, social isolation, self-neglect, abuse, housing, financial resources/benefits, and legal issues – and see that needed services are provided; and
- Utilize one or more technological innovations to better serve the target population and help the program and its staff innovatively address the unmet needs of the target population.

This new round of projects will continue to emphasize the necessity for integrated service delivery that has been characteristic of the previous health integration projects. Additional information about the partnership innovation projects can be accessed on the OMH website.

Accountability and Ensuring High Quality of Care

OMH maintains a strong emphasis on continuous quality improvement efforts, from a clinical and a systems perspective, through the use of data and information to measure outcomes and support the implementation of evidence-based treatments.

OMH Data Portals

The OMH data portals are designed to improve accountability and transparency in New York State government by allowing anyone to use OMH data to make more informed choices about services that best meet their needs and to assess the progress the agency is making toward improving public mental health care. An addition to the OMH menu of data reports is the County Capacity and Utilization Data Book, which is updated annually with the most recent Medicaid, licensing, and surveillance data including SPARCS. This tool's purpose is to help users identify the location and utilization patterns for these psychiatric services to further assist in planning improved service delivery.

Health Information Exchange

OMH is working with DOH to connect OMH providers to information hubs in their region of the State. These Regional Health Information Organizations (RHIOs) collect health record data from the healthcare providers in their area, and, with patient consent, allow this information to be shared securely with other providers. Both individuals and their providers, when securely connected to the health exchange will have complete, accurate, and private access to the information carefully gathered by each one of the specialists the individual has visited. Fewer mistakes will be made, fewer tests repeated, and money and time will be saved on administrative details. Most importantly, the individual and doctor will have more time together to discuss treatment options and recovery.

Center for Practice Innovations

Stemming from OMH's research efforts and the affiliation between OMH's New York State Psychiatric Institute and Columbia University, the Center for Practice Innovations (CPI) assists OMH in promoting the widespread availability of evidence-based practices to improve mental health services, ensuring accountability, and promoting recovery-oriented outcomes.

MyCHOIS (formerly MyPSYCKES)

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

E. Planning for Developmental Disability Services

The New York State Office for People With Developmental Disabilities (OPWDD) is undergoing a large-scale transformation, reflective of the desires and expectations of individuals with developmental disabilities and parents of children with disabilities. The goals embodied in OPWDD's system transformation are designed to ensure that each person is better understood, better served and ultimately experiences better outcomes and community participation to the greatest extent possible. Achieving such transformational goals will require coordination between local and state planning efforts. The following sections outline a variety of initiatives and partnerships designed to enhance quality and the overall experience for people seeking support and receiving services.

System Transformation

The Office for People With Developmental Disabilities has been engaged in a system-wide transformation, aimed at improving opportunities for individuals with developmental disabilities in the areas of employment, integrated living, and self-direction of services. These goals are captured in the Transformation Agreement between New York State OPWDD and the Centers for Medicare & Medicaid Services. OPWDD has made great strides in accomplishing many of these transformation goals and continues to work towards fully implementing the Transformation Agenda. In 2015 the Transformation Panel was established to bring together experts and stakeholders, including individuals with developmental disabilities, their families and provider agencies. The panel was charged with developing a clear vision and strategy for implementing the transformation agenda.

Transformation Panel

OPWDD established the Transformation Panel to consider the future of OPWDD services and address essential questions facing the agency. The panel brought together a diverse group of stakeholders and involved the public through a series of forums held across New York State to promote meaningful dialogue, discussion and input. Their goal was to find ways to make the benefits of the transformation available to each person served through the OPWDD system by providing greater flexibility, more options, and an increased level of personal choice.

The Transformation Panel issued sixty-one recommendations touching on nearly every aspect of the service system, from expanding residential services to streamlining regulations. The purpose of the recommendations was to help transform OPWDD's system of supports to be more responsive, inclusive, and person-centered while building on the positive aspects of the existing system. The feedback of OPWDD's stakeholders was incorporated in the development of the Transformation Panel's recommendations and with the guidance of the Transformation Panel, OPWDD released a report entitled *Raising Expectations, Changing Lives*. This report was the culmination of the findings of this statewide panel, which worked to identify the challenges OPWDD needed to address, and the opportunities that could be seized upon to help people live the fullest lives possible in the community, as citizens, neighbors and friends.

Enhancing Service Design and Delivery

Coordinated Assessment System

The Coordinated Assessment System (CAS) is a comprehensive needs assessment tool, designed to evaluate the strengths and needs of individuals with developmental disabilities, and inform the development of person-centered support plans. OPWDD began assessing people with the CAS in March 2016. People receiving assessments, their families, and providers will use the information from the CAS to help develop their support plan to match his/her interests, goals and needs. Individual choice, among available options, will continue to be at the heart of service planning. The CAS is an essential part of the changes OPWDD is making to better support people receiving services.

New York Systemic, Therapeutic, Assessment, Respite and Treatment (NY START) Services

OPWDD partnered with leaders at the Center for START Services in July 2012 to develop a START model for New York State. NY START is a community-based program that provides crisis prevention and response services to children and adults who present with complex behavioral and mental health needs. START supports people to live successfully in the community by offering training, consultation, therapeutic services, and technical assistance to enhance the ability of the community to support eligible people, and focuses on establishing integrated services with providers. The START Model has been in operation in the Western/Finger Lakes region and the Capital District/Taconic/Hudson Valley region for approximately two years and has recently expanded to NYC. In October 2016, the NYC START program began to take referrals from OPWDD's regional office. A vendor for a START team in Long Island has been identified and staff hiring and training will be initiated in the

first half of 2017. OPWDD plans to have operational START teams across the entire state delivering all of the elements of the national model in each OPWDD region.

Enhancing Self-Direction

Self-direction offers an opportunity for people to have a high level of control over how, when, and by whom their supports are delivered. Individual choice for a self-directed service delivery model has grown considerably over the last several years. In response to stakeholder input, OPWDD has identified areas where improvements can be made to the self-direction model to focus on increased capacity building for the broker and fiscal intermediary (FI) functions, and to increase access and education for a greater understanding of options available within the system.

To increase understanding of self-direction options, OPWDD has focused on the development of enhanced training courses for self-direction support staff, updates and improvement to the website content related to self-direction, development of guidance regarding live-in caregivers, and the initiation of quarterly conferences with agencies who provide self-direction support.

Employment

OPWDD remains committed to helping people with developmental disabilities find work in community-based settings. Increasing integrated employment opportunities for people who receive OPWDD services is a critical strategic goal for the agency identified through the Transformation Panel's recommendations. Five major areas have been identified to reach these employment goals including developing flexible day service models, more volunteer opportunities, improving transportation, workshop transformation, and engaging employers to hire people with disabilities.

For people who are currently employed through sheltered workshops, OPWDD is developing strategies to ensure continuity of employment by assisting workshop providers as they transition to offering other services. OPWDD spent nearly three years engaging individuals, families, and providers regarding the conversion of sheltered workshops to integrated, community-based businesses. OPWDD issued guidance to workshop providers to ensure that person-centered planning is incorporated into this transition from workshops to other services. OPWDD's *Work Settings Report* lays out a comprehensive plan to assist individuals currently working in sheltered workshop programs, as the programs transition to integrated work settings, (consistent with federal requirements). Additionally, the report provides a plan to meet the needs and goals of people who choose not to transition to community-based integrated work settings.

Residential Opportunities

Housing options throughout the OPWDD system range from rental support for an independent apartment, to group homes specialized in around-the-clock supervision. OPWDD is working to advance its housing strategies to better respond to demand and changing models of support that can be more tailored to the individual. It is OPWDD's priority that individuals are served in the most integrated setting, and are able to live with the highest degree of independence possible.

OPWDD has made major strides in reducing the number of individuals living in institutional settings. These efforts continue through the closure of developmental centers (DCs) and the conversion of Intermediate Care Facilities (ICFs) to community-based models of support. Residents in these institutionally-modeled facilities are offered the opportunity to live in the most community integrated setting possible, and be served in the community with appropriate clinical support to ensure their health and safety.

During 2017, OPWDD will continue to define how its largest ICFs will be supported to downsize and close, so that all residents of ICFs can be supported in individualized ways in community settings. To help support this transition, OPWDD established a funding policy and guidance to assist nonprofit providers to convert ICFs into residential models which offer greater community access and integration. This plan does not apply to Children's Residential Projects which serve to prevent children from out of state placements and other less suitable institutional placements.

Home and Community Based Services (HCBS) Settings Transition Plan

OPWDD's Home and Community Based Services (HCBS) Settings Transition Plan is part of the broader NYS transition plan, required by CMS, that reinforces the values of integration, personal choice, and independence throughout OPWDD's waiver supports and services.

The plan focuses on how OPWDD assesses the quality of our service system and ensures that each person is afforded full rights and options for community life. This plan must be implemented no later than October 1, 2018. To ensure proper implementation, OPWDD is taking the following actions:

- Working with stakeholders, including people who receive services, to capture their perspectives and insights;
- Reviewing regulations and policies to identify where changes are needed;
- Changing regulations, such as adopting person-centered planning requirements;
- Creating assessment tools to determine gaps and monitor our standards in certified settings; and
- Designing communication and training tools including a web-based HCBS Settings Toolkit and quality improvement tools for providers.

