2013
Local Services Plan Guidelines
For Mental Hygiene Services

March 2012

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2013 Local Services Plan Guidelines For Mental Hygiene Services

CHAPTER I: INTRODUCTION

A. Interagency Collaboration

The local services planning process for mental hygiene services is a collaborative effort among the three New York State Department of Mental Hygiene agencies - the Office of Alcoholism and Substance Abuse Services (OASAS), the Office of Mental Health (OMH) and the Office for People With Developmental Disabilities (OPWDD). For the fifth consecutive year, these guidelines reflect an integrated local planning approach that fully meets the requirements of the three separate state agencies. Local Governmental Units (each county and the City of New York) need only complete a single integrated plan, which will be submitted to all three agencies electronically via the OASAS online County Planning System (CPS).

The integrated local planning approach not only eliminates the need to submit three separate disability plans to the state, it also facilitates greater cross-disability planning at the local level. It allows for planning to be more person-centered with a greater ability to focus on individuals with multiple disabilities who need services from multiple systems. This approach also strongly encourages collaboration with other local systems in which persons with a mental hygiene disability may also be involved.

The Inter-Office Coordinating Council (IOCC)

The Inter-Office Coordinating Council (IOCC) represents a collaborative effort among the commissioners of OASAS, OMH and OPWDD to improve continuity and coordination of services for people with multiple needs within the three mental hygiene service systems and seeks to eliminate gaps in services for individuals living with more than one disability. It fosters integration and alignment of agency structures and functions to improve patient outcomes and ensures comprehensive planning and implementation of state policy for the prevention, care, treatment and rehabilitation of mental illness, developmental disabilities and addictions. Representatives from the Department of Health (DOH), State Education Department (SED), Office of Children and Family Services (OCFS), and the Developmental Disabilities Planning Council (DDPC) participate as ad hoc members of the IOCC.

There are two standing committees of the IOCC. The Program Committee, consisting of OASAS, OMH, and OPWDD staff, holds periodic conference calls to identify collaborative issues for the IOCC to address, develops agendas for IOCC meetings, assists in the coordination and preparation of the Annual Report, and facilitates communication among member agencies and other state and local partners. In addition, the Program Committee promotes access to services within each system in instances of dispute. The Mental Hygiene Planning Committee became a standing committee of the IOCC in 2008 and includes staff from OASAS, OMH, and OPWDD plus representatives from the NYS Conference of Local Mental Hygiene Directors (CLMHD) and several county mental hygiene agencies. The committee is responsible for coordinating planning efforts of the three state agencies and their local partners.

For additional information about the IOCC and a summary report of ongoing and new initiatives, please see the ***2011 IOCC Annual Report***, which is posted on the OASAS website.

Integrating Behavioral Health and Primary Health Care

When the Medicaid Redesign Team (MRT) was created by Governor Andrew Cuomo in January 2011, its primary objective was to engage Medicaid stakeholders in developing specific cost saving and quality improvement measures for redesigning the Medicaid program in New York State. One of the areas to be addressed by the MRT was to identify ways to improve care management for beneficiaries with complex health conditions, including those with mental health and substance use disorders.

One outcome from the work of the MRT was a requirement to transition Medicaid services from a carved-out fee for service system to one that will be fully managed. For the behavioral health population, this transition will occur in two phases. In Phase I, OASAS and OMH contracted with five regional Behavioral Health Organizations (BHOs) to assist with managing the services that are currently carved out of mandatory Medicaid managed care, i.e., fee-for-service medically managed/supervised detoxification and inpatient rehabilitation. In Phase II, BHOs will support management of fee-for-service outpatient and opioid treatment. During the transition period, behavioral health services will continue to be reimbursed on a fee-for-service basis.

Phase II of the transition to a fully managed system of integrated care and care coordination will begin in 2013. In that phase, the system will involve contracting with specialty managed care plans to address the needs of those individuals whose benefits have been "carved out," in integrated plan arrangements. A more detailed discussion on this topic is included in Chapter III of these guidelines.

The Mental Hygiene Planning Committee

The local services planning process is guided by the Mental Hygiene Planning Committee, which represents a partnership among the three state mental hygiene agencies, the NYS Conference of Local Mental Hygiene Directors (CLMHD), and the LGUs. The Committee is currently co-chaired by Bill Phillips, OASAS Associate Commissioner for Outcome Management and System Information, and Scott LaVigne, Director of Community Services in Seneca County. It includes planning staff from the three state agencies, the CLMHD, and several counties.

The committee meets regularly and is focused on integrated local planning and the development of web-based planning tools and data resources that support and facilitate local planning and needs assessment. The committee has two workgroups which are led by county planners and include the active participation of state agency planners. In addition, an ad hoc Fiscal Analysis Workgroup was established to work with state agencies, insurers, and others to identify, obtain, analyze and share financial data with county planners. Recent accomplishments of the two standing workgroups include the following:

Data Needs Workgroup:

- Worked with OMH and OASAS to develop standard Medicaid Fee-for-Service cost profiles showing cost for other health and behavioral health care services.

- Worked with OPWDD staff to develop new county demographic profiles containing information about residents with developmental disabilities.
- Worked with OASAS staff to enhance existing Inquiry Reports functionality to expand county access to client data, aggregate data previously only available at the program level, and output data in more usable formats for county planners. The first of these enhancements are expected to be implemented in early 2012.

Community of Practice for County Planners (CPLP):

- The CPLP Page in CPS was expanded to include several new links to useful data resources on other agency websites, including OMH, the NYS Council on Children and Families (CCF) and the NYS Department of Health (DOH).
- Convened five webinars and training sessions in 2011 for county planners with an average attendance of 50. Session topics included:
  - Introduction and Practical Application of the OMH County Mental Health Profiles Portal.
  - OMH Medicaid Utilization Reports & Prevention Quality Indicator (PQI) Data, 2012 Local Services Planning (LSP) and CPS Training.
  - Using Performance Reporting to Strengthen Services, Planning and Management.
  - Cross-Systems Planning to Improve Outcomes for Children and Families.
  - Using the Kids' Well-being Indicators Clearinghouse (KWIC).

In the year ahead, the planning committee will continue to work to strengthen the local services planning process and enhance the capabilities of CPS. It will continue to analyze the impact of the significant policy, regulatory, fiscal and programming changes occurring at the state and federal levels and how LGUs can influence those changes in a way that will preserve and improve the local mental hygiene service system.

In addition to informing and guiding local planning efforts, the committee will continue to work to develop relevant and timely data resources and planning tools that will help LGUs conduct effective planning in such a changing environment. The practice of using the local plan guidelines to solicit input from LGUs on a variety of important state policy issues will continue, and OASAS will continue to survey counties and providers in support of ongoing agency planning and programming initiatives. Last year, 98 percent of all county planning forms and 97 percent of all OASAS provider planning forms were completed, resulting in an extensive and valuable source of information.

CPLP webinars and trainings being planned for 2012 will continue to focus on the activities that will help ensure that planning practices result in an efficient, coordinated and well-managed system of care that meets the needs of people with mental illness, developmental disabilities and/or substance use disorders in the most efficient and cost-effective manner.

B. Local Services Planning Process

State Mental Hygiene Law requires that OASAS, OMH and OPWDD guide and facilitate the process of local planning (§41.16(a)). It also requires each LGU to develop and annually submit to each state mental hygiene agency a local services plan that establishes long-range goals and objectives consistent with statewide goals and

objectives (§41.16(b)(1)). In addition, the law requires that state goals and objectives embody the partnership between the state and LGUs (§5.07(a)(1d)), and that each agency's statewide comprehensive plan be formulated from the LGU comprehensive plans (§5.07(b)(1)).

Prior to the establishment of the Mental Hygiene Planning Committee in 2007, each agency conducted its own local planning process, followed its own timetable, and established its own planning requirements for LGUs. At the county level, planning for each disability was frequently conducted independent of the other disabilities. Collaboration was largely absent from this process.

Today, counties enjoy a more integrated mental hygiene local planning process that is guided by the state and carried out at the county level. More attention is focused on enabling LGUs to address cross-system issues that impact people with co-occurring disorders and improve the quality of services and supports. In the five years since the committee was formed, the local planning process has resulted in more efficient and effective planning focused on problems and needs that impact all three disability systems. Major milestones include:

- Establishing an annual planning calendar that aligns local services planning with state planning and budgeting processes.
- Developing comprehensive local services plan guidelines and planning forms to facilitate a more integrated local planning process.
- Integrating the plan guidelines and planning forms into the OASAS online County Planning System (CPS) and providing greater access to all completed plans for the three state mental hygiene agencies and all counties.
- Incorporating extensive county planning resources in CPS and promoting effective local planning practices that facilitate a more data informed and results focused local planning and needs assessment effort.

Many of the improvements to the local planning process, plan guidelines, and CPS resulted from input provided by counties and OASAS service providers through surveys, meetings, and other means of communication throughout the year. Moving forward, the Mental Hygiene Planning Committee will continue to seek input and to act on recommendations that will further improve planning and result in improved outcomes for individuals and families served. In preparation for this year's planning cycle, the Mental Hygiene Planning Committee used this feedback to continue to refine CPS. Those refinements are described in detail in Chapter V of these guidelines.

The Online County Planning System (CPS)

CPS was developed by OASAS in 2004 and implemented statewide in 2005 to enable counties and their service providers to complete and submit required annual local planning forms to the state electronically. CPS quickly became a state-of-the-art platform from which counties could access significant and timely data resources for conducting their needs assessment and planning activities, complete required planning forms, and submit their entire plan to OASAS via the Internet. A number of other tools were developed over the years that help counties to 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.

In 2007, OASAS agreed to collect county mental health priorities through CPS. The following year, county developmental disability priorities were incorporated, thereby creating the first ever fully integrated mental hygiene local services planning process in New York State. For the first time, counties had the ability to develop and submit a single integrated mental hygiene local services plan to all three state agencies at once.

Today, there are more than 2,400 individuals with a CPS user account in one or more of eighteen separate user roles. Each role provides the user with specific entitlements depending on their organization and the features and resources they need to access or use. In addition to user roles for state agency, LGU and OASAS provider staff, a Guest Viewer role was created for those interested in accessing CPS content but who are not staff within any of the above referenced organizations. There are approximately 220 CPS users in the Guest Viewer role with read-only access to all completed county plans and most planning resources currently housed in CPS. A CPS account may be requested by completing the online registration form at https://cps.oasas.ny.gov/cps/. The following table describes the major CPS user roles and the entitlements granted to each role.

Primary CPS User Roles and Entitlements

User Role	User Entitlements
Administrator	This role is appropriate for individuals responsible for managing their organization's presence in CPS. They have the ability to approve and delete staff and viewer 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. A special role was created for Developmental Disabilities Services Offices (DDSO) staff that allows them to approve the OPWDD components of a county's plan. 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.
Viewer	This role is appropriate for LGU and provider employees who only need read-only access to the system. They cannot complete planning forms nor perform any system management functions. Guest viewers and researchers have read-only access to completed plans and most available data resources. LGU and provider staff roles can be approved by any administrator from the same organization. The Guest Viewer role is approved by OASAS.
All Roles	All user roles can view and print forms, run select reports, and access most county planning data resources.

The Mental Hygiene Planning Committee continues to be the primary source for recommending CPS enhancements, developing planning data resources, and providing communication and technical assistance on planning related matters. A major part of this effort is the feedback received through the annual CPS User Satisfaction Survey

and input received from users throughout the year. CPS continues to be supported by all three mental hygiene agencies, administered by the OASAS Bureau of State and Local Planning, and maintained by the OASAS Bureau of Information Technology. CPS login problems should be directed to the OASAS Help Desk at 518-485-2379. All other questions related to CPS should be directed to the planning bureau at oasasplanning@oasas.ny.gov or at 518-485-2410.

Local Services Planning Timeline

The following timeline highlights the critical points in the local services planning process and is intended to provide continuity in planning expectations from year to year.

2013 Local Services Planning Process Timeline	
Ongoing planning and needs assessment conducted by counties	Year round
Local Services Plan (LSP) Guidelines published; CPS updates available	March 1
LSP and CPS training for County Planners	March/April (TBD)
Due date for completed OASAS provider planning forms in CPS	**Monday, April 2**
Due date for completed LGU Plans in CPS	**Friday, June 1**
State summary analyses of county and provider plans completed	September 1
OASAS, OMH, OPWDD Statewide Comprehensive Plans released	October 1
IOCC Annual Report released	December 31
OASAS, OMH, OWPDD Interim Reports released	February 15

Informing Statewide Comprehensive Planning and Budgeting

Local services plans are central to state long-range planning and budgeting. As noted previously, Mental Hygiene Law requires that the OASAS, OMH and OPWDD formulate statewide comprehensive plans in part from local comprehensive plans developed by LGUs. An important achievement of the integrated planning process is that planners at the state and local levels are now able to identify planning priorities that cut across the three disability areas. During the last planning cycle, nearly 48 percent of priorities cut across two or more disability areas, up from 37 percent three years earlier, suggesting that the integrated mental hygiene planning process and CPS are serving as catalysts for more coordinated and focused planning across multiple systems of care.

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. Taken as a whole, systematic processes and tools that lead to efficiencies and effective care continue to play a crucial role in difficult fiscal times. They help to identify resources that can be directed toward areas of high priority and contribute to improved service delivery and outcomes. To help ensure that policies support people with mental illness, developmental disabilities and/or addictions and their families and are planned, developed and implemented comprehensively, OASAS, OMH, and OPWDD will continue to look to the local services plans as a primary source of input.

CHAPTER II: PLANNING FOR ADDICTION SERVICES

A. The OASAS Strategic Framework

The OASAS strategic framework incorporates outcomes thinking into a dynamic, data informed and participatory planning process. In the current environment of increasing competition for limited resources, increasing demands for accountability and transparency, and increasing complexity of client health problems, the delivery of addiction services requires demonstrable outcomes to justify continued public support. At the same time, data must be collected and used to inform management decision making to improve performance.

Outcomes are derived from an agency's mission and program intent. Once established, an organization can consider what inputs, activities and outputs are necessary to achieve the desired outcomes. To demonstrate the use of outcomes management, an organization defines its mission program outcomes, identifies resources needed to achieve the outcomes, tracks and measures activities undertaken, and quantifies the desired impact or change. These steps establish a systematic way to monitor performance, inform management when adjustments are necessary, and ultimately allow a program to perform at an outstanding level. The following are key components that characterize a successful outcomes management program:

Outcomes Management Infrastructure

- **Leadership Support** - There should be visible support from top management in the organization. A top-level administrator should serve on an Outcomes Management (OM) Implementation Team; OM should be an agenda item at agency meetings; and references to OM should appear in the agency's mission statement, annual reports and/or board meeting minutes.
- **Commitment of Time and Staff Resources** - Staff should have a working knowledge of how outcomes management is applied within the program. A percentage of staff time should be dedicated to developing and implementing the outcomes management process. Outcomes management activities may include data collection, analysis, report writing and implementation of program changes based on outcome data.
- **Program Stability** - There should be no major changes in mission or personnel to disrupt the organizational environment.
- **Computer Capability** - Computers and software should be used to manage data and create reports.

Outcomes Management Practices

- Staff at all levels involved in Outcomes Management
- Designated staff to manage and analyze data
- Articulated goals and strategies to improve performance
- Annual target setting
- Use of data to improve outcomes
- Regular meetings to review progress and make course adjustments
- Process to measure outcome

Outcomes management helps to guide all management functions aimed at improving client-level results and the return on investment. It is often described as a business-based or logic model designed to integrate organization-wide management and financial variables with performance metrics. This approach allows management to systematically measure progress towards intended outcomes.

OASAS has utilized outcome management for a number of years in a variety of ways to incorporate quality performance measures into resource allocation, including the Integrated Program Monitoring and Evaluation System (IPMES) to monitor performance of both funded and non-funded treatment programs, the Workscope Objective Attainment System (WOAS) to establish and monitor progress towards meeting program performance objectives for all OASAS-funded treatment programs, and the annual program performance reviews to evaluate each treatment provider in terms of overall program and fiscal management performance.

In 2010, OASAS developed the first ever Chemical Dependence Treatment Program Scorecard as part of the Gold Standard Initiative (GSI). The scorecards provide programs with a score and statewide comparative rating on a number of measures related to access, quality, outcome, efficiency and compliance. In 2011, scorecards were made available to the general public on the OASAS website. Scorecards can also be accessed through a link in CPS.

Since 2007, the OASAS Strategic Map has defined what it means to be a premier system of addiction services and measures the agency's progress towards meeting this goal. The Outcomes Dashboard identifies five major destinations (i.e., the points on the map we want to reach over the next several years) and several supporting metrics and sub-metrics (i.e., the mileposts or markers that we will use to measure our progress toward reaching the destinations).

An analysis of 2012 county plans showed that county priority outcomes loosely or directly aligned with 15 out of the 39 sub-metrics on the 2011 dashboard. The local services planning process will continue to have an emphasis on strengthening this alignment from both a state-to-county and a county-to-state direction.

The 2011 Dashboard is summarized below. A detailed progress report on these metrics can be found in the ***2012 Interim Report of the OASAS Statewide Comprehensive Plan 2011-2015***. The 2012 Dashboard is currently under development and anticipated to be completed later in the spring.

OASAS 2011 Outcomes Dashboard

I. Mission Outcomes: Establish an effective, science-based system which integrates prevention, treatment and recovery.

1. Strengthen addiction services through a comprehensive, integrated, culturally competent system that focuses on individual needs and accessibility.
2. Successfully implement a new evidence-based Drinking Driver Program and enhanced DWI screening and assessment, which will reduce DWI recidivists based on the total number of drivers with a DWI conviction.
3. Reduce rates of past 30-day substance use and reduce levels of substance abuse risk factors including: perception of risk, perception of parental disapproval, and percent of youth exposed to prevention messages in New York State.
4. Recovery: Increase the number of persons successfully managing their addiction within a culturally competent, recovery-oriented system of care.

II. Provider Engagement and Performance: Develop a "Gold Standard," system of service provision.

5. Implement increased program oversight and strengthen provider accountability to ensure culturally competent, quality services.
6. Increase provider engagement in the Gold Standard Initiative.

III. Leadership: Be the state resource on addiction and lead the nation in the field of chemical dependence and problem gambling prevention, treatment and recovery.

7. Utilize outcome management concepts that focus on performance measures and hold both OASAS and its providers accountable.
8. Educate and partner with the community, government agencies and elected officials to advance the agency mission by increasing public awareness through positive media coverage and proactive communication strategies.

IV. Talent Management: Become a "Profession of Choice" for attracting, selecting and developing system-wide talent.

9. Increase cross-systems training to support integrated, culturally competent behavioral health services
10. Increase full knowledge, expertise and retention of a high-performing, diverse staff throughout the field
11. Improve OASAS leadership capabilities.

V. Financial Support: Ensure a system with strong return on taxpayer investment and stewardship of resources.

12. Increase or stabilize system funding resources while ensuring a strong return on taxpayer investment.

Community of Practice for Outcomes Management

A Community of Practice (CoP) is formed by people who engage in regular interaction over a shared topic of interest. Participants learn and develop skills around a topic whether by way of explicit learning objectives or as a secondary effect of sharing experiences, tools and resources, providing peer support or problem solving around an issue. The benefits of participating in a CoP include: access to shared resources; insight from others who are trying to do the same or similar things; and an established support network as you try new approaches to improving performance and patient outcomes.

According to Wenger, the three most important characteristics of a CoP are:

1. The CoP has an identity defined by a shared topic of interest and members are both committed to that topic and have a degree of competence around the topic.
2. In pursuing their selected interest participants engage in joint activities and discussions, help each other, and share information through regular interaction.
3. Participants are not just interested in the topic, but are practicing within the area of interest, and therefore able to share resources and experiences with the other members in their practice as well.

OASAS encourages the use of outcomes management by counties and providers through regional Communities of Practice. These groups enable OASAS and the field to share best practices regarding performance improvement initiatives, especially the use of data to support these efforts. Two regional outcomes management communities of practice have been active in the Mid-Hudson and Long Island regions for more than two years. OASAS would like to expand the number of regions using a community of practice approach to increase the use of outcomes management among providers and at the county level and is interested in identifying providers with experience in outcomes management to sponsor a regional effort.

Providers interested in sponsoring or being part of a regional Community of Practice can expect the following from being an OASAS sponsored Regional Outcomes Management Community of Practice:

- Regular interaction with other participants to include: county administrators, treatment providers, and other service providers working with patients in the substance abuse treatment system.
- Exposure to other practitioners who are engaged in performance improvement and tracking patient outcomes.
- Learning about different tools and data collection mechanisms for collecting data.
- Support and technical assistance from OASAS – Bureau of Planning and Outcomes Management.

OASAS would expect participating members of the Community of Practice to:

- Get regular, consistent attendance from management level staff.
- Have a willingness to share their experiences with performance management.
- Agree to try some new ideas that might be relevant.
- Provide honest feedback on the usefulness of the CoP sessions.

If you are interested in being part of an Outcomes Management Community of Practice in your area, please contact Constance Burke at 518-485-0501 or by e-mail at ConstanceBurke@oasas.ny.gov.

B. Local Needs Assessment and Planning

New York State Mental Hygiene Law requires the county to review existing prevention and treatment services and to determine the addiction service needs of the population within its area of responsibility. To meet this requirement, OASAS requires the county to conduct ongoing needs assessment and planning activities and to report on those activities annually in the local services plan. Identifying and assessing local needs is expected to be an ongoing inclusive process that engages consumers, providers and other stakeholders. In support of local needs assessment efforts, OASAS makes a significant amount of resources available to the counties, including Service Need Profiles which reflect the most current county and regional prevalence and treatment need estimates updated every six months and posted in CPS for easy access.

OASAS Prevalence and Service Need Methodologies

OASAS has developed and maintained county level, service specific need methodologies for a variety of purposes and applications for many years. Service specific need estimates coupled with current resources allow OASAS, counties and providers to determine the relative need for various services on an ongoing basis. Need estimates provide a planning ceiling for service development and have been applied as a criterion in the OASAS certification process for new or expanded programming. Need and unmet need can be utilized by policy makers, funding sources and planners to document and support specific program development initiatives.

The need for specific treatment services is based on estimates of the number of persons with a chemical dependence problem who could benefit from treatment and would likely seek treatment if it was available. Prevalence estimates utilized by OASAS are based on surveys and other information-gathering techniques which distinguish problem use, abuse and dependence estimates for alcohol, heroin, and non-opiate drugs. Separate estimates are generated for adolescents and adults. A detailed description of the OASAS Chemical Dependence Need Methodology is posted in CPS along with the County Service Need Profiles.

Counties are strongly encouraged to conduct their own needs assessments to determine how unique local circumstances may influence treatment needs and demand. **If the county's own research contradicts the needs determined by the OASAS prevalence and service need methodologies, those differences should be documented in the plan so that they can be considered during the review of certification applications submitted to OASAS.**

Over the years, OASAS developed additional tools for counties when applying the service need methodology to local needs assessment efforts. For example, the ***OASAS Outpatient Sub-County Service Plan Form*** gives counties the opportunity to identify those local circumstances that may impact uniquely on the availability or delivery of outpatient treatment services in their particular jurisdiction. The OASAS adult outpatient need methodology can be applied to an approved sub-county outpatient

service plan for project review and certification purposes. A completed sub-county service planning form must be submitted in the county's local services plan and approved by OASAS before it is implemented. Currently, four counties are taking advantage of this tool. Additional guidance on using the Outpatient Sub-County Service Plan Form can be found in Chapter V.

Another need methodology tool that is available to counties is the ***OASAS Community Residence Multi-County Collaborative Agreement*** option. The OASAS service need methodology considers community residential services to be a county-level resource. However, in certain areas of the state where the county bed need estimate does not support the development of a community residence program or where community residence services could be more efficiently and cost effectively provided in a collaborative way among two or more neighboring counties, OASAS may approve a multi-county agreement to have the community residence need methodology applied at a multi-county level, rather than at the individual county level. Today, 14 counties in five separate multi-county areas are taking advantage of this tool. Additional guidance on using the Community Residence Multi-County Collaboration Agreement Form can be found in Chapter V.

OASAS Prevention Planning

In March 2010, the *OASAS Prevention Strategic Plan 2010-2014* was published on the OASAS website. It was developed from data on the consumption patterns and consequences of substance use in New York State and sets priorities that will guide the collaborative prevention efforts of OASAS, state partner agencies, counties, service providers, coalitions, and other stakeholders. It is intended to focus statewide prevention efforts on a limited number of data-driven priorities where measurable change can be achieved and to help guide prevention decision making and policy development at the state, county, and provider levels.

Based on a statewide epidemiological needs assessment process, the prevention strategic plan identified the following priorities to be targeted through evidence-based programs and practices:

- Reduce underage drinking, binge drinking, and alcohol misuse in the New York population across the lifespan;
- Reduce illegal drug abuse and medication misuse to include marijuana use and prescription painkiller abuse among youth;
- Reduce any gambling among youth and problem gambling among adults;
- Reduce parental attitudes favorable towards problem behavior and substance use; and
- Increase family opportunities for pro-social involvement and family attachment.

The OASAS *2012 Prevention Guidelines*, which updates the 2009 guidelines, define and describe acceptable prevention services, strategies and activities for OASAS funded prevention providers and sets minimum program performance standards. It is intended to guide OASAS, providers, counties, and other stakeholders in planning prevention services to effectively address the statewide priorities as well as identified local priorities.

How Local Services Plans Inform OASAS

New York State Mental Hygiene Law requires that OASAS guide and facilitate a process of local planning and that the LGU conduct that process in a manner that engages local providers, consumers and other stakeholders. An ongoing participatory local planning process enables the county to identify and address the addiction needs in the community in an informed and comprehensive manner. Those community needs, and the county's strategies to address them are described in the annual local services plan that is submitted to OASAS. Additional information may also be required in those plans, typically in the form of county and provider planning surveys.

OASAS carefully reviews all information collected through the local services plans to inform and shape agency priorities and to support other agency initiatives. That information represents a key component of OASAS' statewide comprehensive planning efforts. A summary analysis of information collected from the 2012 planning cycle can be found in the *OASAS Statewide Comprehensive Plan 2011-2015*, which is available on the OASAS website. Those summary analyses are also posted in the OASAS Online County Planning System (CPS) to close the feedback loop with counties and providers.