The OPWDD HCBS Settings Transition Plan activities will help to ensure that all people enjoy the highest quality of life possible based on their personal needs, goals and preferences. The Plan will help to sustain and improve the entire system of community-based services and supports.
Enhancements to service design and delivery will:

- Help people thrive in communities and live the fullest life possible;
- Increase independence, self-determination, and choice for all people supported;
- Provide more flexibility in supports to people in the community to do the things they want to do, in the places they want to do them, and live and work where they want to;
- Enable service providers to better respond to changing needs and preferences;
- Support goal achievement and personal outcomes; and
- Instill a greater level of quality and accountability.

Strengthening the Direct Support Workforce

The stability of the Direct Support Professionals (DSP) in the OPWDD workforce is critical to the success of the system transformation. Support for DSPs and the important role they play in supporting people is an essential element in quality outcomes. OPWDD is investing in the workforce to ensure staff have the tools and support they need to excel at the important work they do supporting individuals with developmental disabilities.

<u>Positive Relationships Offer More Opportunities to Everyone (PROMOTE)</u>

OPWDD developed a new curriculum called PROMOTE (Positive Relationships Offer More Opportunities to Everyone) which trains DSP staff to emphasize positive relationships and strategies to support people with developmental disabilities; and offers the opportunity for increasing skills needed for success through this training for employees and supervisors.

<u>Direct Support Professional Core Competencies</u>

To advance the skills and abilities of direct support professionals, the New York State Direct Support Professional (DSP) Core Competencies were created. The core competencies are areas of focus for delivering high quality services, are based on nationally validated community support skill standards, and center on the belief that knowledge, skills and ethics are the foundation of quality. Staff supervisors are being provided training and other tools to ensure all DSPs are proficient in the core competency areas.

Direct Support Professional (DSP) Credentialing Program

In January 2016, OPWDD presented a study of service providers and a model for a DSP Credential to the NYS Legislature. The report explained how a DSP credential would help stabilize the workforce, professionalize the work, close the wage gap, and improve the skills and abilities of the workforce. In August 2016, the NYS Credential Stakeholder Advisory Group was reconvened to strategize on how to advance a credential program in New York the full report and its findings are available: Direct Support Professional Credentialing Report

CHAPTER 3: County Plan Guidance and Forms

The mental hygiene local services planning process is an ongoing, data-driven process that engages providers, individuals with disabilities, and other stakeholders in identifying local needs and developing strategies to address those needs. As noted in Chapter 1 of these guidelines, Mental Hygiene Law requires each LGU to annually develop a local services plan that establishes long-range goals and objectives consistent with statewide goals and objectives. The law also requires that each agency's statewide comprehensive plan be formulated from the LGU comprehensive plans. In addition to meeting statutory mandates, LGUs are required to comply with other requirements that support statewide planning efforts. This chapter provides guidance to assist counties in meeting those requirements.

All plans must be completed, certified, and submitted in CPS by Friday, June 1, 2018.
Questions, problems or concerns regarding planning forms or the County Planning System (CPS) may be directed to oasasplanning@oasas.ny.gov.

A. Mental Hygiene Goals and Objectives Form

Mental Hygiene Law, § 41.16 "Local planning; state and local responsibilities" states that "each local governmental unit shall: establish long range goals and objectives consistent with statewide goals and objectives." The Goals and Objectives Form allows LGUs to state their long-term goals and shorter term objectives based on the local needs identified through the planning process and with respect to the State goals and objectives of each Mental Hygiene agency.

The information input in the 2018 Goals and Objectives Form will be brought forward into the 2019 Form. LGUs can use the 2018 information as starting point for the 2019 but should ensure that each section contains relevant, up-to-date responses.

Instructions for completing the Goals and Objectives Form

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

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

a. Indicate how the level of unmet **mental health service needs**, in general, has changed over the past year:
○ Improved ○ Stayed the Same ○ Worsened
Please Explain: [ ]

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

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

The second section of the form includes; goals based on local need; goals based on state initiatives and goals based in other areas. The form allows counties to identify forward looking, change-oriented goals that respond to and are based on local needs and are consistent with the goals of the state mental hygiene agencies. County needs and goals also inform the statewide comprehensive planning efforts of the three state agencies and help to shape policy, programming, and funding decisions. For county needs assessments, goals and objectives to be most effective, they need to be clear, focused and achievable. The following instructions promote a convention for developing and writing effective goal statements and actionable objectives based on needs, state or regional initiatives or other relevant areas.

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

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

- **For each need identified you will have the opportunity to outline related goals and objectives, or to discuss the need more generally if there are no related goals or objectives.**

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

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

(After a need issue category is selected, related follow-up questions will display below the table)

Background Information – (Required) The Background Information box is a free-text box for LGUs to provide any additional information or more details related to the need and the Goal, such as:

- Data sources used to identify need (e.g., hospital admission data),
- Assessment activities used to indicate need or formulate goal (e.g., community forum), and
- Narrative describing importance of goal.

This form will allow attachments, so in the Background Information box you could reference an attached document for more information.

BACKGROUND INFORMATION: [ ]

[FOR EACH ISSUE CATEGORY CHECKED ABOVE] Do you have a Goal related to addressing this need?
○ Yes ○ No

Goal Statement – The following section will prompt for a goal statement for each Issue Category indicated as high need. (*If you do NOT have a goal statement for the selected need category: Indicate No when prompted and enter MANDATORY explanation of challenges).* The Goal Statement should be a specific, clear, and succinct statement of a desired outcome. It should be focused on a change that is tangible, achievable and within the control of the LGU. Avoid vague statements that focus on "maintaining" or "continuing" activity that simply maintains the status quo. The following are examples of possible Goal Statements:

Example #1: Increase access to affordable housing with support services for people with behavioral health disorders.

Example #2: Build and strengthen connections between children's primary care and mental health provider systems.

If "No", Please discuss any challenges that have precluded the development of a goal (e.g., external barriers): [ ] **REQUIRED**

If "Yes", state Goal: [ ]

Change Over Past 12 Months (Optional) - This optional, free-text box allows LGUs to describe any change in the need driving the goal or any progress made towards the goal in the last year. Where possible, include specific measurable accomplishments and milestones achieved. You may also want to identify barriers to achieving stated goals and objectives and describe the rationale for any changes made to the goal statement or associated strategies.

CHANGE OVER PAST 12 MONTHS: [ ] Optional

Priority Goal? - Not all goals are of equal value. When the state agencies analyze individual county goals, or objectives on a regional or statewide basis, there has to be a way to provide relative weight to them. After all goals and objectives have been entered onto the form and you are ready to certify the form for submission, you will need to indicate five priority goals. You do not have to rank priorities by disability. If the plan contains fewer than six goals, all goals will be priority. You will not be able to certify this form until you have indicated your five priority goals. Please identify five goals from all goals listed in questions 2, 3, and 4 as "Priority Goals"- those goals which are the most significant in your county.

PRIORITY GOAL? Only can select "Yes" for five goals ○ Yes ○ No

Objective Statement - Objective Statements should describe a shorter-term action the LGU will take to achieve the longer-term goal. Each goal should have at least one objective. You may have multiple objectives for each

goal. The objective should identify the approach to be taken to help achieve the desired outcome. It answers the question, "How will the goal be achieved?"

Example #1: Reduce the number of people waiting for acceptance to supported housing by 25 percent in 2018

Example #2: School-based clinic satellites will be established in the three largest districts in the county.

OBJECTIVE: [ ] **At least one is required for each goal; add more as necessary**

+ Add an additional objective

Applicable State Agency – You will already have selected the applicable state agency when you select the need category for the linked goal. For *each objective* please indicate the state mental hygiene agency to which the objective pertains.

☐ OASAS
☐ OMH
☐ OPWDD

3. Goals Based On State Initiatives –

The next section includes goals that are based on behavioral health state initiatives. Please select any of the State Initiatives below for which your LGU has a related goal. For each State Initiative identified you will be asked if you have a goal. If you DO have a goal, you will be asked to state your related goals and objectives. *If you DO NOT have a goal, you will be REQUIRED to explain.* **You will be limited to one goal for each state initiative category but will have the option for multiple objectives.**

State Initiative	Applicable State Agenc(ies)		
	OASAS	OMH	OPWDD
a) Medicaid Redesign	☐	☐	☐
a) Delivery System Reform Incentive Payment (DSRIP) Program	☐	☐	☐
b) Regional Planning Consortiums (RPCs)	☐	☐	☐
c) NYS Department of Health Prevention Agenda	☐	☐	☐

(After state initiative category is selected background information, goal text box, change over last 12 months and priority goal? will display)

BACKGROUND INFORMATION: [ ] **REQUIRED**
GOAL: [ ]
No? **Explain** **REQUIRED**
CHANGE OVER PAST 12 MONTHS: [ ] **Optional**
PRIORITY GOAL: **Only can select "Yes" for five goals** ○ Yes ○ No

OBJECTIVE: [ ]
APPLICABLE STATE AGENCY:
☐ OASAS
☐ OMH
☐ OPWDD

+ Add an additional objective

4. Other Goals –

This section should include any additional Mental Hygiene goals for your LGU not addressed in questions 2 or 3 above. Optional

+ Add a Goal
GOAL:
BACKGROUND INFORMATION: REQUIRED
CHANGE OVER PAST 12 MONTHS: Optional
PRIORITY GOAL: Only can select "Yes" for five goals ○ Yes ○ No

OBJECTIVE:
+ Add an additional objective

Thank you for participating in the 2019 Mental Hygiene Local Services Planning Process by completing this survey. Any technical questions regarding the County Planning System please contact the OASAS by email at oasasplanning@oasas.ny.gov.

(end of survey)

Glossary of Terms Used on this Form

Cross-Systems Need Definitions by Disability
For some definitions please refer directly to the linked content for explanations.

Housing:

OASAS: OASAS-funded permanent supportive housing services that include one and two-bedroom apartments with support services necessary to assist families in gaining stability, daily life skills and marketable work skills, with supportive services to help families maintain physical and emotional health, assist with educational and employment opportunities, and sustain healthy relationships and quality of life. May also include non-OASAS funded short-term transitional housing options for individuals leaving substance use disorder treatment.

OMH: Residential services are provided to maximize access to housing opportunities, particularly for persons with histories of repeated psychiatric hospitalizations, homelessness, involvement with the criminal justice system, and co-occurring substance abuse. They are also provided to persons leaving adult homes and to persons receiving court-ordered Assisted Outpatient Treatment. Residential services are also offered to children to provide short-term residential assessment, treatment, and aftercare planning.

Residential services include support programs (community residence single room occupancy (CR-SRO), support apartment, support congregate), treatment programs (community residence for children and youth, treatment apartment, treatment congregate) and unlicensed housing (supported housing, supported/single room occupancy (SP-SRO)). Visit OMH's Mental Health Program Directory for a full description of each housing type.

Transportation:

OASAS: The ability of individuals involved in the substance use disorder service system to get to SUD treatment services, as well as other needed health care services, school, work, training, or other destinations necessary to support their treatment and recovery.

OPWDD: The ability of individuals involved in the OPWDD service system to get to supports and services, as well as other needed health care services, school, work, training, or other destinations necessary to enjoying a full life.

Crisis Services:

OASAS: OASAS-certified chemical dependence withdrawal and stabilization services (Part 816), including medically managed withdrawal, medically supervised withdrawal (inpatient or outpatient), and medically monitored withdrawal services. May also include non-OASAS certified hospital-based detoxification services.

OMH: Residential and non-residential services to reduce acute symptoms and restore individuals to pre-crisis levels of functioning. These services include crisis intervention, crisis residence, crisis/respite beds, and Home-Based Crisis Intervention (HBCI). Visit OMH's Mental Health Program Directory for a full description of each crisis service type.

OPWDD: http://www.opwdd.ny.gov/ny-start/home

Workforce Recruitment and Retention (service system):

OASAS: The ability of OASAS-certified and funded prevention and treatment programs to effectively provide high quality, qualified, trained, and culturally competent services to individuals suffering from a substance use disorder and their families. This does not refer to recruiting and retaining LGU staff or vocational services for clients.

OMH: The ability of mental health program programs to staff appropriately to offer high quality, culturally competent services that comply with regulatory and payment requirements.

OPWDD: The ability of OPWDD and provider agencies to offer high quality, qualified, trained, and culturally competent services to individuals with developmental disabilities and their families.

Employment/ Job Opportunities (clients):

OASAS: Vocational services and assistance available and accessible for substance use disorder treatment clients.

OMH: Vocational services and integrated, competitive employment opportunities for individuals with mental illness.

OPWDD: http://www.opwdd.ny.gov/opwdd_services_supports/employment_for_people_with_disabilities

Prevention Services:

OASAS: Can be either:
a) OASAS-funded primary prevention services, which may include service approaches such as: prevention education, environmental strategies, community capacity building, positive alternatives, and information awareness; or other prevention services such as prevention counseling and early intervention services; or
b) A public health approach to preventing and reducing substance use and related consequences, as well as Mental, Emotional and Behavioral (MEB) disorders, which focuses on population-wide prevention of health problems and promotion of healthy living.

OMH: Primary, secondary, or tertiary prevention strategies; including but not limited to the interventions and strategies identified under the NYS Department of Health Prevention Agenda: https://www.health.ny.gov/prevention/prevention_agenda/2013-2017/plan/mhsa/ebi/

Inpatient Treatment Services:

OASAS: OASAS-certified chemical dependence inpatient rehabilitation services (Part 818) and chemical dependence residential rehabilitation services for youth (Part 817).

OMH: Inpatient services provide stabilization and intensive treatment and rehabilitation with 24-hour care in a controlled environment. They are the programs of choice only when the required services and supports cannot be delivered in community settings. Inpatient service settings include State Psychiatric Centers (PCs), psychiatric unit(s) of general hospitals (Article 28 hospitals), private psychiatric hospitals (Article 31 hospitals), or residential treatment facilities (RTFs) for children and youth. Visit OMH's Mental Health Program Directory for a full description of each inpatient service setting.

Recovery and Support Services:

OASAS Services that help to support recovery from a substance use disorder that are not tied to housing and that are in addition to transportation. May include educational and vocational services, peer support services, and services provided by OASAS Recovery Centers or clubhouses

OMH: This category refers to recovery, recreation, self-help, advocacy, outreach, and general support services. This may include adult and children's behavioral health home and community based services.

Reducing Stigma:

OASAS: Stigma refers to a cluster of negative attitudes and beliefs that motivate the general public to fear, reject, avoid, and discriminate against people with substance use disorders. Needs in this category include efforts to educate and raise awareness about addiction and to reduce the stigma associated with this disease.

OMH: OMH recognizes that stigma has no place in our society today that presenting the facts about mental illness can change attitudes. Needs in this category include conducting educational programs and services dedicated to eliminating the stigma attached to mental illness and reducing the fear and cultural obstructions that lead some people to hide their mental illness or avoid seeking help all together.

Other: Any need not mentioned in the above categories.

SUD-Specific Need Definitions

SUD Outpatient Treatment Services: OASAS-certified treatment programs that provide outpatient services that assist individuals suffering from a substance use disorder and their family members and/or significant others (Part 822). May also provide outpatient rehabilitation services designed to assist individuals with more chronic conditions. May also include outpatient chemical dependence services for youth (Part 823).

SUD Residential Treatment Services: OASAS-certified treatment programs that provide 24/7 structured treatment/recovery services in a residential setting. Programs may provide residential stabilization, rehabilitation, and/or reintegration services in congregate or scatter-site settings (Part 820). May also include intensive residential rehabilitation, community residential, and supportive living services (Part 819).

Heroin and Opioid Programs and Services: Can refer specifically to a) OASAS-certified treatment programs that are approved to administer methadone or other approved medications to treat opioid dependency (OTP programs), including opioid detoxification, opioid medical maintenance, and opioid taper services; or more generally to b) any other needs related to the heroin and opioid crisis besides OTP services such as overdose prevention or community opioid abuse coalitions.

Coordination/Integration with Other Systems for SUD clients: The need to coordinate services with other systems that individuals with a substance use disorder may be involved with, including mental health, developmental disabilities, public health, social services, criminal justice, education, etc. Also refers to

engagement in regional and statewide initiatives such as DSRIP, PPS, PHIP, Prevention Agenda, RPC, etc. In addition, can refer to coordination between SUD service providers.

Mental Health Services:

Mental Health Clinic: Clinic treatment programs provide treatment designed to minimize the symptoms and adverse effects of illness, maximize wellness, and promote recovery. Clinic treatment programs for adults provide the following services: outreach, initial assessment (including health screening), psychiatric assessment, crisis intervention, injectable psychotropic medication administration, psychotropic medication treatment, psychotherapy services, family/collateral psychotherapy, group psychotherapy, and complex care management. The following optional services may also be provided: developmental testing, psychological testing, health physicals, health monitoring, and psychiatric consultation.

Clinic treatment programs for children provide the following services: outreach, initial assessment (including health screening), psychiatric assessment, crisis intervention, psychotropic medication treatment, psychotherapy services, family/collateral psychotherapy, group psychotherapy, and complex care management. The following optional services may also be provided: developmental testing, psychological testing, health physicals, health monitoring, psychiatric consultation, and injectable psychotropic medication administration.

Other Mental Health Outpatient Services (non-clinic): Non-clinic outpatient services provide treatment and rehabilitation in settings such as partial hospital programs, day treatment, Assertive Community Treatment (ACT), and Personalized Recovery-Oriented Services (PROS). Visit OMH's Mental Health Program Directory for a full description of each outpatient service type.

Mental Health Care Coordination: Services include Health Home Care Management, Health Home Non-Medicaid Care Management and Non-Medicaid Care Coordination. Visit OMH's Mental Health Program Directory for a full description of each care coordination type.

Developmental Disability Services:

For some definitions please refer directly to the linked content for explanations.

Developmental Disability Clinical Services:
http://www.opwdd.ny.gov/opwdd_resources/information_for_clinicians

Developmental Disability Children Services: http://www.opwdd.ny.gov/opwdd_services_supports/children

Developmental Disability Adult Services: Refers to the supports and services available to adults with developmental disabilities. This includes OPWDD's ability to support aging adults live a high quality life.