This year, OASAS has included a number of planning surveys that are intended to provide information on a variety of important topics. The purpose of each survey is explained later in these guidelines. Also included in these guidelines are all the questions being asked in those surveys (including all the follow-up and "if-then" questions) and a glossary of terms or phrases contained in the survey to provide further clarification for those completing the surveys? All surveys are completed in CPS. That enables OASAS staff to retrieve the data electronically which ensures more accurate and timelier analysis. The planning surveys include the following:

- **Prevention Planning Survey (LGU)** – Surveys counties on the current and desired role of the LGU in community prevention coalitions and efforts to combat underage drinking.
- **Outcomes Management Survey (LGU & all providers)** – Fourth annual survey on utilizing outcomes management practices in county and provider agencies; supports the Outcomes Management metric on the OASAS Dashboard.
- **Health Coordination Survey (treatment providers)** – Surveys treatment providers on mandated health coordination services; supports required reporting to federal government in compliance with the annual Substance Abuse Prevention and Treatment (SAPT) Block Grant Application.
- **Communicable Disease Activity Log (treatment providers)** – Collects client data related to HIV and HCV admissions, testing and referrals; data not currently collect through the OASAS Client Data System but will be a federal requirement in the SAPT Block Grant Application.
- **Electronic Health Records Survey (treatment providers)** – Follow-up to survey conducted in 2007 to assess the extent to which OASAS providers are utilizing or in the process of purchasing an EHR product.
- **Evidence-based and Best Practice Interventions Survey (treatment programs)** – Third biennial survey to assess the extent to which OASAS

treatment programs have implemented evidence-based practices; supports the Gold Standard metric on the OASAS Dashboard.

- **Domestic Violence Assessment Survey (treatment programs)** – Follow-up to last year's brief survey on the extent to which OASAS treatment programs assess and refer for domestic violence victimization and perpetration; this year's survey assesses the use of standardized domestic violence screening tools.

CHAPTER III: PLANNING FOR MENTAL HEALTH SERVICES

The 2013 Local Services Plan Guidelines provide insight into the areas in which OMH is focusing in an effort to transform NYS' mental health system – a transformation from an episodic, "casualty model" that waits for problems to arise and then offers extensive and expensive treatment, to an "early intervention model" that promotes maintenance of one's wellness and aims to address mental health needs through community-based services with increased capacity. With these changes underway, the prospect for substantial improvements to the mental health system, the promise of recovery, or the possibility for full and meaningful participation in one's community has never been greater for New Yorkers with mental illness. These guidelines outline the context for mental health planning and priority setting at the state and local levels.

Recovery, resiliency and empowerment are the principles underlying these transformational reforms. They help to anchor and guide us through these challenging times of change. The core mission of OMH remains the maintenance and upkeep of the mental health safety net of services; however, that safety net is evolving. As science's ability to offer better treatments for mental illness continues to improve, the mental health system's ability to effectively engage individuals improves, and society's willingness to embrace/accept people with mental illnesses as part of our communities increases – these factors move our mental health system further from institution-based inpatient services and closer toward expanded of community-based, outpatient capacity with the ability to address mental health issues when they first appear. In collaboration with local governmental units and stakeholders, OMH seeks to further strengthen our community-based safety net of mental health services to further the principles and mission of OMH, and help individuals with mental illness live as full, contributing residents of our communities throughout the state.

A. Integrating Behavioral Health and Physical Health Care

In recognition of the need for improved coordination of mental health and substance use disorder services (behavioral health), and physical health services, NYS is engaged in an number of changes that will bring about life-altering improvements for New Yorkers with behavioral health needs and drastically alter the future of behavioral health services in New York State.

Behavioral Health Organizations

As part of Governor Cuomo's efforts to reform and redesign NYS' Medicaid program, OMH and OASAS were granted authority as part of the 2011-12 NYS Budget to contract with regional BHOs. This authority is the first step toward transitioning from a fee-for-service environment to a care management environment. This first step, commonly referred to as "BHO Phase 1," resulted in five regional Behavioral Health Organizations (BHO) selected (Western NY, Central NY, Hudson River, Long Island and New York City) and will provide OMH, OASAS and DOH with the opportunity to learn more about effective care management practices for populations of individuals with behavioral health needs who have never before been included in a managed care structure in NYS. Specifically, contracted BHOs are to:

- Monitor behavioral health inpatient lengths of stay
- Reduce unnecessary behavioral health inpatient hospital days
- Reduce behavioral health inpatient readmission rates
- Improve rates of engagement in outpatient treatment post discharge
- Improve understanding of the clinical conditions of children diagnosed as having a Serious Emotional Disturbance (SED)
- Profile provider performance

The goal of BHO Phase I is to successfully move to Phase II; therefore, the focus of Phase I is on readiness. Contracted BHOs in Phase 1 are utilizing their tools and expertise, collecting and submitting data, and helping to identify where improvements can be made in relation to: inpatient discharge planning; ambulatory engagement/continuity of care; and, utilization of Medicaid data to inform treatment and care planning. BHO Phase 1 will also provide the opportunity to test and develop dynamic, useful metrics for monitoring behavioral health system performance.

MRT Behavioral Health Reform Work Group and BHO Phase 2

In 2013, BHO reform will begin moving to Phase II, involving contracting with specialty managed care plans that will bear financial and clinical risk for establishing and managing systems that address the needs of individuals whose benefits have been "carved out," in integrated plan arrangements. In an effort to develop parameters for this transition, the Governor's Medicaid Redesign Team (MRT) established a Behavioral Health Reform Work Group (BH Reform Work Group) and charged it to:

- Consider the integration of substance abuse and mental health services, as well as the integration of these services with physical health care services, through the various payment and delivery models.
- Examine opportunities for the co-location of services and also explore peer and managed addiction treatment services and their potential integration with Behavioral Health Organizations (BHO).
- Provide guidance about health homes and propose other innovations that lead to improved coordination of care between physical and mental health services."[1]

After a series of presentations on topics pertinent to the BH Reform Work Group's charge and discussion, the BH Reform Work Group submitted final recommendations to the MRT, outlining a set of recommended principles that should apply to the delivery of behavioral health services in any managed care environment as well as specific recommendations in areas pertaining to finance and contracting with plans, eligibility, performance metrics/evaluation; peer services; Health Homes implementation; as well as some issues that were considered important for the Work Group to provide recommendations on, but that were outside the scope of the Work Group's mission: http://www.health.ny.gov/health_care/medicaid/redesign/docs/mrt_behavioral_health_reform_recommend.pdf for the BH Reform Work Group's final report). A few of their recommendations were to:

[1] http://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health_reform.htm

- Invest or reinvest into community-based systems of care (including care coordination, housing, health information exchanges) in order to create the strong, well-functioning system of care necessary to meet the needs of individuals no longer utilizing inpatient care.
- Risk-bearing managed care approaches should bear responsibility to pay for inpatient care at OMH Psychiatric Centers and to coordinate discharge planning from these facilities, and other inpatient settings. As downsizing of these facilities continues, such resources would be reinvested into community-based services (mentioned above).
- Advance the core principle that managed care approaches for people with behavioral health care needs should assist enrollees in recovery and in functioning in meaningful life roles.
- Ensure access to front-line services/benefits to prevent, screen and treat behavioral health disorders by identifying the core elements of the benefit package, including those specific to children.
- Develop outcomes measurements and standards to review performance that are meaningful, easy to measure, validated and readily available, and easy to use – for both adult and children's behavioral health services.

Moving into Phase II, contracted entities will indeed bear risk, be responsible, and be held accountable for the behavioral health services delivered through their network. OMH and OASAS, in consultation with DOH, will be the stewards of this transition to a care management environment. The BHO initiative, is expected to act as a fulcrum to bring about additional transformative efforts, including: replacement of excess institutional capacity with targeted community care and affordable housing; re-orientation of community care staffing to prioritize use of trained/credentialed peer staff to promote recovery; and, the expanded use of data for care coordination, performance measurement and in electronic medical records.

Health Homes

Parallel with the efforts contained within the BHO initiative, NYS is also establishing Health Homes, as is authorized under the federal Patient Protection and Affordable Care Act (ACA), enacted in 2010. This initiative is intended to improve coordination amongst the various medical, behavioral and long-term care needs of individuals on Medicaid – and thereby reduce the $6.3B in costs associated with 400,000 New Yorkers on Medicaid with the most complex and serious mental illnesses/substance use disorders. "A Health Home is a care management service model whereby all of an individual's caregivers communicate with one another so that all of a patient's needs are addressed in a comprehensive manner."[2] Health Homes will consist of a network of organizations that provide a variety of services, all working together to meet the needs of the individuals they serve. These services include: "comprehensive care management; care coordination and health promotion; comprehensive transitional care from inpatient to other settings, including appropriate follow-up; individual and family support, which includes authorized representatives; referral to community and social support services, if relevant; and, the use of health information technology to link services, as feasible and appropriate."[3] "...The use of the

[2] http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/
[3] https://www.cms.gov/smdl/downloads/SMD10024.pdf.

health home service delivery model will result in lower rates of emergency room use, reduction in hospital admissions and re-admissions, reduction in health care costs, less reliance on long-term care facilities, and improved experience of care and quality of care outcomes for the individual."[4]

In essence, Health Homes are responsible for coordinating the various aspects of a Medicaid recipient's medical needs, paid through Medicaid managed care (or fee-for-service until BHO Phase II is implemented beginning in 2013), and promoting communication amongst caregivers. Health Homes are being developed, in part, through "conversion" of OMH's current Targeted Case Management (TCM) program. This will allow Health Homes to utilize the extensive expertise of former TCM providers in engaging and reaching out to people in the mental health system, but includes responsibility for coordinating all medical, behavioral and long-term care needs. This more comprehensive care coordination approach is anticipated to significantly benefit individuals with behavioral health needs by providing more integrated service delivery.

The MRT BH Reform Work Group submitted recommendations to the MRT and DOH on the implementation of the Health Homes initiative. See complete descriptions at:
http://www.health.ny.gov/health_care/medicaid/redesign/docs/mrt_behavioral_health_reform_recommend.pdf). Some of those recommendations were:

- Health homes must include behavioral health expertise and leadership.
- A transitional strategy must be in place to assure the smooth transition of behavioral health services (especially "case management" services) from the 2 year enhanced FMAP stage into the SNP/BHO/IDS environment that will be put in place for 2013.
- All Health Homes should include networks providing both physical and behavioral health care and rules should not distort spending on category of care, whether in health homes with a specialty capacity to serve individuals with SMI and SUD, or other health homes.
- Health homes must coordinate with non-health service providers and have explicit relationships with local governments that often coordinate these services.
- Screening and Brief Intervention for Referral to Treatment (SBIRT) and standard depression screening should be a mandatory element of every Health Home patient assessment.
- The state must clarify the roles and responsibilities of health homes participants.
- The state should work to preserve patient/consumer choice.
- If patients/consumers are automatically assigned to health homes, the state should take steps to ensure that assignment is appropriate.
- The state should incentivize health homes to reach culturally diverse communities and measure performance in this domain.
- Clearer timelines and paths for the implementation of health homes are needed.
- Both the state and health homes should present consumers with user-friendly information.
- Health home employees should be held to appropriate qualification standards, in which the standards of the state BH agencies should be considered.

[4] https://www.cms.gov/smdl/downloads/SMD10024.pdf.

- The State should implement health homes in a fashion that reduces regulatory burden while improving the quality and continuity of care.

In addition, recognizing the unique needs of children and families served by multiple systems of care, the BH Reform Work Group's Children's Subcommittee also submitted a recommendation for a comprehensive and integrated model approach that can be established through the creation of care coordination entities, a model for which is currently under development by the child serving state agencies. A full listing of Children's recommendations found at:
http://www.health.ny.gov/health_care/medicaid/redesign/docs/mrt_behavioral_health_reform_recommend.pdf

After receiving more than 150 applications to become a Health Home, NYS has established a three phase process to the Health Homes roll-out, with an increasing number of counties moving to the Health Home model in each phase; Health Homes are scheduled to be fully implemented in all counties by July 1, 2012. Community-based providers, including mental health organizations, have been strongly encouraged either to take the lead in establishing a Health Home or to partner with an organization taking the lead in establishing a Health Home network in their region. A full listing of all the designated Health Homes participating in Phase 1 can be found at:
http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/prov_lead_designated_health_homes.htm

"Eligible health home members will be assigned directly to approved (Health Home) networks by the state and will be assigned through health plans for members enrolled in Medicaid Managed Care. Initial assignment to state approved Health Home providers will be based on:

1. Higher Predictive Risk for Negative Event (Inpatient, Nursing Home, Death)
2. Lower or no Ambulatory Care Connectivity
3. Provider Loyalty (Ambulatory, Case Management, ED and Inpatient)
4. Geographic Factors

The state has provided each managed care plan with a Health Home eligible list of patients sorted from highest to lowest predictive risk. The state is working on the development of Patient Rosters for each county in the wave one rollout that take the factors above into priority consideration for initial health home assignment. The goal is to assign and outreach to the highest risk (based on a predictive model) and highest cost members with the lowest primary and ambulatory care connectivity in each health home area. Once those members have been assigned and enrolled then the state and health plans will move down the list using provider loyalty and geography as markers for initial health home assignment. The details of this algorithm will be approved by all the State partners (DOH, OMH, AIDS Institute and OASAS) and will be recommended to health plans as one means of distributing members through intelligent assignment to each of the State approved health homes." [5] Once individuals have been assigned to a Health Home, they will have the option to choose a different Health Home provider or opt out of Health Home enrollment altogether.