Developmental Disability Student/Transition Services:
http://www.opwdd.ny.gov/opwdd_services_supports/children/transition-students-developmental-disabilities

Developmental Disability Respite Services:
http://www.opwdd.ny.gov/opwdd_services_supports/supports_for_independent_and_family_living/respite_services

Developmental Disability Family Supports:
http://www.opwdd.ny.gov/opwdd_services_supports/supports_for_independent_and_family_living

Developmental Disability Self-Directed Services: http://www.opwdd.ny.gov/selfdirection

Autism Services: http://www.opwdd.ny.gov/opwdd_community_connections/autism_platform

Developmental Disability Person Centered Planning:
http://www.opwdd.ny.gov/opwdd_services_supports/person_centered_planning

Developmental Disability Residential Services:
http://www.opwdd.ny.gov/opwdd_services_supports/residential_opportunities

Developmental Disability Service Coordination:
http://www.opwdd.ny.gov/opwdd_services_supports/service_coordination

B. 2019 Office of Mental Health Agency Planning Survey

1. To the extent known and available, please rate the level of difficulty faced by licensed mental health (Article 31) clinic treatment providers in your county for recruiting and retaining the following professional titles. Rank 1 as not difficult at all, and 5 as very difficult. This judgment should be made for clinic programs county-wide, when there is more than one clinic. If the title does not apply, or you are unable to make a determination, select "n/a". This should only apply for staff positions that are available to fill; not unfunded positions.

	Recruitment	Retention	Please indicate the reasons for difficulty, when known (e.g., no available workers, salary competitiveness, etc.), along with any other detail that may be useful to understand the issue.
Psychiatrist			
Physician (non-psychiatrist)			
Psychologist (PhD/PsyD)			
Nurse Practitioner			
RN/LPN (non-NP)			
Physician Assistant			
LMSW			
LCSW			
Licensed Mental Health Practitioner (LMHC/LMFT/LCAT/Lpsy)			
Peer specialist			
Family peer advocate			

2. Please list any professions or titles not listed above, for which *any* mental health providers in your county face difficulty recruiting or retaining. _____

3. Please indicate how many, if any, programs in your county provided input specific to this questions set. _____

Questions regarding this survey item should be directed to Jeremy Darman jeremy.darman@omh.ny.gov.

(end of survey)

C. Community Services Board Roster (New York City)

Community Services Board Chair:

Name: _____ Name: _____

☐ Physician ☐ Psychologist ☐ Physician ☐ Psychologist

Represents: _____ Represents: _____

NYC Borough: _____ NYC Borough: _____

Term Expires: Month _____ Year _____ Term Expires: Month _____ Year _____

Email Address: _____ Email Address: _____

Name: _____ Name: _____

☐ Physician ☐ Psychologist ☐ Physician ☐ Psychologist

Represents: _____ Represents: _____

NYC Borough: _____ NYC Borough: _____

Term Expires: Month _____ Year _____ Term Expires: Month _____ Year _____

Email Address: _____ Email Address: _____

• •
• •
• •

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

(End of survey)

D. Community Services Board Roster (Counties Outside NYC)

LGU: _____

Community Services Board Chair

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

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

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

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

Note: There must be 15 board members (counties under 100,000 population may opt for a 9-member board). Indicate if member is a licensed physician or certified psychologist. Under item labeled "Represents", enter the name of the member's organization or enter "Consumer", "Family", "Public Representative", etc. to indicate the perspective the member brings to the board. Members shall serve four-year staggered terms.

(End of survey)

E. Alcoholism and Substance Abuse Subcommittee Roster

Subcommittee Chair

Name: ______________________

CSB Member: ☐ Yes ☐ No

Represents: ______________________

Email Address: ______________________

Name: ______________________

CSB Member: ☐ Yes ☐ No

Represents: ______________________

Email Address: ______________________

Name: ______________________

CSB Member: ☐ Yes ☐ No

Represents: ______________________

Email Address: ______________________

Name: ______________________

CSB Member: ☐ Yes ☐ No

Represents: ______________________

Email Address: ______________________

Name: ______________________

CSB Member: ☐ Yes ☐ No

Represents: ______________________

Email Address: ______________________

Name: ______________________

CSB Member: ☐ Yes ☐ No

Represents: ______________________

Email Address: ______________________

Name: ______________________

CSB Member: ☐ Yes ☐ No

Represents: ______________________

Email Address: ______________________

Name: ______________________

CSB Member: ☐ Yes ☐ No

Represents: ______________________

Email Address: ______________________

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

F. Mental Health Subcommittee Roster

Subcommittee Chair

Name: ______________________

CSB Member: ☐ Yes ☐ No

Represents: ______________________

Email Address: ______________________

Name: ______________________

CSB Member: ☐ Yes ☐ No

Represents: ______________________

Email Address: ______________________

Name: ______________________

CSB Member: ☐ Yes ☐ No

Represents: ______________________

Email Address: ______________________

Name: ______________________

CSB Member: ☐ Yes ☐ No

Represents: ______________________

Email Address: ______________________

Name: ______________________

CSB Member: ☐ Yes ☐ No

Represents: ______________________

Email Address: ______________________

Name: ______________________

CSB Member: ☐ Yes ☐ No

Represents: ______________________

Email Address: ______________________

Name: ______________________

CSB Member: ☐ Yes ☐ No

Represents: ______________________

Email Address: ______________________

Name: ______________________

CSB Member: ☐ Yes ☐ No

Represents: ______________________

Email Address: ______________________

Name: ______________________

CSB Member: ☐ Yes ☐ No

Represents: ______________________

Email Address: ______________________

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

G. Developmental Disabilities Subcommittee Roster

Subcommittee Chair

Name: ______________________

CSB Member: ☐ Yes ☐ No

Represents: ______________________

Email Address: ______________________

Name: ______________________

CSB Member: ☐ Yes ☐ No

Represents: ______________________

Email Address: ______________________

Name: ______________________

CSB Member: ☐ Yes ☐ No

Represents: ______________________

Email Address: ______________________

Name: ______________________

CSB Member: ☐ Yes ☐ No

Represents: ______________________

Email Address: ______________________

Name: ______________________

CSB Member: ☐ Yes ☐ No

Represents: ______________________

Email Address: ______________________

Name: ______________________

CSB Member: ☐ Yes ☐ No

Represents: ______________________

Email Address: ______________________

Name: ______________________

CSB Member: ☐ Yes ☐ No

Represents: ______________________

Email Address: ______________________

Name: ______________________

CSB Member: ☐ Yes ☐ No

Represents: ______________________

Email Address: ______________________

Name: ______________________

CSB Member: ☐ Yes ☐ No

Represents: ______________________

Email Address: ______________________

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

H. LGU Emergency Manager Contact Information

Emergency Manager Contact information is necessary for OASAS to communicate directly with each LGU and OASAS-certified treatment programs to ensure proper planning and preparedness during emergency situations. A rapid and coordinated response to an emergency is necessary to ensure the safety of staff and patients and continuity of care. The information entered here will be maintained in CPS until it can be incorporated into the OASAS Provider Directory System (PDS) where other program contact information is maintained.

We are asking this survey to be completed by **Friday, June 1, 2018**. All questions regarding this survey should be directed to Kevin Doherty, OASAS Emergency Manager, at (518) 485-1983, or at Kevin.Doherty@oasas.ny.gov.

First Name:

Last Name:

Job Title:

Email Address:

Main Work Phone:

Desk Work Phone:

Home Phone:

Mobile Phone:

NOTE: To ensure privacy, home and mobile phone numbers will not be displayed in CPS output reports.

(End of survey)

I. Local Services Planning Assurance Form

LGU: _____

Pursuant to Article 41 of the Mental Hygiene Law, we assure and certify that:

Representatives of facilities of the offices of the department; directors of district developmental services offices; directors of hospital-based mental health services; directors of community mental health centers, voluntary agencies; persons and families who receive services and advocates; other providers of services have been formally invited to participate in, and provide information for, the local planning process relative to the development of the Local Services Plan;

The Community Services Board and the Subcommittees for Alcoholism and Substance Abuse, Mental Health, and Developmental Disabilities have provided advice to the Director of Community Services and have participated in the development of the Local Services Plan. The full Board and the Subcommittees have had an opportunity to review and comment on the contents of the plan and have received the completed document. Any disputes which may have arisen, as part of the local planning process regarding elements of the plan, have been or will be addressed in accordance with procedures outlined in Mental Hygiene Law Section 41.16(c);

The Community Services Board and the Subcommittees for Alcoholism and Substance Abuse, Mental Health, and Developmental Disabilities meet regularly during the year, and the Board has established bylaws for its operation, has defined the number of officers and members that will comprise a quorum, and has membership which is broadly representative of the age, sex, race, and other ethnic characteristics of the area served. The Board has established procedures to ensure that all meetings are conducted in accordance with the Open Meetings Law, which requires that meetings of public bodies be open to the general public, that advance public notice of meetings be given, and that minutes be taken of all meetings and be available to the public.

OASAS, OMH and OPWDD accept the certified 2019 Local Services Planning Assurance form in the Online County Planning System as the official LGU assurance that the above conditions have been met for the 2019 local services planning process.

Thank you for participating in the 2019 Mental Hygiene Local Services Planning Process by completing this survey. Any technical questions regarding the online County Planning System, please contact the OASAS Planning Unit by email at oasasplanning@oasas.ny.gov.

CHAPTER 4: OASAS Provider Plan Guidance and Forms

The local services planning process for addiction services relies on the partnership between OASAS, the LGUs, and OASAS-funded and certified providers. The involvement of providers and other stakeholders in the local planning process is necessary to ensure that community needs are adequately identified, prioritized, and addressed in the most effective and efficient way.