[5] http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/2012-01-24_preliminary_hh_rollout_plan.pdf

After recently receiving approval from the Centers for Medicare & Medicaid Services (CMS) for the State Plan Amendment that will allow the first phase of Health Home implementation to proceed, NYS is now working to commence assignment of individuals into provider-led Health Homes in March and allow programs to bill for patients they are already serving under Health Homes retroactive to January 1, 2012.

The BHO and Health Home initiatives, when considered together, are designed to accomplish common goals: to improve healthcare delivery and integration of care; to improve outcomes for Medicaid beneficiaries; to reduce or eliminate unnecessary state expenditures; to facilitate recovery; and, to improve the capacity of communities to achieve those goals. Together, these initiatives will create fundamental changes in the way in which mental health and substance use disorder services are delivered and usher in a new era of accountability and integration.

B. Recovery-Focused Initiatives

First Episode Psychosis Teams and Employment

As part of the shift underway toward supports and services that are recovery-focused, OMH is initiating a number of initiatives that it believes will successfully help bend the curve of individuals with mental illness who experience long-term disability, in part resulting from mental health services that have often done more to perpetuate long-term disability than prevent it.

One such initiative is aimed at establishing the first statewide “First Episode Psychosis” team capacity in the country, here in NYS. Currently, care for people with psychotic disorders such as schizophrenia involves cycles of decompensation, hospitalization, discharge without a well-coordinated plan, relapse, and repeating the cycle. In an effort to break that cycle, OMH intends to develop this capacity to immediately engage individuals when they first experience psychotic symptoms. These teams will seek to provide early intervention, engaging the individual to develop a realistic and clinically informed plan that helps them quickly realize the prospect of recovery and assists them in maintaining and building upon their recovery. Using models proven effective in Australia, the UK, and selected locations in the U.S., OMH believes that significant numbers of individuals can avoid long-term disability and continue living in the community.

Another such example is OMH’s work to promote competitive employment amongst people with mental illnesses and increase the employment rate for people with mental illnesses, which currently stands at approximately 10% in NYS. For the past several years, OMH has overseen the Medicaid Infrastructure Grant related to supporting competitive employment opportunities and outcomes for people with disabilities in NYS. Utilizing this grant, OMH partnered with the NYS Department of Labor to develop a comprehensive employment services coordination, job-matching and data system – the New York Employment Services System (NYESS) (www.nyess.ny.gov). Through NYESS, NYS will considerably enhance its ability to improve employment outcomes for New Yorkers with disabilities, and prove greatly beneficial to businesses/employers and providers of employment supports. Amongst the benefits of NYESS is the ability to automatically generate documentation necessary for

providers of employment-related supports to claim milestone payments under the Social Security Administration's Ticket-To-Work program. These resources will allow both providers of employment services and NYS to invest further in their employment programs, including the development of a benefits counseling/life coaching capacity employing individuals with disabilities to assist others with disabilities to make the transition to economic self-sufficiency.

Housing

Reducing reliance on more costly, traditional mental health housing models and improving the supply of supportive housing remain priorities for OMH. OMH works closely with providers of housing services and stakeholders to evaluate and convert (where possible) staffed housing programs to integrated housing settings, supported housing and treatment apartments. As part of the Governor's proposed budget, OMH plans to support an additional 1,000 supported housing units for residents of nursing homes (600 by the end of 2013); 5,100 supported housing beds over the next three years to deal with emerging needs, including individuals in adult homes and those moving to the community from state psychiatric hospitals (2,100 by the end of 2013); and 3,400 beds for the NY-NY III program (800 by the end of 2013).

Children's Initiative

The Children's Plan

The Children's Plan, developed in October 2008 by nine state agency Commissioners from child-serving agencies in NYS, represents a blueprint for how to support the social and emotional well-being of children and their families. Under the leadership of the Council on Children and Families, the heads of the child-serving state agencies, with the active participation of family and youth partners and other stakeholders, work towards following paths that demonstrate fidelity to the values and principles underlying the Children's Plan. Two exciting efforts initiated in The Children's Plan include Promise Zones and various Early Childhood initiatives.

NYS Promise Zones

In recognition of the multiple and complex needs of children and their families, Promise Zones (http://www.ccf.state.ny.us/Init/ChildPlan/cpPromPrac.htm#pz) were developed as a strategy to achieve New York State's goals of student engagement, academic achievement, dropout prevention, social and emotional competence, establishing positive school culture and school safety. This nationally recognized initiative formalizes partnerships among local school districts and child-serving state and local agencies, with initial sites located in Syracuse, Buffalo and New York City. Updates on the progress in each site can be found at:
http://www.ccf.state.ny.us/Init/ChildPlan/cpResources/PromiseZoneUpdateMarch2011.pdf

The goals of these efforts is to increase positive engagement in the instructional process measured by improved academic outcomes, attendance and other indicators of an increase in instructional time, including reduced absenteeism, truancy and incidents resulting in discipline; and to identify a replicable model for collaborative planning and

service delivery to improve educational and health outcomes for children in high need districts/schools statewide.

Early Childhood Initiatives

Historically, the children's mental health system has not played an active role in early childhood programs and services for children under the age of five and their families. As a result of *The Children's Plan,* OMH has since become an active participant, including membership on the steering committee of the Early Childhood Advisory Council (ECAC), which provides advice to the Governor on issues related to the development of a comprehensive system of supports and services for young children and their families.

In addition, OMH serves as the co-chair of the Promoting Healthy Development Workgroup of the ECAC, which is a cross-systems collaboration to promote optimal health and development in all domains, including social-emotional development for young children. Out of these efforts, the workgroup developed recommendations for Social and Emotional Development Consultation in Early Childhood settings. These recommendations have led to the creation of a focus on increasing awareness and understanding of social-emotional development through trainings, supports and resources throughout the state. For more information on ongoing early childhood initiatives go to http://www.ccf.state.ny.us/NavPages/early.htm.

Addressing the Quality and Vitality of Children's Clinic Services

Currently, it is a challenging time for clinics due to recent changes in regulations, financing, and the overall environment. Clinics must be more productive, more efficient, and more business-savvy. As a result, they need support and technical assistance to negotiate this rapidly changing environment. Two efforts are underway to support clinics in reaching policy objectives centered on early identification, comprehensive assessment, family engagement, and improved access to effective treatment.

Redesigning Child and Family Clinic-Plus

Child and Family Clinic-Plus (Clinic-Plus) was OMH's effort to establish social and emotional development as a statewide priority through early identification and evidence-based treatment. Over time, it became clear that stigma associated with seeking mental health services, as well as challenges in effective business planning, were contributing to provider's inability to meet performance targets associated with Clinic-Plus program elements.

Therefore, OMH has redesigned the Clinic-Plus program to focus on performance-based early recognition, coordination and screening, for which contracts were recently awarded. Selected providers will be required to screen at least 1000 children annually in order to retain their contract and are encouraged to develop partnerships with other children serving entities in the community in order to maximize the number of children who are identified and served. In addition, Clinic-Plus redesign includes one-year incentive grants to support the development of new mental health satellite clinics located in primary care settings, which will help develop a comprehensive approach to integrated care that OMH is seeking to establish. This partnership will

provide a unique opportunity to identify those children and families who might not otherwise seek treatment and strengthens the capacity for earlier recognition and treatment options in an atmosphere that recognizes the interconnectedness between physical and mental health.

Children's Technical Assistance Center

As a result of clinic restructuring and the lessons learned through Clinic-Plus, it became apparent that children's clinic providers would benefit from ongoing support and technical assistance aimed at the development of strong business and financial models to ensure sustainability.

The Children's Technical Assistance Center(C-TAC) initiative assists children's clinic providers in enhancing the infrastructure necessary to support their evolution towards the new clinic model. C-TAC engages a number of organizations to provide training and support on quality improvement strategies, including clinical and organizational skills, and evidence-based practices, to all interested NYS child-serving mental health clinics with the overall goal of improving mental health outcomes for children and their families. Participation in C-TAC activities takes place on a project-by-project basis and agencies are invited to participate in projects that are relevant to their individual needs.

C. Creating Additional Opportunities for Integration

As part of the Executive Budget proposal, the Governor recommends the creation of a Behavioral Health Services Advisory Council that would replace the OMH Mental Health Services Advisory Council and the OASAS Advisory Council on Alcoholism and Substance Abuse Services. This new body would assume the responsibilities of the two previous Councils, allowing OMH and OASAS to begin to work even more closely, especially with regard to licensing of services and regulations. In addition, the Governor's proposal would change the current Statewide Comprehensive Planning process, allowing OMH and OASAS, and OPWDD, the opportunity for more collaborative planning that would assist the agencies in moving closer toward a seamless system of service delivery. Lastly, Governor Cuomo's proposed budget includes granting DOH, OMH, OPWDD and OASAS authority and flexibility to jointly establish operating, reporting and construction requirements for service providers that can demonstrate expertise and competence in the delivery of health, mental health and alcohol and substance abuse and developmental disabilities services.

CHAPTER IV: PLANNING FOR DEVELOPMENTAL DISABILITY SERVICES

A. Background

This year's *Local Services Plan Guidelines* build upon our successful partnership with the Conference of Local Mental Hygiene Directors, the Office of Alcoholism and Substance Abuse Services (OASAS), and the Office of Mental Health (OMH). In the 2012 planning cycle, OPWDD continued to invest in an integrative planning approach which allowed for improved outcomes for individuals with disabilities and streamlined processes for counties.

The purpose of the local services planning process is to assist OPWDD in determining local priorities for services and inform the agency's strategic plan. Counties specify outcomes for the future service system and identify strategies to reach these outcomes. Counties should also consider opportunities for increased collaboration around cross systems concerns, or issues which require cooperation between different service systems.

The guidelines for developmental disability services highlight OPWDD's commitment to "Putting People First" by supporting individuals with developmental disabilities to live richer lives through individualized, person-centered services. To better align the county planning process with the OPWDD mission and vision, the *OPWDD Statewide Comprehensive Plan: 2011-2015*, located on the OPWDD Website, has also been made available on the county data page of CPS. Counties will be able to connect their local priorities with priorities shared throughout the state as described in the Plan.

As in previous years, we emphasize the need for involving all stakeholders in the planning process, including individuals with developmental disabilities, their family members, advocates, providers, and state/local government staff. This can be done many different ways, including public forums or hearings, focus group discussions, interviews or surveys. Information and feedback should be solicited on an ongoing basis from stakeholders, and steps should be taken to address issues that may cross various systems of service delivery. Regular dialogue between self-advocate councils, planning committees, and the Community Services Board subcommittee is strongly encouraged.

For the past three years, OASAS, OMH and OPWDD have worked cooperatively with our county partners to design, implement and improve upon the local services planning process through the development of CPS. Much has been accomplished through this collaboration, and OPWDD is excited about what the future holds.

B. Guiding Principles

As required by Article 41 of the New York Mental Hygiene Law (MHL), it is the responsibility of the county to work with the state to develop a local services program and plan for its citizens with developmental disabilities. To develop a comprehensive, coordinated Local Services Plan for people with developmental disabilities, the county must research, review and determine local best practices, issues, concerns and needs in terms of supports, services and infrastructure. The county may also assume a leadership role in promoting public understanding and awareness of, and facilitating interagency collaboration to meet the needs of people with developmental disabilities.

To that end, the county is required by Article 41 to submit to OPWDD an annual plan. This plan is developed by the county in collaboration with the local Developmental Disabilities Services Office (DDSO) and all local stakeholders. To facilitate a more meaningful and efficient process, the planning processes of OPWDD, OMH and OASAS are integrated as one process through CPS.

Given multiple, ongoing state level initiatives such as health homes, behavioral health organizations, and the People First Waiver, counties have a responsibility to ensure information on concerns for all disability populations is regularly updated. Each year the county will assume a leadership role in identifying the most important local issues of concern and create an action plan for responding to these issues. It is anticipated many outcomes and strategies will be continued from year to year in the plan. This year, the county has the option to build upon information from the previous year or may decide to develop new priorities and outcomes in response to the changing environment. It is important to understand that the Local Services Plan does not have to be inclusive of all services planned, although local services and proposed projects should be consistent with the Plan. The Plan should not be project- or provider-specific, but rather should set directions for future planning.

In planning for OPWDD services, counties must develop their priority outcomes based on OPWDD's mission and vision for individuals with developmental disabilities:

Mission Statement: *We help people with developmental disabilities live richer lives*.