Providers are expected to participate in the local services planning process and to comply with these plan guidelines. Each provider must have at least one person with access to the County Planning System (CPS) to complete the required planning forms that help to support various OASAS initiatives. Please refer to Chapter One of these guidelines for additional information about CPS and the appropriate user roles for provider staff.

This year, providers are once again being asked to complete a limited number of planning surveys that provide OASAS with important information in support of a variety of programming, planning, and administrative projects. Some surveys are repeated to measure changes over time, while other surveys are new. In every case, the information being requested is not collected through existing data reporting systems. Some surveys are to be completed at the provider level on behalf of the entire agency, while other surveys are to be completed at the program level. In all cases, the provider should make sure that the surveys are completed by staff able to provide accurate and reliable information, or who can coordinate with appropriate staff within the agency to obtain the information.

All provider surveys must be completed in CPS no later than **Monday, April 2, 2018**. Each survey includes the name and contact information of the OASAS staff person responsible for that survey and who can answer any questions you have about it. Each survey in CPS also contains a link back to the relevant section of the plan guidelines associated with that survey.

Each of the following surveys includes a brief description of its purpose and the intended use of the data collected. All questions included in the survey (including skip patterns and follow-up questions built into the CPS version) and definitions of certain terms used in the survey are shown.

A. Health Coordination Survey (Treatment Providers)

Under New York State regulations, providers certified under the following parts are required to "have a qualified individual designated as the Health Coordinator who will ensure the provision of education, risk reduction, counseling and referral services to all patients regarding HIV and AIDS, tuberculosis, hepatitis, sexually transmitted diseases, and other communicable diseases":

- Chemical Dependence Residential Rehabilitation Services for Youth (Part 817)
- Chemical Dependence Inpatient Rehabilitation Services (Part 818)
- Chemical Dependence Residential Services (Part 819)
- Residential Services (Part 820)
- Non-Medically Supervised Chemical Dependence Outpatient Services (Part 821)
- Chemical Dependence Outpatient and Opioid Treatment Programs (Part 822)

Regulatory requirements regarding Health Coordinators and comprehensive treatment plans are defined for each chemical dependence treatment service category in the Official Compilation of the Codes, Rules and Regulations of the State of New York. For additional information, please refer to the applicable regulations located on the OASAS Website.

The **Health Coordination Survey** documents compliance with OASAS regulations and, for those programs that are funded by OASAS, additionally documents requirements of the Federal Substance Abuse Prevention and Treatment (SAPT) Block Grant. Early HIV Intervention Services (EIS), which under the SAPT Block Grant must be provided on site of chemical dependence treatment, are defined as: pre- and post-test counseling for HIV, the actual testing of individuals for the presence of HIV and testing to determine the extent of the deficiency in the immune system, and the provision of therapeutic measures to address an individual's HIV status. OASAS has determined that Health Coordinators and OTP comprehensive treatment planning provide EIS.

All questions on this form should be answered as they pertain to each program operated by this agency. The responses to this survey should be coordinated to ensure accuracy of responses across all programs within the agency. We are asking that the survey be completed by **Monday, April 2, 2018**. Any questions related to this survey should be directed to Matt Kawola by phone at 518-457-6129, or by e-mail at Matt.Kawola@oasas.ny.gov.

1. What is the overall average fringe benefit rate paid to employees by this agency? This number must be entered in number format as a percentage of salary, without the percent sign (example: 20.0).

   ☐

2. How are **health coordination** services provided to patients in each program operated by your agency? (check all that apply)

	PRU	Program Name	Paid Staff	In-kind Services	Contracted Services
a)	PRU #1	Program Name #1	☐	☐	☐
b)	PRU #2	Program Name #2	☐	☐	☐
c)	PRU #3	Program Name #3	☐	☐	☐
d)	PRU #4	Program Name #4	☐	☐	☐

3. Please provide the following information for each PRU where those paid staff and in-kind services are provided. If multiple individuals provide these services at a single program, provide the total hours worked and the hourly pay rate for each individual. For hourly pay rate, use number format without a dollar sign (example: 35.00).

	Health Coordinator #1	Health Coordinator #2

	PRU	Program Name	Services Provided On-site	Services Provided Off-site	Hours/Week Worked as a Health Coordinator	Hourly Rate (dollars)	Services Provided On-site	Services Provided Off-site	Hours/Week Worked as a Health Coordinator	Hourly Rate (dollars)
a)	PRU #1	Program Name #1	☐	☐			☐	☐		
b)	PRU #2	Program Name #1	☐	☐			☐	☐		
c)	PRU #3	Program Name #1	☐	☐			☐	☐		
d)	PRU #4	Program Name #1	☐	☐			☐	☐		

4. Please provide the following information for each PRU where those contracted services are provided. If multiple contracted individuals provide these services at a single program, provide the total hours worked per week and the average hourly rate paid. For dollars paid, use number format without a dollar sign (example: 35.00).

	PRU	Program Name	Service Provided On-site	Service Provided Off-site	Hours per Week Worked as a Health Coordinator	Hourly Rate (dollars)
a)	PRU #1	Program Name #1	☐	☐		
b)	PRU #2	Program Name #2	☐	☐		
c)	PRU #3	Program Name #3	☐	☐		
d)	PRU #4	Program Name #4	☐	☐		

(End of survey)

B. 2019 Treatment Provider Staffing Survey (Treatment Providers)

OASAS is seeking information to quantify the feedback we have heard about the obstacles in recruiting and retaining qualified staff. The survey asks OASAS **Treatment providers** to report on a variety of staffing related topics including salaries and benefits of direct care, administrative, and support staff and recent experiences with filling vacant positions. The information will be used to demonstrate the needs related to the Substance Use Disorder workforce.

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

We are asking that the survey be completed by **Monday, April 2, 2018**. All inquiries this survey should be directed to Julia Fesko at 518-457-6511 or at Julia.Fesko@oasas.ny.gov.

1. Does this agency provide a salary incentive for achieving a **treatment** professional credential?
   - ○ Yes
   - ○ No
2. Does this agency provide reimbursement to **treatment** staff for the following (please check all that apply)?
   - ☐ College Tuition
   - ☐ Professional Development Courses
   - ☐ Continuing Education Credits for credentials, licenses and certifications
   - ☐ Professional credential/licensure/certification application fees
   - ☐ Professional credential/licensure/certification exam fees
   - ☐ Other _____
3. Does the agency provide paid time off for **treatment** staff to participate in professional development coursework?
   - ○ Yes
   - ○ No
4. Does this agency increase **treatment** employees' base salaries annually through cost of living or planned salary increases?
   - ○ Yes
   - ○ No
   - ○ Some staff but not all (please explain): _____
5. If no, does this agency provide annual bonuses or other incentives for **treatment** staff?
   - ○ Yes
   - ○ No
   - ○ Some staff but not all (please explain): _____
   - ○ An incentive other than an annual bonus, please explain _____
6. Does this agency contribute to the retirement/pension plan of its **treatment** employees?
   - ○ Yes, the agency contributes up to _____%
   - ○ No
7. Does this agency give an increased retirement/pension contribution to **treatment** employees with specific years of service?

○ Yes, Please describe how the increased retirement/pension contribution plan works in your agency

_____

○ No

8. Does this agency provide healthcare benefits for the following **treatment** staff (please check all that apply)?

☐ Full-time
☐ Part-time
☐ Per-Diem

9. Does this agency provide an Employee Assistance Program for their employees as part of their benefit package for the following **treatment** staff? Check all that apply.

☐ Full-time
☐ Part-time
☐ Per-Diem

10. If yes to 9, what type of EAP is it?

○ Internal

○ External

11. Please provide any additional information not covered above regarding the impact of **treatment** employee compensation on this agency's operations.

_____

12. Please enter the total number of **treatment** staff and vacancies, for the entire agency, in each broad category listed below.

Category	Number of Part-Time Staff	Number of Full-Time Staff	Number of Part-time Vacancies	Number of Full-Time Vacancies
Total # of Clinical Staff (Counseling and Medical)				
Total # of Non-Direct Care Support Staff (Food Service, Facilities, Maintenance, etc.)				
Total # of Non-Direct Care Administrative Staff (HR, Finance, etc.)				

C. Prevention Provider Staffing Survey (Prevention Providers)

OASAS is seeking information to quantify the feedback we have heard about the obstacles in recruiting and retaining qualified staff. The survey asks OASAS **Prevention** providers to report on a variety of staffing related topics including salaries and benefits of direct care, administrative, and support staff and recent experiences with filling vacant positions. The information will be used to demonstrate the needs related to the Substance Use Disorder Prevention workforce.

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

1. Does this agency provide a salary incentive for achieving a professional credential for **prevention** staff?
   - ○ Yes
   - ○ No

2. Does this agency provide reimbursement to **prevention** staff for the following (please check all that apply)?
   - ☐ College Tuition
   - ☐ Professional Development Courses
   - ☐ Continuing Education Credits for credentials, licenses and certifications
   - ☐ Professional credential/licensure/certification application fees
   - ☐ Professional credential/licensure/certification exam fees
   - ☐ Other _____

3. Does the agency provide paid time off for **prevention** staff to participate in professional development coursework?
   - ○ Yes
   - ○ No

4. Does this agency increase **prevention** employees' base salaries annually through cost of living or planned salary increases?
   - ○ Yes
   - ○ No
   - ○ Some staff but not all (please explain): _____

5. If no, does this agency provide annual bonuses or other incentives for **prevention** staff?
   - ○ Yes
   - ○ No
   - ○ Some staff but not all (please explain): _____
   - ○ An incentive other than an annual bonus, please explain _____

6. Does this agency contribute to the retirement/pension plan of its **prevention** employees?
   - ○ Yes, the agency contributes up to _____%
   - ○ No

7. Does this agency give an increased retirement/pension contribution to **prevention** employees with specific years of service?
   - ○ Yes. Please describe how the increased retirement/pension contribution plan works in your agency

_____

○ No

8. Does this agency provide healthcare benefits for the following **prevention** staff (please check all that apply)?

☐ Full-time
☐ Part-time
☐ Per-Diem

9. Does this agency provide an Employee Assistance Program for their employees as part of their benefit package for the following **prevention** staff? Check all that apply.