Vision Statement: *People with developmental disabilities enjoy meaningful relationships with friends, family and others in their lives, experience personal health and growth, live in a home of their choice, and fully participate in their communities.*

- **People First:** People who have developmental disabilities have plans, supports, and services that are person centered and as self-directed as they choose
- **Home of Choice**: People who have developmental disabilities are living in the home of their choice
- **Work or Contributing to the Community:** People who have developmental disabilities are able to work at paying jobs and/or participate in communities through meaningful activities
- **Relationships:** People who have developmental disabilities have meaningful relationships with friends, family, and others of their choice
- **Good Health:** People who have developmental disabilities have good health

Each of the "people first" areas guide the *OPWDD Statewide Comprehensive Plan for 2011-2015.* Also, the *OPWDD Strategic Framework* in the county data section of CPS offers a concise presentation of statewide goals, outcomes, and key activity areas. The key outcomes and activities correspond to areas identified as important by self-advocates, family members, providers, and other stakeholders. Local priorities should be carefully balanced with these statewide priority areas:

People First

- Person-centered Planning
- Self-directed Supports and Services
- Self-Advocacy
- Brokerage
- Simplified and Streamlined Processes for Individualized Services
- Provider Capacity to Deliver Individualized Supports and Services

Home of Choice

- Supporting Families
- Community Living
- Individual Support Services
- Housing Initiatives
- Shared Living
- Family Care
- Children's Residential Services
- Nursing Home Diversion
- Deinstitutionalization

Work or Contributing to the Community

- Employment
- Transition Planning
- Seamless Supports between Work and Habilitation
- Volunteerism
- Fostering Community Acceptance

Relationships

- Community Inclusion
- Building Relationships with Staff
- Staff Recognition and Mentorship for Inclusion
- Community Participation
- Faith-Based Initiatives

Good Health

- Prevention
- Smoking Cessation
- Quality Dental and Medical Care
- Telemedicine
- Osteoporosis
- Medication Management
- Nutrition
- Article 16 Clinical Services
- Behavioral Health
- Electronic Records
- Medicaid Managed Care
- Medicare
- Guardianship, Advance Health Care Directives, and Surrogate Decision-Making

Themes Affecting All Services

- Quality Management
- Workforce Development
- Personal Responsibility
- Special Populations
- Interagency Collaboration
- Public Information and Outreach
- Crisis Intervention
- Access to Services
- Coordination of Services
- Research and Best Practices Identification
- Regulatory or Policy Reform

The county may also consider other topic areas that impact services for people with developmental disabilities that do not readily fall into one of these categories.

The planning process incorporates input from the local constituency to inform the local Developmental Disabilities Services Office (DDSO) of critical needs and priorities. DDSOs consider the identified key outcomes when issuing "Requests for Proposals" and

when partnering with stakeholders in forums promoting any *"new"* services development, and enrollments for *NYS-CARES*, *Family Support Services (FSS)* and *Home and Community Based Services (HCBS)*. The county plans are also analyzed for themes that help determine the state's strategic planning and annual budget requests.

The county is jointly responsible, in partnership with the state, for the policies, administration and supervision of developmental disabilities services within the locality. Cooperation with other county departments and access to all local resources should also be sought to ensure advancement of the plan.

A unified and comprehensive planning process will enable people with developmental disabilities, families, providers, planners, funders, regulators and legislators to participate as full planning partners. It is very important to involve individuals with developmental disabilities in creating the plan so their input can provide the foundation for service planning.

C. The Planning Process

1. **A working relationship between DDSOs, counties or boroughs, individuals with developmental disabilities, their families or advocates, voluntary providers and other state agencies** must be formed as a first step in the planning process. This collaboration between the county, the DDSO and other stakeholders is essential to the production of a meaningful plan reflecting the needs of all county residents.

2. The new plan will be for the year **2013,** but the outlook should be for three years.

3. The identification of local issues and needs through **a discovery process** and the development of strategies should occur through an ongoing needs assessment process. In preparing the Local Services Plan, counties are requested to periodically conduct discovery activities in order to identify and measure the issues, concerns, problems or service gaps that exist within the local community. The discovery process should be representative of the stakeholders in the county.

   A. Counties can gather information from various constituent groups, including:

      - Individuals with developmental disabilities
      - Families
      - Existing advocacy entities, such as Consumer Councils, Borough Councils and self-advocacy groups
      - Providers of services for people with developmental disabilities, including Medicaid Service Coordinators
      - Community Service Boards
      - Schools and Boards of Education
      - Early Intervention Officials
      - Hospitals
      - Other organizations that may support people with developmental disabilities, such as Departments of Social Services, Mental Health providers or Offices for the Aging

The **DD Subcommittee Membership Form** tab is for identifying the members of the Community Services Board Subcommittee on Developmental Disabilities.

B. Various methods of discovery can be conducted including:

- Surveys
- Community forums
- Key informant interviews
- Focus groups on topics of targeted interest or for specific populations
- OPWDD county specific data upon request to Director/NYCRO Associate Commissioner
- Analysis of prevalence, demographic, and risk indicator data available through other resources:

  - CDC Metropolitan Atlanta Developmental Disabilities Study (provides US population-based epidemiological data on the prevalence of mental retardation, cerebral palsy, epilepsy, visual impairments and hearing loss in school-aged children) www.cdc.gov/ncbddd/dd/madds.htm
  - State of the States in Developmental Disabilities (profiles NY's long term care services and supports for children and adults with developmental disabilities; 2008 is now available for purchase) www.cu.edu/ColemanInstitute/stateofthestates/
  - US Census Bureau statistics. www.census.gov/
  - The American Community Survey http://www.factfinder.census.gov/servlet/DatasetMainPageServlet?_program=ACS&_submenuId=&_lang=en&_ts=
  - CDC National Center for Health Statistics. www.cdc.gov/nchs/
  - CDC National Center on Birth Defects and Developmental Disabilities www.cdc.gov/ncbddd/
  - Disability and Health State Chartbook – 2006 http://www.cdc.gov/ncbddd/disabilityandhealth/chartbook/states.html
  - NYS Touchstones/Kids COUNT Data Book
  - http://www.omh.state.ny.us/omhweb/PCS/survey07/
  - NYS Office for the Aging. http://www.aging.ny.gov/Index.cfm
  - NYS Department of Health Community Health Data Set and other data links http://www.health.state.ny.us/statistics/chac/nysdoh_program_data.htm
  - Vital Statistics www.health.state.ny.us/statistics/
  - County Health Indicator Profiles www.health.state.ny.us/statistics/chip/index.htm
  - NYS Department of Health SPARCS Annual Report http://www.health.state.ny.us/statistics/sparcs/annual.htm

- Congenital Malformations Registry http://www.health.state.ny.us/diseases/congenital_malformations/2006/index.htm
- Number of Medicaid Eligibles by Category of Eligibility by Social Service District http://www.health.state.ny.us/nysdoh/medstat/medicaid.htm
- Community Health Assessment Clearinghouse links http://www.health.state.ny.us/statistics/chac/
- Administration on Aging http://www.aoa.gov/AoARoot/Aging_Statistics/index.aspx
- Disability Data at InfoUse http://www.infouse.com/disabilitydata/home/index.php
- National Institutes of Health http://report.nih.gov/
- National Institute on Disability and Rehabilitation Research http://www.ed.gov/about/offices/list/osers/nidrr/index.html
- 2008 Disability Status Report for the US http://www.disabilitystatistics.org
- Disability Statistics Center http://dsc.ucsf.edu/main.php
- National Dissemination Center for Children with Disabilities http://www.nichcy.org/Pages/Home.aspx
- Bureau of Justice Statistics www.ojp.usdoj.gov/bjs/
- FEDSTATS (lists many resources) http://www.fedstats.gov/

C. The discovery process will provide the means to confirm and document what is observed or reported anecdotally about problems and needs within a community. **It is important that the outcomes identified as the most important for the development of an action plan be validated by the planning group based upon documentation from at least two different types of information sources**.

D. **The discovery process should be used to develop outcome statements in common language which describe a three year plan for the county service system**. These outcomes will guide the county in discussing what activities and strategies may be necessary to move the local system in the desired directions. *Examples* of outcome statements are:

- *Increased accessible housing for young adults waiting to move out of their family homes*
- *Greater choice and control of individualized services*
- *Increased access to psychiatry services for children*
- *More systems collaboration to support people with challenging dual diagnoses needs*

A way to collect this information is to ask stakeholders to identify **what their vision is for a "better system," what is currently working, what is not working well, and what should be done to reach the "better system."**

E. OPWDD will continue to provide current registration data on the number of people who are registered for out-of-home residential opportunities as

documented through the NYS-CARES program. This information is available under the **County Data** tab of the Web-based application.

4. **Following the identification of outcomes, the county will facilitate a decision-making process to build consensus between planning stakeholders regarding the most important outcomes to address over the next three years. These outcomes do not need to be ranked in order of importance, but will provide guidance on the local priorities for service development.** The selected outcomes should not be viewed as excluding development in other areas.

   Selected priority outcome statements should be documented on the **Priority Outcomes** tab of the Web-based application.

5. Following development of a list of the selected outcomes to be addressed, the county will begin dialogue with the various stakeholders on the **strategies and action steps necessary to resolve or begin to address the identified issues. Strategies are required and should be documented on the appropriate planning form; a detailed action plan is not required for submission.** However, a general action plan will be necessary in order to assess progress each year towards reaching desired outcomes. The county should consider timeframes, and which stakeholders will assume responsibility in follow-up activities. An action plan would appropriately identify:

   A. Those activities that OPWDD would need to support/implement,
   B. Those activities that local provider agencies will engage in,
   C. Those activities families and advocates can best address, and
   D. Those activities the county is best prepared to respond to.

   Stakeholders other than OPWDD may be better poised to address gaps in services between systems or may provide resources to help facilitate bridges for service gaps.

6. In order to develop an action plan, counties will need to **assess the local capacity and resources** currently available that can address the identified needs. OPWDD will provide data annually in the **County Data** section of the Web-based application on the number of service-specific enrollments and the average costs of services. More detailed enrollment data reports by agency may be available upon request from NYCRO or DDSO. Also, though OPWDD makes every effort to assure that the data provided is correct, there may be some differences between the information in the **County Data** reports and the most recent DDSO data**.** DDSOs should be consulted for verification.

   The action plan should also identify an inventory of generic services available within the county that can meet the needs of people with developmental disabilities and their families (e.g., health and medical services, education, housing options, transportation, mental health services, drug and alcohol services, organized recreational opportunities, senior services, social services). Identifying these resources will help to ensure they are being utilized to the fullest

extent, to define barriers to access, and to develop strategies to address those barriers as appropriate.

The **County Data** section provides annual average per person funded amounts for the services and supports in your region. These amounts are derived from the Fiscal Year 2010-2011 budgeted amounts for these services in your region. The regions are defined for budgeting purposes as follows:

Region I: The five counties (boroughs) of New York City
Region II: Nassau, Orange, Rockland, Suffolk, Sullivan, Westchester Counties
Region III: All counties not in Regions I and II

The budget figures included in the **County Data** are regional averages and as such may not reflect specific local amounts. Counties may estimate the approximate total public funding by multiplying the regional per person funding amounts with the number of people with developmental disabilities in each service category (in their county). Regional funding information and amounts for all funding elements were not available for all service categories.

Space for narrative information and a grid are provided in the **Planning Activities Report** for documenting the current local services capacity, but **submission to OPWDD is optional.** Specific information related to the local capacity to provide services to people with cross systems disability needs is provided on the **Multiple Disabilities Consideration Form**.

The **County Data** also contains two sources of data regarding counties and participation of residents in campus programs such as developmental centers. One source provides a count of the number of people in various campus programs who live in the county. In some instances, these numbers will be large and reflect the presence of a developmental center in the county.

The **County Data** contains another dataset that presents a summary of enrollment of former county residents in campus programs, labeled *County of Interest/Origin*. This data presents the number of people living in a DC (Developmental Center), Autism unit, MDU (multiple disabilities unit), CIT (Center for Intensive Treatment), RBTU (Regional Behavioral Treatment Unit), LIT (Local Intensive Treatment Unit), RIT (Regional Intensive Treatment Unit) or SRU (Small Residential Unit).

For people who have a reported county of interest, the county of *interest* is used; for people with no county of interest on record, the county of *origin* is used. The county of interest is *the county to which a person would return if he or she was discharged from a campus program today*, whereas the county of origin is *the county in which the person lived when he or she was first admitted to a developmental center.*

This total provides the best available count of county residents enrolled in campus services. There may be charge-backs to counties under the Criminal Procedures Law for some, but not all, of the people who have enrolled in campus services.

7. **For outcomes already underway, progress on strategies should be reported and priorities updated** as needed. Specific elements for reporting include:
    - Statement of progress on previously selected outcomes
    - Explanation of specific actions undertaken to resolve issues
    - Best or promising practices
    - Obstacles or barriers in achieving progress
    - Planned actions or recommendations for overcoming obstacles

1. The **preliminary draft** should be made available for public review and comment with special attention given to the input of individuals with developmental disabilities and their families.

B. Upon receipt of all comments to the preliminary draft, a **final plan** should be developed which incorporates the input received.

C. The final Local Services Plan **must be approved by the County Director of Community Services and the DDSO Director.** The plan should be submitted first to the County Director for certification and subsequently to the DDSO Director, who is acting as the OPWDD Commissioner's designee for the purposes of compliance with Article 41. **The DDSO Director is requested to respond to the proposed plan within 30 days of receipt of the completed Plan.** All portions of the Plan to which OPWDD agrees shall be promptly approved and such approvals shall not be delayed pending approval of other portions of the plan whenever permissible. Article 41 provides additional guidance for those portions of plans not approved.

D. If you have questions, please contact:

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CHAPTER V: COUNTY PLAN GUIDANCE AND FORMS

The mental hygiene local services planning process is intended to be an ongoing, data driven process that appropriately engages providers, consumers and other stakeholders in identifying local needs and developing strategies to address those needs. As noted in Chapter I of these guidelines, NYS Mental Hygiene Law requires each LGU to develop and annually submit to each mental hygiene agency a local services plan that establishes long-range goals and objectives consistent with statewide goals and objectives. In addition, the law 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 and needs assessment efforts.

This chapter provides guidance to assist counties in meeting those requirements. The guidelines and planning forms contained in this chapter have been streamlined in an effort to reduce the reporting burden of the LGUs while improving the clarity and overall quality of the information reported to the state. As always, all local services plans will be completed and submitted using electronic forms contained in the Online County Planning System (CPS). At the discretion of the LGU, additional support documentation may be attached to the online forms.

A. Mental Hygiene Priority Outcomes Form

The Mental Hygiene Priority Outcomes Form was introduced in 2008 as the first fully integrated county planning form. Its purpose was to facilitate a more person-centered planning process that focuses on cross-system collaboration. The form was designed to provide counties with a process for developing priorities in a consistent manner across the three mental hygiene disabilities. It was intended to improve the ability of counties to conduct local planning and develop priorities consistent with state goals and priorities.

After four years of minimal changes to this form, an analysis was conducted to assess how well the form was meeting the needs of the three state mental hygiene agencies and what improvements could be made to the form and the process. That analysis revealed several opportunities for improvement:

1. Some priority outcome statements were too vague or general, written in a way that made it very difficult to identify what the priority was or not focused enough on a clear and achievable outcome.
2. Some priority outcome statements were too detailed or specific, focused on activities that the county or providers engage in on a routine basis.
3. Some priorities were general statements of ongoing activities that the county identified as maintenance of effort, rather than focused on a desired change.
4. Some priorities and strategies were too wordy, defeating the intended objective of identifying desired change in a clear and succinct way.
5. Some priorities and strategies indicated one or more applicable disability agencies that appeared inconsistent with the stated priority or strategy.
6. Some counties included a significant number of priority outcomes. The number of priorities included in last year's plans ranged from a low of four to a high of 53; 21 counties had more than ten priorities; the average was 11. In some cases, it

was clear that certain priorities could have been combined, while others would have more been more appropriate as strategies under a single priority outcome.

Based on this analysis and input from the annual CPS User Satisfaction Survey, the Mental Hygiene Planning Committee proposed the first substantive changes to this form since its inception. The primary purpose of these changes is to streamline the form and to provide clearer guidance on the development of meaningful priority outcomes and strategies that better inform the comprehensive statewide planning efforts of the three state mental hygiene agencies.

The following is a simple crosswalk between the components of the previous priority outcomes form and the revised form that counties will be utilizing in this year's plan. Unlike previous years, this form has not been pre-populated with the information contained on last year's form. Because of the significant changes to the form, all information will need to be entered anew. Please note that you can still go into the CPS 2012 archive and retrieve any information contained on last year's forms and copy it into the new form.

Crosswalk Between Old and New Priority Outcomes Form

Old Priority Outcomes Component	New Priority Outcomes Component
Priority Outcome Statement - Clear and succinct statement of desired outcome.	**Priority Outcome Statement** - Remains unchanged.
Description of Outcome Statement - Allowed for detailed explanation of the priority outcome.	**Rationale** - Limited to one or two brief paragraphs (text only) and will provide the basis for addressing the priority issue.
Current Status - Indicates if the priority is in progress, accomplished, or dropped.	**Dropped** - All priorities included on the form will be considered "in progress."
Anticipated Year of Completion - Provided a timetable for completing within a 3-year planning horizon.	**Dropped** - Counties will no longer be locked into a specific planning timetable.
Applicable State Agency - Indicates to which state mental hygiene agency the priority applies.	**Applicable State Agency** - Remains unchanged.
A Top Two Priority - Indicates that the priority is a top two by disability.	**A Top Two Priority** - Remains unchanged.

Old Strategy Component	New Strategy Component
Strategy Description - Identifies the approach to be taken to help achieve the desired outcome.	**Strategy Description** - Remains unchanged.
Applicable State Agency - Indicates to which state mental hygiene agency the strategy applies.	**Applicable State Agency** - Remains unchanged.
Current Status – Indicates if the priority is in progress, accomplished, or dropped.	**Dropped** - All strategies included on the form will be considered "in progress."
Anticipated Year of Completion - Provided a timetable for completing within a 3-year planning horizon.	**Dropped** - Counties will no longer be locked into a specific planning timetable.
	Metric - A meaningful, measurable and manageable target that will demonstrate the success of the strategy.
Progress Report - Summary of progress made on the strategy of the past year.	**Progress Report** – Brief report only on strategies continued from previous year. (Not included in CPS 2013)
Strategy Focus – A drop down menu to select up to two areas on which the strategy focuses.	**Dropped**
Innovative Practice – Indicates if the strategy represents an innovative or effective planning practice.	**Dropped**

In addition to the changes noted in the crosswalk chart above, there are a number of other important aspects of the new Priority Outcomes Form that you should be aware of, including:

- In previous years, counties were required to include a minimum of three priorities per disability. On the new form, that requirement has been dropped. However, it is expected that the county's priorities will adequately address each disability.
- Since counties will no longer be required to include a minimum of three priorities per disability, there will no longer be a requirement to indicate the "top two" priorities per disability. However, counties will now be required to indicate their top three to five priorities, overall, depending on the number of priorities included in the plan. Top priorities will not be required by disability.
- In previous years, there was no maximum limit on the number of priorities a county could include in the plan. On the new form, the county may still include any number of priorities it chooses, but the state agencies will likely only consider the top 10. The Mental Hygiene Planning Committee has adopted the philosophy that "if everything is a priority, nothing is a priority." We believe that with improved guidance and training on the development of priority outcomes and strategies, most counties will ultimately have no more than ten priorities,

anyway. In the plan, the first ten priorities will be designated as "Tier 1 Priorities," while all priorities beyond the first ten will be designated as "Tier 2 Priorities."

- In an effort to force brevity, all text items on the new Priority Outcomes Form will be limited to no more than 200 words. That is about two average paragraphs. If a county wishes to add more documentation, you will have the option of attaching documents to the form.
- Based on input from county planners, you will now have the flexibility to reorder priorities after they are entered on the form. It is important to note that the order in which priorities appear in the plan does not signify a rank ordering of priorities.

Instructions for completing the Priority Outcomes Form

The Priority Outcomes Form is designed to allow counties to identify forward looking, change-oriented priorities that respond to local needs and are consistent with the goals of the state mental hygiene agencies. County priorities also inform the statewide comprehensive planning efforts of the three state agencies and help to shape policy, programming and funding decisions. For county priorities to be most effective, they need to be clear, focused, and achievable. The following instructions will help counties develop effective priority outcomes statements and associated strategies and metrics.

Priority Outcome Statement

The priority outcome statement should be a 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. It should not be a broad philosophical statement about how things should be, nor should it be a statement about ongoing activity that simply maintains the status quo. The following are examples of acceptable priority outcome statements:

Example #1: Expand access to safe and affordable housing.

Example #2: Enhance the quality of treatment services provided to persons served by county's mental hygiene service system.

Rationale

The rationale should be a brief (one to two paragraphs) explanation of the basis for including the priority outcome in the plan. It answers the question "Why is the desired change necessary?" Note: There will be a 200-word limit built into the form for this item. If additional documentation is necessary, it may be attached to this form.

Applicable State Agency

Indicate the state mental hygiene agency that this priority outcome pertains to. If this outcome pertains to more than on agency, check all that apply.

☐ OASAS
☐ OMH
☐ OPWDD

A Top Priority

After all priority outcomes and related strategies have been entered onto the form and you are ready to certify the form for submission, you will need to indicate the top three to five priorities in your plan. The number will depend on the overall number of priorities in your plan. You cannot certify this form until you have indicated the top priorities.

Strategy Description

The strategy description should identify the approach to be taken to help achieve the desired outcome. It answers the question "How will the outcome be achieved?" There is no limit on the number of strategies associated with a priority outcome. The following are examples of strategies associated with the earlier examples of acceptable priority outcome statements:

Example #1: Increase the number of transitional supportive housing beds for individuals leaving treatment.

Example #2: Increase the number of clinical staff who have been trained in integrated treatment for co-occurring disorders.

Metric

A metric is a **meaningful**, **measurable**, and **manageable** target that will demonstrate progress on the associated strategy. It answers the question "How will we know if we are successful?" The best guide to writing realistic and effective metrics is to be sure that it meets the following criteria:

- **Meaningful** – You want to measure something that is directly related to the strategy and, ultimately, achieves the desired outcome. A metric must be important enough to devote resources necessary for collecting and analyzing data and communicating results. It could include such things a people served, staff trained, capacity added, etc.
- **Measurable** – The metric must be quantifiable, typically expressed in terms of an increase or decrease in number or percentage over a specific timeframe.
- **Manageable** – The desired change resulting from the strategy should be within the control of the LGU. It does not mean that the actions of the LGU are solely responsible for accomplishing the strategy, as success may be dependent on collaboration with other partners. For example, do not include strategies that depend solely on state agency actions (e.g., regulatory, funding, or process changes), but include strategies involving local task forces, workgroups, etc. on which the LGU is a partner.

The following are examples of metrics associated with the earlier examples of strategies:

Example #1: Add 20 new supportive living beds in the county over the next two years.

Example #2: Increase the number of CD and MH clinical staff trained through the online Focus on Integrated Treatment (FIT) modules by 10 percent (from X to Y) by the end of 2013.

Progress Report

The progress report provides a summary of progress made on the strategy over the past year. Since the Priority Outcomes Form has been significantly revised in this year's guidelines, and counties are being asked to create new priority outcomes and strategies, you will not need to report on progress in this year's plan. Next year, you will be asked to provide a very brief progress report only on strategies that are carried over from the previous planning cycle. Like the rationale for the priority outcome, this item will be limited to a 200-word text-only entry. Additional information could be attached to the form, if necessary.

After a thorough analysis of the various components of the Priority Outcomes Form that had been used for the past four years, the Mental Hygiene Planning Committee decided to drop those that either added unnecessary complexity to the form or did not provide the state agencies with the information they needed in the form they needed it. Feedback received from county planners also supported changes made to this form. As a result, the following components of the form have been dropped:

- Current Status (Priority Outcome and strategy)
- Anticipated Year of Completion (Priority Outcome and strategy)
- Strategy Focus
- Innovative Practice

B. OASAS Prevention Planning Survey

Prevention provider activity reports indicate that only 16% of NYS children and youth participate in a direct recurring substance abuse prevention service funded by OASAS. The risk and protective factors for substance abuse operate across many social and institutional domains that can only be addressed comprehensively by coordinated community planning. To increase the reach of prevention efforts and improve comprehensive community level planning, OASAS is supporting the work of over 80 community prevention coalitions statewide. To train and support these existing and new coalitions, OASAS has funded six regional Prevention Resource Centers to increase coalition efforts and effectiveness. Many of the current coalitions are county level and would benefit from LGU guidance and support.

To reduce underage drinking and its associated health, behavioral health and criminal justice costs, OASAS is supporting increased use of evidence-based environmental strategies, including policy change and enhanced law enforcement efforts. Examples of policies include on-premise alcohol outlet regulations, policies to require alcohol outlet server/seller training, community event alcohol regulations, and public availability policies.

OASAS funds prevention providers to partner with law enforcement, media outlets, colleges and others to implement environmental strategies to reduce youth alcohol access, better enforce underage drinking laws and change population norms regarding underage drinking. OASAS has developed partnerships with the State Police,

State Liquor Authority, Governor's Traffic Safety Committee, Division of Criminal Justice Services and other state and local agencies to increase the use of these prevention strategies. Community partnerships between prevention professionals and law enforcement agencies have resulted in training programs for retail alcohol outlet employees and for in police party patrols and dispersals, for increased underage alcohol sales compliance checks and for parent and community media campaigns designed to change community attitudes and norms to better support these efforts.

The purpose of this survey is to help OASAS better understand the current and potential roles the counties play in planning, coordinating, or otherwise supporting these community systems change efforts. All questions regarding this survey should be directed to Barry Donovan at 518-485-2109 or at BarryDonovan@oasas.ny.gov.

OASAS Prevention Planning Survey (LGU)

1. Six OASAS regional Prevention Resource Centers are working to increase the efforts of community prevention coalitions in addressing substance abuse consequences and costs.

   a. Has your agency had any involvement with local community prevention coalitions?
   ☐ Yes
   ☐ No

   b. If "Yes", please describe your agency's involvement?

   _____

   c. What role do you see for LGUs in supporting coalitions?

   _____

2. To reduce underage drinking and its associated health, behavioral health and criminal justice costs, OASAS is supporting evidence-based environmental policy change and law enforcement strategies.

   a. Has your agency had any involvement with prevention providers, coalitions or others to support these environmental strategies?
   ☐ Yes
   ☐ No

   b. If "Yes", please describe your agency's involvement?

   _____

   c. What role do you see for LGUs in supporting these efforts?

   _____

C. OASAS Outcomes Management Survey

Since 2007, OASAS has been committed to using and promoting outcomes management (also referred to as performance management) as a tool to improve client level outcomes and communicate results. We define outcomes management as **"the systematic use of client and program level data to set targets, assess and improve performance."** OASAS is again administering the Outcomes Management Survey in order to better understand and assist counties and providers with their outcomes management efforts. All questions regarding this survey should be directed to Constance Burke at 518-485-0501 or at ConstanceBurke@oasas.ny.gov.