☐ Full-time
☐ Part-time
☐ Per-Diem

10. If yes to 9, what type of EAP is it?

○ Internal

○ External

11. Please provide any additional information not covered above regarding the impact of employee compensation on this agency's **prevention** program operations.

_____

12. Please enter the total number of **prevention** staff and vacancies, for the **prevention** programs, in each broad category listed below.

Category	Number of Part-Time Staff	Number of Full-Time Staff	Number of Part-time Vacancies	Number of Full-Time Vacancies
a) Total # of Direct Service Prevention Staff				
b) Total # of Non-Direct Service Support Staff (Facilities, Maintenance, Transportation etc.)				
c) Total # of Non-Direct Service Administrative Staff (HR, Finance, etc.)				
d) Total # of Prevention Supervisors				
e) Total # of Prevention Program Directors/Managers				

13.Please enter the number of **prevention** staff who hold each title/credential. For **prevention** staff that hold more than one credential please list them multiple times in the specified categories.

Category	Number of Part-Time Staff	Number of Full-Time Staff	Number of Part-Time Vacancies	Number of Full-Time Vacancies
a) Credentialed Prevention Specialist				
b) Credentialed Prevention Professional				
c) Credentialed Prevention Specialist – Gambling Designation				
d) Credentialed Prevention Professional – Gambling Designation				

e) Other Certified Prevention Staff (Staff holding other qualifying certifications/licenses – CASAC, certified teacher, LMSW, LMHC, etc.)				

14. Please identify reasons staff do not obtain a CPP/CPS or other certification/license which meets the Prevention Staffing requirements.

- ☐ Cannot afford the application fees
- ☐ Cannot afford the exam fees
- ☐ Difficulty completing additional education requirements due to time constraints
- ☐ Difficulty completing additional education requirements due to financial constraints
- ☐ Difficulty completing the work experience/supervision requirements
- ☐ Difficulty passing the exam
- ☐ Provisional certification expired
- ☐ It is not required for all staff
- ☐ Other (please specify)_____

15. For each staff category below, indicate the number of full-time **prevention** staff employed in each salary range. Enter "0" if no staff are currently in those salary ranges.

	Full-Time Salary Range (in thousands						
Staff Category	<30	30s	40s	50s	60s	70s	>80
a) Non Certified Prevention Staff							
b) Credentialed Prevention Specialist							
c) Credentialed Prevention Professional							
d) Coalition Coordinator							
e) Student Assistance Counselor							
f) Other Certified Prevention Staff							
g) CASAC Trainee							
h) CASAC							
i) Non-Direct Care Support Staff							

16. For each staff category below, indicate the number of full-time **prevention** staff employed in each salary range. Enter "0" if no staff are currently in those salary ranges.

	Full-Time Salary Range (in thousands)						
Staff Category	<30	30s	40s	50s	60s	70s	>80
a) Registered Nurse (RN)							
b) Licensed Master Social Worker							
c) Licensed Clinical Social Worker							
d) Licensed Mental Health Counselor							
e) Other Qualified Prevention Professional							
f) Prevention Supervisor/Coordinator							
g) Program Director/Manager							

17. Has this program filled any vacant **prevention** staff positions during the past 12 months?

- ○ Yes
- ○ No (End)

18. If "Yes" to #17, for each staff category below, indicate the typical experience this program has had filling **prevention** vacancies during the past 12 months. Enter the average length of time (in weeks) that it has taken to fill vacancies and the average number of years the employee who vacated the position was employed. Enter "N/A" where a staff category does not apply.

	Filling Vacancies				
Staff Category	**Not a Problem**	**Minor Problem**	**Serious Problem**	**Average # of weeks to fill**	**Average # years retention**
a) Non-Certified Prevention Staff	○	○	○		
b) Credentialed Prevention Specialist	○	○	○		
c) Credentialed Prevention Professional	○	○	○		
d) Coalition Coordinator	○	○	○		
e) Student Assistance Counselor	○	○	○		
f) Coalition Coordinator	○	○	○		
g) Student Assistance Counselor	○	○	○		
h) Non-QHP Clinical Staff	○	○	○		
i) CASAC Trainee	○	○	○		
j) CASAC	○	○	○		
k) Non-Direct Care Support Staff	○	○	○		
l) Registered Nurse (RN)	○	○	○		
m) Licensed Master Social Worker	○	○	○		
n) Licensed Mental Health Counselor	○	○	○		
o) Other Qualified Health Professional (QHP)	○	○	○		
p) Prevention Supervisor	○	○	○		
q) Program Director/Manager	○	○	○		

D. 2019 Treatment Program Staffing Survey (Treatment Programs)

Please answer the questions below for your individual **treatment program** (PRU),

1. Please enter the number of staff who hold each title/credential. For staff that hold more than one credential please list them multiple times in the specified categories.

Category	Number of Part-Time Staff	Number of Full-Time Staff	Number of Part-Time Vacancies	Number of Full-Time Vacancies
CASACs				
a) Credentialed Alcoholism and Substance Abuse Counselor - Trainee				
b) Credentialed Alcoholism and Substance Abuse Counselor (All levels)				
c) Credentialed Alcoholism and Substance Abuse Counselor – Gambling Designation				
Other Non-Certified Staff				
d) Entry-level Non-QHP Clinical Staff				
e) Other Non-Certified Direct Care Staff				
Peers				
f) Certified Recovery Peer Advocate- Provisional				
g) Certified Recovery Peer Advocate				
h) Certified Addiction Recovery Coach				
i) Certified Peer Specialist				
j) Non-Certified Peer				
Social Work and Mental Health Practitioner Degrees and Licenses				
k) Bachelor of Social Work				
l) Master of Social Work, license eligible				
m) Licensed Master Social Worker (LMSW)				
n) Licensed Clinical Social Worker (LCSW)				
o) Master of Mental Health Counseling (MHC), license eligible				
p) Licensed Mental Health Counselor (LMHC)				
q) Master of Marriage and Family Therapy (MFT), license eligible				
r) Licensed Marriage and Family Therapist (LMFT)				
s) Master of Creative Arts Therapy, license eligible				
t) Licensed Creative Arts Therapist (LCAT)				
u) Master of Psychoanalysis, license eligible				
v) Licensed Psychoanalyst				
Supervisors/Directors/Managers				
w) Clinical Supervisor				
x) Recovery Services Supervisor				
y) Program Director/Manager				
Nationally Certified QHPs				
z) Certified Rehabilitation Counselor (CRC)				
aa) Certified Therapeutic Recreation Specialist (CTRS)				
ab) National Board Certified Counselor (NBCC)				

Medical Staff				
ac) Licensed Practical Nurse (LPN)				
ad) Registered Nurse (RN)				
ae) Nurse Practitioner (NP)				
af) Nurse Practitioner with DATA 2000 Waiver				
ag) Physician Assistant (PA)				
ah) Physician Assistant with DATA 2000 Waiver				
ai) Physician (MD)				
aj) Physician (MD) with DATA 2000 Waiver				
ak) Physician with Addiction Board Certification				
al) Psychiatrist				
Non- Direct Care Staff				
am) Non- Direct Care Administrative Staff (HR, Finance, Secretarial)				
an) Non-Direct Care Support Staff (Food Service, Facilities, Maintenance)				
Other				
ao) Others (Please List)				

2. Please identify reasons staff do not convert a provisional or trainee status to a full credential or license (i.e. CASAC-Trainee to CASAC, MSW or LMSW-LP to LMSW, CRPA-P to CRPA). Please check all that apply.

- ☐ Cannot afford the application fees
- ☐ Cannot afford the exam fees
- ☐ Difficulty completing additional education requirements due to time constraints
- ☐ Difficulty completing additional education requirements due to financial constraints
- ☐ Difficulty completing the work experience/supervision requirements
- ☐ Difficulty passing the exam
- ☐ Provisional certification expired
- ☐ None of the above
- ☐ Other (please specify) _____

3. For each staff category below, indicate the number of full-time staff employed by this program in each salary range. Enter "0" if no staff are currently in those salary ranges.

	Full-Time Salary Range (in thousands						
Staff Category	<30	30s	40s	50s	60s	70s	>80
a) Non-QHP Clinical Staff							
b) CASAC Trainee							
c) CASAC							
d) Non-Direct Care Support Staff							

4. For each staff category below, indicate the number of full-time staff employed by this program in each salary range. Enter "0" if no staff are currently in those salary ranges.