OASAS Outcomes Management Survey (LGU)

1. Using the definition above, does this agency have an active outcomes management program in place?
   - ☐ a) Yes
   - ☐ b) No (go to #3)

2. How long has this agency been using outcomes management?
   - ☐ a) At least ten years
   - ☐ b) At least five, but less than ten years
   - ☐ c) At least three, but less than five years
   - ☐ d) At least one, but less than three years
   - ☐ e) Less than one year

3. How often do managers in this agency review progress towards established program outcomes?
   - ☐ a) Monthly
   - ☐ b) Quarterly
   - ☐ c) Semi-Annually
   - ☐ d) Annually
   - ☐ e) Never

4. How often do managers in this agency meet with line staff to review progress towards established program outcomes?
   - ☐ a) Monthly
   - ☐ b) Quarterly
   - ☐ c) Semi-Annually
   - ☐ d) Annually
   - ☐ e) Never

5. Which of the following data sources does this agency use to track progress toward performance targets? (check all that apply)
   - ☐ a) Program Scorecard
   - ☐ b) IPMES
   - ☐ c) Other data source (please specify): ☐
   - ☐ d) None

6. With whom does this agency regularly discuss program performance and progress toward achieving outcomes? (Check all that apply)
   - ☐ a) Community Services Board
   - ☐ b) Program Administrators
   - ☐ c) OASAS Field Office
   - ☐ d) Other (please specify): ☐

7. Which of the following does this agency use to disseminate data and/or summary information about program performance? (Check all that apply)
   - ☐ a) County dashboard or report card
   - ☐ b) Annual Report
   - ☐ c) County agency website
   - ☐ d) Grant applications
   - ☐ e) Other (please specify): ☐
   - ☐ f) None

8. In which areas of the following areas does this agency use program performance information to support decision making? (Check all that apply)
   - ☐ a) Strategic planning
   - ☐ b) Program service operations
   - ☐ c) Policy development
   - ☐ d) Budget development
   - ☐ e) Staff performance appraisals
   - ☐ f) Individual staff supervision or staff meetings
   - ☐ g) Other (please specify): ☐
   - ☐ h) None

9. Is this agency interested in participating in an Outcomes Management Community of Practice (CoP) to share your experience in using performance measures to track program outcomes or to learn from others' experience in using this approach to program management?
   - ☐ a) Yes
   - ☐ b) No

10. How often has this agency accessed information available on the OASAS Gold Standard Initiative web page about Outcomes Management (OM), which includes tools and resources to support the implementation of OM within your program?
   - ☐ a) Often
   - ☐ b) Occasionally
   - ☐ c) Once
   - ☐ d) Never

Glossary Terms Associated with this Survey

Outcomes Management – An outcome is a desired result from a program or client perspective; outcomes management, also referred to as performance management, is the systematic use of client and program level data to set performance targets, assess and improve performance.

Performance Target – the intended result or goal a program intends to achieve for a client or other customer as a result of program operations or service provision.

Community of Practice - Communities of practice are formed by people who engage in regular interaction over a shared topic of interest. Participants learn and develop skills around a topic whether by way of explicit learning objectives or as a secondary effect of sharing experiences, tools and resources, providing peer support or problem solving around an issue. The benefits of participating in a Community of Practice (CoP) include: access to shared resources; insight from others who are trying to do the same or similar things; and, an established support network as you try new approaches to improving performance and patient outcomes.

Gold Standard Initiative – an opportunity for programs to participate in a comprehensive, relevant review of program infrastructure and performance which is designed to define, support and recognize excellence in the provider community by way of enhanced operating certificates and Gold Standard recognition.

D. OASAS Outpatient Sub-County Service Plan Form (Optional)

The outpatient sub-county service planning option gives counties the opportunity to identify those local circumstances that may uniquely affect the availability or delivery

of outpatient treatment services in their particular jurisdiction. The OASAS outpatient need methodology would be applied to an approved sub-county outpatient service plan for project review and certification purposes. A completed sub-county service planning form must be submitted in the county's local services plan and approved by OASAS before it is implemented.

A sub-county plan may only be completed for the adult population which means that adolescent visits are removed from the utilization data that is applied to the sub-county service areas. In most counties, this adjustment is not significant. The service need and utilization matrix should be completed using the countywide visit totals for adults from the most recent County Service Need Profile and distributing across service areas based to the adult population (aged 18+) distribution. A map delineating the sub-county service areas must be included in the plan.

Counties that have an approved outpatient sub-county service plan need only update the data in the Service Need and Utilization section. Unless the sub-county service area map previously submitted by the county has changed, a new map does not need to be submitted. Counties with an approved Outpatient Sub-County Plan include Broome, Erie, Orange, and Ulster Counties.

Instructions for Completing the Outpatient Sub-County Service Planning Form

STEP 1: Rationale for Sub-County Service Planning - The narrative should include a brief description of the local circumstances that may affect the availability of or access to outpatient services in the county. Factors for delineating service area boundaries may include population density or distribution (e.g., presence of a major central city and significant outlying rural areas in the county), natural boundaries that may isolate certain parts of the county (e.g., rivers, mountains), or significant political subdivisions (e.g., towns, groupings of towns, school districts, etc.). If a county delineates sub-county service areas, it must provide the most current adult population data for each service area. ***Note: While OASAS does not limit the number of sub-county service areas within a county, no service area should contain an adult population that is not sufficiently large enough to reasonably support a small outpatient clinic.***

STEP 2: Service Need and Utilization Distribution - The most recent adult population should be shown for the county and each sub-county service area. The percentage distribution of the population in each service area should be determined. The countywide service need estimate (from the county's current Service Need Profile) should then be proportioned across all service areas based on the percentage distribution of the county's adult population. Once a need estimate is determined for each service area, the most recent annual service volume (total primary visits of at least 30 minutes) should be subtracted from the total need estimate to determine the unmet need in each service area. (Note: The service volume provided at an additional location should be applied to the service area in which it is located; i.e., additional location service volume reported to the main clinic located in another service area should be subtracted from that service area total and applied to the service area of the additional location. You may need to contact the OASAS Planning Unit for assistance in determining the adult population served by each program and additional location.

STEP 3: Delineation of Sub-county Service Areas on a Map - A county map clearly delineating the outpatient sub-county service areas must be included in the sub-county service plan. The location of existing outpatient clinics and additional locations should be indicated on the map. The map should be attached to the sub-county plan form.

E. OASAS Community Residence Multi-County Collaboration (Optional)

The OASAS chemical dependence need methodology identifies the community residence service category as one that could be considered a multi-county resource in certain areas of the state where the county bed need estimate does not support the development of a community residence program or where community residence services could be more efficiently and cost effectively provided in a collaborative way among two or more counties. In some counties, this has been the practice, if not the stated policy.

In 2004, OASAS asked that these arrangements be formally documented in the plan of each county involved in the collaboration, for two very important reasons. First, it establishes such arrangements as official policy in a public planning document. Second, it provides OASAS with the basis for applying the need methodology at a geographic level other than the standard county level. The following 14 counties have entered into five separate Community Residence Multi-County Collaborative Agreements.

- Broome, Chenango, Delaware, Otsego, Tioga
- Genesee, Orleans
- Warren, Washington
- Essex, Franklin
- Schuyler, Seneca, Yates

Based on an approved collaborative agreement, the need methodology would redefine the community residence service area to include all counties signing the agreement. That means the combined certified community residence capacity in the multi-county collaborative would be compared against the combined estimated bed need in the collaborative. It also means that any application for new or expanded community residence bed capacity that is submitted to OASAS will be reviewed against the combined estimated unmet need in the collaborative.

Instructions for Completing the Community Residence Multi-County Collaboration Agreement Form

The Community Residence Multi-County Collaboration Agreement should be completed and submitted in CPS. Each county that is in an approved collaboration is asked to complete and certify the form so that it will become part of the online plan submission. Each year, the form would only need to be edited (if necessary) and recertified. The agreement states that:

A. The counties agreeing to enter into this collaborative agreement shall plan and develop community residence services based on the combined geographic service areas covered by each county;

B. All existing and future community residence services in each county in the collaborative shall be a shared resource that is accessible to residents of each county in the collaborative;

C. The counties agreeing to enter into this collaborative agreement request that OASAS apply the existing combined certified community residence bed capacity of all counties in the collaborative against the combined estimated bed need of all counties in the collaborative;

D. Any application submitted to OASAS for new or expanded community residence bed capacity under an approved collaborative agreement shall be reviewed against the combined estimated unmet need in the collaborative; and

E. This Community Residence Multi-County Collaborative Agreement shall remain in effect until OASAS approves a county's written request to be removed from the collaborative agreement.

If any county in the collaborative wishes to opt out of the agreement, it must do so in writing. Each remaining county must amend its collaborative agreement to reflect the names of the remaining counties. Once a Community Residence Multi-county Collaboration Agreement has been approved, the OASAS Certification Bureau will be notified and all future certification applications for new or expanded community residence services from any county in the collaborative will be considered based on the need and capacity of the combined counties.

F. 2013 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 2013 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 2013 local services planning process.

G. 2013 Multiple Disabilities Consideration Form

LGU: _____

The term "multiple disabilities" means, in this context, persons who have at least two of the following disabling conditions: a developmental disability, a mental illness, or an addiction. In order to effectively meet the needs of these individuals, several aspects should be addressed in a comprehensive plan for services. Accordingly:

1. Is there a component of the local governmental unit which is responsible for identifying persons with multiple disabilities?

   ☐ Yes ☐ No

   If yes, briefly describe the mechanism used to identify such persons:

   _____
   _____
   _____

2. Is there a component of the local governmental unit which is responsible for planning of services for persons with multiple disabilities?

   ☐ Yes ☐ No

   If yes, briefly describe the mechanism used in the planning process:

   _____
   _____
   _____

3. Are there mechanisms at the local or county level, either formal or informal in nature, for resolving disputes concerning provider responsibility for serving persons with multiple disabilities?

   ☐ Yes ☐ No

   If yes, describe the process(es), either formal or informal, for resolving disputes at the local or county level and/or at other levels of organization for those persons affected by multiple disabilities:

   _____
   _____
   _____

H. Community Services Board Roster (New York City)

Community Services Board Chair

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

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

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

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

⋮ ⋮

Note: There must be 15 board members including at least <u>two</u> 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.

I. Community Services Board Roster (Counties Outside NYS)

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.

J. Alcoholism and Substance Abuse Sub-Committee 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.

K. 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.

L. 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: _____

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.

M. 2013 DDSO Plan Approval Form

LGU: _____

On behalf of the Commissioner of the New York State Office for People With Developmental Disabilities, I, as Director of the DDSO, assure and certify that the development and content of the Local Government Plan which is noted as applicable to OPWDD represent reasonable and appropriate efforts by OPWDD, local, voluntary and other community stakeholders to extend and/or improve local, community-based services for persons with mental retardation or developmental disabilities in accordance with OPWDD statewide priorities and goals, and are in compliance with the requirements of Article 41 of the Mental Hygiene Law.

DDSO Director Name: _____ Date: _____

--- OR ---

On behalf of the Commissioner of the New York State Office for People With Developmental Disabilities, I, as Director of the DDSO, assure and certify that the development and content of the Local Government Plan which is noted as applicable to OPWDD, with any exceptions as noted below, represent reasonable and appropriate efforts by OPWDD, local, voluntary and other community stakeholders to extend and/or improve local community-based services for persons with mental retardation or developmental disabilities in accordance with OPWDD statewide priorities and goals, and are in compliance with the requirements of Article 41 of the Mental Hygiene Law.

DDSO Director Name: _____ Date: _____

Exceptions:

Parts of Plan applicable to OPWDD Not Approved:

_____

_____

_____

_____

_____

_____

CHAPTER VI: OASAS PROVIDER PLAN GUIDANCE AND FORMS

The local services planning process for chemical dependence services relies on the partnership between OASAS, the local governmental unit (LGU), and OASAS funded and certified providers. The involvement of providers and other stakeholders in local planning and needs assessment efforts is necessary to ensure that community needs are adequately identified, prioritized, and addressed in the most effective and efficient way.

Providers are required 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 OASAS Online County Planning System (CPS) in order to complete the required planning forms that help to support various OASAS initiatives. Please refer to Chapter I 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 small 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 in order to show changes over time, while other surveys are new. In every case, the information being requested is information not otherwise 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 who are in a position 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, 2012**. The one exception is the Communicable Disease Activity Log, which is intended to collect certain information on a monthly basis throughout the year. Each survey includes the name and contact information of the OASAS staff person responsible for that survey and who can answer any questions you might have about the survey. Each survey in CPS also contains a link back to the relevant section of the plan guidelines associated with that survey.

For each of the following surveys, there is a brief description of the purpose and intended use of the data collected, all the questions included in the survey (including the skip patterns and follow-up questions built into the electronic version of the survey which you may not see in CPS, depending on how you answer the questions), and definitions of certain terms used in the survey.

A. Outcomes Management Survey (all providers)

Since 2007, OASAS has been committed to using and promoting outcomes management (also referred to as performance management) as a tool to improve client level outcomes and communicate results. We define outcomes management as **the systematic use of client and program level data to set targets, assess and improve performance.** OASAS is again administering the Outcomes Management Survey as part of the annual local planning process in order to better understand and assist counties and providers with their outcomes management efforts. All questions regarding

this survey should be directed to Ms. Constance Burke at 518-485-0501 or at ConstanceBurke@oasas.ny.gov.