	Full-Time Salary Range (in thousands)						
Staff Category	<30	30s	40s	50s	60s	70s	>80
a) Registered Nurse (RN)							
b) Licensed Practical Nurse (LPN)							
c) Licensed Master Social Worker							

d) Licensed Clinical Social Worker _____ _____ _____ _____ _____ _____ _____
e) Licensed Mental Health Counselor _____ _____ _____ _____ _____ _____ _____
f) Other Qualified Health Professional _____ _____ _____ _____ _____ _____ _____
g) Clinical Supervisor _____ _____ _____ _____ _____ _____ _____
h) Program Director/Manager _____ _____ _____ _____ _____ _____ _____
i) Nurse Practitioner _____ _____ _____ _____ _____ _____ _____
j) Physician Assistant _____ _____ _____ _____ _____ _____ _____
k) Physician _____ _____ _____ _____ _____ _____ _____

5. Has this program filled any vacant staff positions during the past 12 months?

   ○ Yes

   ○ No (skip to End)

6. If "Yes" to #5, for each staff category below, indicate the typical experience this program has had filling vacancies and retaining employees during the past 12 months. Enter the average length of time (in weeks) that it has taken to fill vacancies and the average length of time in years the employee(s) who created the vacancy were employed. Enter "N/A" where a staff category does not apply.

	Filling Vacancies				
Staff Category	**Not a Problem**	**Minor Problem**	**Serious Problem**	**Average # of weeks to fill**	**Average # years retention**
a) Non-QHP Clinical Staff	○	○	○		
b) CASAC Trainee	○	○	○		
c) CASAC	○	○	○		
d) Non-Direct Care Support Staff	○	○	○		
e) Registered Nurse (RN)	○	○	○		
f) Licensed Master Social Worker	○	○	○		
g) Licensed Mental Health Counselor	○	○	○		
h) Other Qualified Health Professional (QHP)	○	○	○		
i) Clinical Supervisor	○	○	○		
j) Program Director/Manager	○	○	○		
k) Nurse Practitioner	○	○	○		
l) Nurse Practitioner & DATA 2000 Waiver	○	○	○		
m) Physician Assistant	○	○	○		
n) Physician Assistant & DATA 2000 Waiver	○	○	○		
o) Physician	○	○	○		
p) Physician & DATA 2000 Waiver	○	○	○		
q) Addiction Board Certified Physician	○	○	○		
r) Addiction Board Certified Physician & DATA 2000 Waiver	○	○	○		
s) Psychiatrist	○	○	○		

7. We understand that programs are experiencing increasing numbers of client/patient deaths, primarily due to the opioid crisis. OASAS seeks to better understand how this impacts the staff and what resources programs have implemented to address patient deaths when they occur.

   Has your program experienced client/patient deaths in the past year?

- ○ Yes
- ○ No

8. If yes to 7
   a) How many client/patient deaths has your program experienced in the past year? _____
   b) What protocols does your program have in place to address the impact client/patient deaths have on staff, other patients, families and the community? (check all that apply)

- ☐ Provider has a crisis response protocol to address client/patient deaths.
- ☐ Employee Assistance Program provides crisis response to our program when client deaths occur.
- ☐ Employee Assistance Program provides crisis response to individual staff who are impacted when client deaths occur.
- ☐ Our Quality/Assurance process includes a review of all client deaths and the program's subsequent response.
- ☐ The community has a crisis response program that our program can take advantage of when client/patient deaths occur.
- ☐ Our program has enough resources to address client deaths.
- ☐ Our program does not have enough resources to address client /patient deaths.
- ☐ Other protocols your program has in place to address client/patient deaths, please list _____
- ☐ Other services your program could benefit from to address client/patient deaths, please list _____

E. Hepatitis C Infrastructure and Technical Assistance Needs Survey (Treatment Programs)

The New York State Office of Alcoholism and Substance Abuse Services (OASAS) treatment programs play an important role in the elimination of Hepatitis C virus (HCV) in New York State (NYS), by providing addiction treatment services to approximately 232,000 individuals each year. Many people infected with HCV have co-occurring substance use disorders (i.e., injection drug use-IDU). IDU accounts for 68% to 80% of all HCV infections in the world. The increase in opioid use in NYS has also resulted in an increase in the number of new HCV cases reported. As highly effective antiviral therapy for HCV infection is now available, efforts to diagnose HCV and to identify treatment-eligible candidates is an increasingly important priority, particularly among persons with substance use disorders. We understand OASAS providers routinely face challenges to providing HCV services (i.e., screening, diagnosis and treatment) for individuals actively engaged in addiction treatment.

OASAS, the New York State Department of Health (DOH) and the New York City Department of Health and Mental Hygiene (NYCDOHMH), are conducting a survey of OASAS programs statewide to better understand current infrastructure to provide HCV services, including screening, diagnosis and treatment, as well as to identify the barriers to providing these services. The purpose of this survey is to determine high-priority technical assistance needs for HCV care. This survey will not be used to evaluate the performance of any individual program. Together, OASAS, DOH, and NYCDOHMH will work to address these technical assistance needs, so more New Yorkers will know their HCV status and be cured of their disease, thus, helping to eliminate HCV in NYS. All OASAS programs certified pursuant to Parts 820 or 822 are required to offer Hepatitis testing to clients upon admission, either on-site or by referral, and in accordance with Local Services Bulletin 2013 - 01.

Each treatment program should identify the most appropriate person to complete this survey. Input from additional staff may be necessary. Thank you in advance for taking the time to complete this survey. If you have any questions regarding the survey subject matter, please email: Michele.Falkowski@oasas.ny.gov.

NOTE: When completing the survey, please complete it based on data, capacity and activities during 2017.

1. A *Hepatitis C Champion* is person who promotes changes in the organization related to HCV that benefit the organization and its providers, staff and clients.

a) Is there a Hepatitis C Champion within your program? ○ YES ○ NO

b) If yes to a, name and email of Champion: _____

Hepatitis C Testing Services

To appropriately identify clients with active HCV infection, two laboratory tests must be conducted. The first is a test that screens for HCV antibodies. If this initial HCV antibody test is reactive, it should be immediately followed with an HCV RNA test.

2. During 2017, which clients were routinely offered an HCV test?

	Yes	No
a) All clients	○	○
b) Clients requesting to be tested	○	○
c) Clients with an identified risk	○	○
d) Clients born between 1945 and 1965	○	○
e) Clients with symptoms or medical indication	○	○
f) Other	○	○
g) If yes to f, specify:		

3. How is HCV testing being provided at your treatment program?

- ○ On-site by OASAS staff
- ○ On-site by an outside program. Please specify: _____
- ○ By referral, off-site. Please specify where: _____

4. If HCV testing is being provided onsite, which tests are currently available:

Test Type	YES	NO
a) Rapid/point of care HCV antibody test	○	○
b) Serum HCV antibody test	○	○
c) Serum antibody testing with reflex to HCV RNA test	○	○
d) HCV RNA testing	○	○

5. If HCV testing is being provided by referral off site:

a) Does the treatment program track the referrals for testing?

- ○ Yes
- ○ No

b) Does the treatment program receive the test results?

- ○ Yes
- ○ No

6. When newly diagnosed HCV clients OR clients with a positive HCV screening test are discharged, do they receive a referral to a medical provider for HCV care and treatment?

- ○ Yes
- ○ No

7. If yes to 6, who are they referred to?

- ○ Their own medical provider, if they have one.
- ○ The treatment center has a referral agreement with an HCV provider in the community. Please specify where: _____

Hepatitis C Treatment Services

8. Is your program offering HCV treatment on-site?

- ○ Yes (go to 9)
- ○ No - these clients are referred to treatment off-site (Skip to 12)

9. If treatment is being offered on-site, who is providing the treatment?

HCV treatment provider	Yes	No
a) Primary care provider	○	○
b) Gastroenterology/liver practice	○	○
c) Infectious Diseases	○	○
d) Addiction Specialist	○	○
e) Tele-medicine/video consulting	○	○
f) If yes to e, please specify		

g) Other	○	○
h) If yes to g, please specify		

10. During 2017, of those clients diagnosed with HCV on admission, what was the estimated number of clients treated for HCV at your treatment program: _____

11. For which population is HCV treatment currently available for on-site?

a) HCV monoinfected clients: ○YES ○NO

b) HIV/HCV coinfected clients: ○YES ○NO

12. Which of the following HCV treatment-related services are available on-site at your treatment program?

HCV Treatment-related Service	Yes, available	No, not available
a) Consultative relationship with liver specialist	○	○
b) Resources to assess for liver fibrosis/scarring in patients with HCV (i.e., Fibroscan, Fibrosure)	○	○
c) Assistance with prior authorization process to obtain HCV medications	○	○
d) Resources to assess patient readiness to adhere to HCV treatment	○	○
e) Established relationship with specialty pharmacies	○	○
f) Medication adherence support for patients on HCV treatment	○	○
g) Resources to educate patients about HCV and treatment	○	○

Hepatitis C Supportive Services

13. Are the following supportive services available to hepatitis C clients at your treatment program?

Supportive Service	Yes	No
a) HCV support groups	○	○
b) Peer services	○	○
c) Patient navigator	○	○
d) Care coordinator	○	○
e) Community health worker	○	○
f) Case management	○	○
g) Social worker	○	○
h) On-site pharmacy	○	○
i) Specialty pharmacy support	○	○
j) Other	○	○
k) if yes to j, please specify:		

Barriers to HCV Testing and Treatment Services

14. Which of the following are barriers to implementing HCV testing or providing HCV treatment at your program?

Barrier	A barrier in implementing TESTING (Check if "yes")	A barrier in implementing TREATMENT (Check if "yes")
a) Lack of system to identify clients who need HCV services	☐	☐
b) Treatment center staff do not view HCV care as a priority	☐	☐
c) Lack of capacity to perform HCV testing	☐	☐
d) Lack of support staff to provide medical care coordination (i.e., patient navigation, prior authorization, medication adherence)	☐	☐
e) Lack of medical providers to refer HCV positive or diagnosed	☐	☐
f) Medical providers lack the knowledge and skills to manage and treat HCV.	☐	☐
g) Clients lack health insurance coverage to pay for HCV screening	☐	☐
h) Clients lack health insurance coverage to pay for HCV treatment	☐	☐
i) Lack of education/knowledge of HCV among program staff	☐	☐
j) Lack of awareness/knowledge of HCV among clients	☐	☐
k) Number of program staff cannot accommodate HCV screening	☐	☐
l) Competing clinical priorities	☐	☐
m) Social stigma associated with HCV	☐	☐
n) Clients most often refuse HCV testing	☐	☐
o) HCV positive clients most often refuse HCV treatment	☐	☐
p) Our clients need to be in recovery before they can begin HCV treatment	☐	☐
q) Current policy states that HCV should not be treated in a substance use treatment setting	☐	☐
r) Not cost-effective	☐	☐
s) Lack of financial support to provide HCV-related services	☐	☐
t) Other barriers (please specify):		

IT Infrastructure

15. Does your treatment program currently utilize an Electronic Health Record (EHR)?

○ Yes

○ No

16. If yes to 15, indicate how your treatment program currently uses the EHR for screening, care, and treatment for patients living with HCV:

EHR Activity	Yes	No
a) EHR provides point of care reminders for HCV screening	○	○
b) EHR alerts providers to abnormal or positive HCV test results	○	○
c) EHR tracks HCV referrals until the consultant or specialist report is available	○	○
d) EHR electronically exchanges key clinical information and provides an electronic summary of care record for referrals	○	○

e) EHR access in patient examination areas	○	○

Hepatitis C Technical Assistance Needs

We are interested to know what types of technical assistance you would be interested in receiving to increase your capacity to implement HCV testing and treatment at your treatment center.

17. What are the preferred methods for providing training to the staff at your treatment program (check all the apply)?

- ☐ On-site
- ☐ Live webinars
- ☐ Archived webinars
- ☐ On-line educational modules
- ☐ Off-site conferences/seminars

18. Indicate if you are interested in receiving any of the following technical assistance at your treatment center:

Technical Assistance	Yes, interested	No, not interested
a) Hepatitis C – General overview.	○	○
b) Information on HCV rapid antibody testing.	○	○
c) Trainings on HCV clinical management, including HCV treatment.	○	○
d) Support to build flags for HCV testing into electronic health record.	○	○
e) Assistance with implementing HCV RNA reflex testing.	○	○
f) Assistance with identifying HCV specialists to refer patients to and seek consultation from.	○	○
g) Assistance with proper billing/reimbursement for HCV-related services.	○	○
h) Assistance with delivering appropriate and effective HCV counseling messages.	○	○
i) Information on tele-medicine opportunities for HCV treatment, including how to improve bandwidth to support telemedicine.	○	○

19. Is your program interested in receiving printed HCV educational materials for your patients?

○ Yes

○ No

F. Clinical Supervision Contact Information Form (Treatment Programs)

The OASAS Clinical Supervision Survey should be completed by all OASAS-certified treatment programs. The goal of clinical supervision is to continuously improve client care, support ongoing staff development and, ultimately, improve client outcomes. The implementation of a strong Clinical Supervision program results in enhanced staff understanding of clinical situations, prevention of escalating clinical crises, better assessment, stronger case conceptualization, treatment strategies and discharge planning. It also provides a vehicle by which directives are followed and helps facilitate the implementation of evidence-based practices and institutional awareness.

OASAS is developing a type of "Community of Learning" for its constituency of clinical supervisors with the intention that this initiative will result in the development of a "culture" based clinical supervision practice. It will also enable OASAS to hear and respond to areas of concern, interest and ongoing assessment, collect data through ongoing survey responses, and establish clinical supervision as a fundamental and foundational element of "best practice." Clinical supervisors will be contacted soon with more information on how they can become involved in the important development of this new community and how OASAS can offer technical assistance and support for this endeavor.

To ensure that the agency has the most up-to-date information, all OASAS-certified and funded treatment programs are being asked to complete the following brief survey and provide contact information for each clinical supervisor in the program. In addition to developing a culture based practice, this information will facilitate communication on relevant topics and resources to clinicians and provide clinical guidance issued by OASAS. Accordingly, clinical supervisors will have additional tools to better perform their essential role in assuring quality treatment to clients.

We are asking that the survey be completed by **Monday, April 2, 2018**. If you have any questions about this survey, please contact Brenda Harris-Collins at Brenda.Harris-Collins@oasas.ny.gov or 646-728-4673.

Thank you for taking the time to complete this survey and for your agency's role in helping us to update our information.

For each clinical supervisor employed by this program, please enter his/her name and email address. If you need to enter contact information for additional clinical supervisors, click on the **+** sign next to the first supervisor's name and a new row will open for you to enter the additional information.

	Name	Email Address	Phone Number
+			

(end of survey)

G. Program Emergency Manager Contact Information Form (Treatment Programs)

Emergency Manager Contact information is necessary for OASAS to communicate directly with each certified treatment program to ensure proper planning and preparedness during emergency situations. A rapid and coordinated response to an emergency is necessary to ensure the safety of staff and patients and continuity of care. An Emergency Manager must be designated for each program site, so we are asking that contact information be provided for each PRU. The information entered here will be incorporated into the OASAS Provider Directory System (PDS) where other program contact information is maintained.

We are asking that the survey be completed by **Monday, April 2, 2018**. All questions regarding this survey should be directed to Kevin Doherty, OASAS Emergency Manager, at (518) 485-1983, or at KevinDoherty@oasas.ny.gov.

First Name:

Last Name:

Job Title:

Email Address:

Main Work Phone:

Desk Work Phone:

Home Phone:

Mobile Phone:

NOTE: To ensure privacy, home and mobile phone numbers will not be displayed in CPS output reports.

(End of survey)

Appendix I: CPS Registration and User Roles

To register an account with CPS:

1. Obtain an OASAS Applications user account, by completing an OASAS External Access Request Form, an IRM-15, available on the OASAS website and submitting the form to the NYS OASAS PROVIDER HELP DESK as instructed. Please indicate on the form that it is a request access to the County Planning System.
2. Once an OASAS Applications user account is created, go to the CPS website to register a CPS user account.

The table for CPS User roles shows the primary user roles, with each providing the user with specific entitlements depending on their organization and the features and resources they need to access or use. Each role provides the user with specific entitlements depending on their organization and the features and resources they need to access. While the system was designed primarily for county and OASAS provider use, it has expanded significantly over the years. Additional roles have been added for anyone not employed by the three state agencies, the county mental hygiene agencies, or OASAS provider agencies.

Primary CPS User Roles and Entitlements

User Role	Entitlements
Planning Coordinator	This role is identical to the Administrator role and was developed so that state agency staff can communicate with a single individual within a LGU or OASAS provider organization on planning related matters. This will help to eliminate confusion when action is requested, allowing a single point of contact to coordinate an organization's response.
Administrator	This role is appropriate for individuals responsible for managing their organization's presence in CPS. They can approve and delete staff accounts within their organization and can use the broadcast email feature and other system management features. LGU and provider administrators can also complete and submit required planning forms. All administrator accounts are approved by OASAS.
Staff	This role is appropriate for individuals in LGU and provider organizations that need to complete planning forms but do not need to perform system management functions. Completed forms can be submitted to the CPS administrator within the organization for approval. State agency staff roles have read-only access to the entire system. LGU and provider staff roles can be approved by any administrator from the same organization. State agency staff roles are approved by the appropriate state agency administrators.
Guest Viewer	This role has read-only access to completed plans and most available data resources. These are typically individuals not employed by one of the three state agencies, an LGU, or an OASAS provider agency but have a need to access resources in CPS. They may include researchers, students, consultants, or staff from another state or county agency. The Guest Viewer role is approved by OASAS.
All Roles	All user roles can view and print forms, run special reports, and access most county planning data resources.

NOTES

[i] Non-Medical Transportation will be carved out of the MCO benefit, managed by a Medicaid Transportation Manager based on the Plan of Care, and paid FFS directly to the transportation provider. In addition to Non-Medical Transportation, transportation to BH HCBS included in an individual's Plan of Care will be treated the same way as medically necessary Medicaid Transportation. Please see Managed Care Transition Manual for additional plan requirements for this service.

[ii]The host model can be found on the Department of Health website at http://www.health.ny.gov/health_care/medicaid/redesign/dsrip/regulatory_waivers/licensure_thresholds.htm

[iii] Table from link in note above.

[iv] Curtin, S., Warner, M., Hedegaard, H. (2016). Increase in suicide in the United States, 1999–2014. NCHS data brief, no 241. Hyattsville, MD: *National Center for Health Statistics.*

[v] Centers for Disease Control and Prevention. Injury prevention and control: Data and statistics (WISQARS). http://www.cdc.gov/injury/wisqars/fatal_injury_reports.html