Outcomes Management Survey (All Providers)

1. Using the definition above, does this agency have an active outcomes management program in place?
   - ☐ a) Yes
   - ☐ b) No (go to #3)

2. How long has this agency been using outcomes management?
   - ☐ a) At least ten years
   - ☐ b) At least five, but less than ten years
   - ☐ c) At least three, but less than five years
   - ☐ d) At least one, but less than three years
   - ☐ e) Less than one year

3. How often do managers in this agency review progress towards established program outcomes?
   - ☐ a) Monthly
   - ☐ b) Quarterly
   - ☐ c) Semi-Annually
   - ☐ d) Annually
   - ☐ e) Never

4. How often do managers in this agency meet with line staff to review progress towards established program outcomes?
   - ☐ a) Monthly
   - ☐ b) Quarterly
   - ☐ c) Semi-Annually
   - ☐ d) Annually
   - ☐ e) Never

5. Which of the following data sources does this agency use to track progress toward performance targets? (check all that apply)
   - ☐ a) Scorecard
   - ☐ b) IPMES
   - ☐ c) Workscopes
   - ☐ d) STAR-QI
   - ☐ e) Focus Groups
   - ☐ f) Client/Customer Satisfaction Surveys
   - ☐ g) Other data source (please specify): ☐
   - ☐ h) None

6. With whom does this agency regularly discuss program performance and progress toward achieving outcomes? (Check all that apply)
   - ☐ a) Board of Directors
   - ☐ b) Program Administrators
   - ☐ c) Program Staff
   - ☐ d) OASAS Field Office
   - ☐ e) LGU
   - ☐ f) Other (please specify): ☐

7. Which of the following does this agency use to disseminate data and/or summary information about program performance? (Check all that apply)
   - ☐ a) Agency or program dashboard or report card
   - ☐ b) Annual Report
   - ☐ c) Program brochures
   - ☐ d) Agency web page
   - ☐ e) Grant applications
   - ☐ f) Other (please specify): ☐
   - ☐ g) None

8. In which areas of the following areas does this agency use program performance information to support decision making? (Check all that apply)
   - ☐ a) Strategic planning
   - ☐ b) Program service operations
   - ☐ c) Policy development
   - ☐ d) Budget development
   - ☐ e) Staff performance appraisals
   - ☐ f) Individual staff supervision or staff meetings
   - ☐ g) Other (please specify): ☐
   - ☐ h) None

9. Is this agency interested in participating in an Outcomes Management Community of Practice (CoP) to share your experience in using performance measures to track program outcomes or to learn from others' experience in using this approach to program management?
   - ☐ a) Yes
   - ☐ b) No

10. How often has this agency accessed information available on the OASAS Gold Standard Initiative web page about Outcomes Management (OM), which includes tools and resources to support the implementation of OM within your program?
    - ☐ a) Often
    - ☐ b) Occasionally
    - ☐ c) Once
    - ☐ d) Never

Glossary Terms Associated with this Survey

Outcomes Management: An outcome is a desired result from a program or client perspective; outcomes management, also referred to as performance management, is the systematic use of client and program level data to set performance targets, assess and improve performance.

Performance Target: The intended result or goal a program intends to achieve for a client or other customer as a result of program operations or service provision.

Community of Practice: Communities of practice are formed by people who engage in regular interaction over a shared topic of interest. Participants learn and develop skills around a topic whether by way of explicit learning objectives or as a secondary effect of sharing experiences, tools and resources, providing peer support or problem solving around an issue. The benefits of participating in a Community of Practice (CoP) include: access to shared resources; insight from others who are trying to do the same or similar things; and, an established support network as you try new approaches to improving performance and patient outcomes.

Gold Standard Initiative: An opportunity for programs to participate in a comprehensive, relevant review of program infrastructure and performance which is designed to define, support and recognize excellence in the provider community by way of enhanced operating certificates and Gold Standard recognition.

B. 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)
- 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: http://www.oasas.ny.gov/regs/

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.

This survey should be completed by all OASAS certified treatment programs, and should be completed in CPS. The following are the questions included on the survey. All responses to the questions on this form should be based on 2011 Fiscal Year data. If an individual is responsible for carrying out the Health Coordinator function in more than one program, the data must be reflected separately for each program reporting unit. Any questions related to this survey should be directed to Shonna Clinton by phone at 518-485-7578, or by e-mail at ShonnaClinton@oasas.ny.gov.

Health Coordination Survey (Treatment Providers)

1. Are you including your Health Coordinator(s) in your preparations for Health Care Reform?
   - ☐ a) Yes
   - ☐ b) No

2. What is the fringe benefit rate paid to employees by this agency?

☐

3. How are **health coordination** services provided to patients in each program? (check all that apply)

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

If "Paid Staff", answer question #4; if "Contracted Services", answer question #5.

4. Please provide the following information for each PRU where those staff services are provided. (Note: If multiple paid staff provide these services at a single program, provide the total hours worked and the total annual salary and fringe benefits for each individual. If there are more than two staff carrying out the health coordinator function at a single program, contact Shonna Clinton to discuss how to complete this form.)

	Health Coordinator #1				Health Coordinator #2			
	Services Provided		Hours Worked	Annual Salary	Services Provided		Hours Worked	Annual Salary
Program	On-site	Off-site	Per Week	(in dollars)	On-site	Off-site	Per Week	(in dollars)
a) PRU #1	☐	☐	☐	☐	☐	☐	☐	☐
b) PRU #2	☐	☐	☐	☐	☐	☐	☐	☐
c) PRU #3	☐	☐	☐	☐	☐	☐	☐	☐
d) PRU #4	☐	☐	☐	☐	☐	☐	☐	☐

5. Please provide the following information for each PRU where those contracted services are provided. (Note: If multiple contracted individuals provide these services at a single program, provide the total hours worked per week and the total dollars paid per year.)

	Service Provided		Hours Worked	Dollars Paid
Program	On-site	Off-site	Per Week	Per Year
a) PRU #1	☐	☐	☐	☐
b) PRU #2	☐	☐	☐	☐
c) PRU #3	☐	☐	☐	☐
d) PRU #4	☐	☐	☐	☐

C. Communicable Disease Activity Log (treatment programs)

In compliance with the federal Substance Abuse Prevention and Treatment (SAPT) block grant requirements, OASAS is being asked to provide certain information related to communicable diseases. Like the information provided on the annual Health Coordination Survey, this information will be required as a condition for receiving the important block grant funding that OASAS utilizes to support program operations. Programs should use this Activity Log to track selected information that is not currently collected through the OASAS Client Data System (CDS).

Data on the number of persons admitted to this program known to be HIV+ or HCV+, the number of HIV and HCV tests provided or reported on, test results identified or reported on, and the number of HIV+ and HCV+ patients referred to treatment for those diseases should be entered on this form in CPS on a monthly basis for the 3-month period beginning with **April 2012** and concluding with **June 2012**. All questions related to this activity log should be directed to Bob Killar at 518-485-2123, or by e-mail at RobertKillar@oasas.ny.gov.

2012-2013 Communicable Disease Activity Log (Treatment Programs)

	Human Immunodeficiency Virus (HIV)				Hepatitis C Virus (HCV)			
Month	Known HIV+ Admissions	HIV Tests Provided to or Reported on Patients	HIV+ Results Identified or Reported	HIV+ Patients Referred to Treatment	Known HCV+ Admissions	HCV Tests Provided to or Reported on Patients	HCV+ Results Identified or Reported	HCV+ Patients Referred to Treatment
Apr 2012								
May 2012								
Jun 2012								

Glossary Terms Associated with this Form

Known HIV+ Admissions: The number of patients admitted during the month living with Human Immunodeficiency Virus (HIV+).

HIV Tests Provided to or Reported on Patients: The number of HIV tests performed at the program or reported to the program by patients and/or outside labs during the month.

HIV+ Results Identified or Reported: Of those HIV tests performed at the program or reported to the program by patients and/or outside labs during the month, how many were reported back as positive.

HIV+ Patients Referred to Treatment: The number of HIV positive patients who were referred for HIV assessment and treatment during the month.

Known HCV+ Admissions: The number of patients admitted during the month living with Hepatitis C Virus (HCV+) at the time of admission.

HCV Tests Provided to or Reported on Patients: The number of HCV tests performed at the program or reported to the program by patients and/or outside labs during the month.

HCV+ Results Identified or Reported: Of those HCV tests performed at the program or reported to the program by patients and/or outside labs during the month, how many were reported back as positive.

HCV+ Patients Referred to Treatment: The number of HCV positive patients who were referred for HCV assessment and treatment during the month.

D. Electronic Health Records Survey (treatment providers)

Health care reform is creating major changes in the way health care will be delivered in the future. One of these changes is the growing adoption of Electronic Health Records (EHRs) which will improve the quality, efficiency and care coordination of the America's health care system.

An EHR is a computerized record of health information about individual patients. Such records may include a whole range of data in comprehensive or summary form, including demographics, medical history, medication and allergies, immunization status, laboratory test results, radiology images, vital signs, personal stats like age and weight, and billing information. Its purpose is to be a complete record of patient encounters that allows the automation and streamlining of the workflow in health care settings and increases safety through evidence-based decision support, quality management, and outcomes reporting. Under health care reform, the Federal government has identified a number of core requirements that will be components of an EHR.

The purpose of this survey is to assess your agency's:

- Current status on the adoption of an EHR, including the inclusion of the core federal requirements;
- Barriers that limit your organization's ability to adopt an EHR; and
- Understanding of the potential federal funding opportunity for EHR adoption by your organization.

The information obtained through this survey will help OASAS to identify how best we can assist providers in achieving their participation with this health reform initiative. All questions related to this survey should be directed to David Gardam by phone at 518-485-2351, or by e-mail at DavidGardam@oasas.ny.gov.

Electronic Health Records Survey (Treatment Providers)

1. What is your organization's current status on the adoption of an Electronic Health Record (EHR)?
   - ☐ a) This agency currently utilizes an EHR.
   - ☐ b) This agency is actively pursuing the adoption of an EHR within the next 12 months.
   - ☐ c) This agency is interested in adopting an EHR but has yet to actively pursue it. (Skip to Q4)
   - ☐ d) This agency has no plans to adopt an EHR. (Skip to end of survey)

2. Please identify the name of the EHR system that your agency currently uses or plans to acquire within the next 12 months. (Note: If your agency developed its own system, identify it as "Internal System")

   ☐

3. Does your agency currently use, or plan to acquire, an EHR system that incorporates the following?

	Yes	No	Partially	Not Sure
e) Bills for services	☐	☐	☐	☐
f) Records patient demographics	☐	☐	☐	☐
g) Records patient smoking	☐	☐	☐	☐
h) Maintains active medication list	☐	☐	☐	☐
i) Implements drug-drug, drug-allergy interactions	☐	☐	☐	☐
j) Generates and transmits prescriptions electronically	☐	☐	☐	☐
k) Records and charts changes in vital signs	☐	☐	☐	☐
l) Maintains an up-to-date list of current diagnoses	☐	☐	☐	☐
m) Implements at least one clinical decision support tool	☐	☐	☐	☐
n) Incorporates lab test results into clinical record	☐	☐	☐	☐

o) Generates lists of patients by specific conditions for for quality improvement, reduction of disparities, research, and outreach	☐	☐	☐	☐
p) Provides patients with an electronic copy of their Health information upon request	☐	☐	☐	☐
q) Sends reminders to patients per patient preference for preventive/follow-up care	☐	☐	☐	☐
r) Provides patients with electronic access to their health information	☐	☐	☐	☐
s) Provides summary care record for transitions in care or referrals	☐	☐	☐	☐
t) Exchanges key clinical information electronically to other health providers	☐	☐	☐	☐
u) Reports quality measures to the state	☐	☐	☐	☐

4. Indicate the extent to which each of the following barriers has hindered your agency's ability to adopt an EHR.

	Significant Barrier	Minor Barrier	Not a Barrier
FINANCIAL BARRIERS			
a) Cost of adapting facility (network, PCs, etc.) to use EHRs	☐	☐	☐
b) Cost of buying EHR software or web service	☐	☐	☐
c) Cost of staff training	☐	☐	☐
d) Cost of maintaining EHR service	☐	☐	☐
EHR FUNCTIONALITY BARRIERS			
e) Choosing the right solution	☐	☐	☐
f) Adapting the system to meet substance use disorder requirements	☐	☐	☐
g) Less detailed and complete patient notes	☐	☐	☐
h) Conversion efforts from existing computer systems	☐	☐	☐
i) Risk to patient confidentiality	☐	☐	☐
j) Inability to use dictation to create notes	☐	☐	☐
USABILITY BARRIERS			
k) Staff learning curve due to lack of technical skills	☐	☐	☐
l) Staff resistance to change	☐	☐	☐
m) Increase in staff time devoted to administration/record keeping at the expense of time with patients	☐	☐	☐

5. Prior to these guidelines and this survey, how would you describe your agency's level of understanding about the Federal American Recovery and Reinvestment Act's Health Care Electronic Health Records Initiative?

☐ a) Very Knowledgeable
☐ b) Somewhat Knowledgeable
☐ c) Not at all Knowledgeable

6. In an effort to expand awareness of the Federal American Recovery and Reinvestment Act's Health Care Electronic Health Records Initiative, the federal government has funded the NYS Department of Health to promote EHR adoption, established Health Information Technology (HIT) extension centers, and funded demonstration programs in New York State. Please indicate whether or not the following pertain to this agency.

	Yes	No	Not Sure
a) As a Medicaid provider, the Department of Health has made outreach efforts to this agency and/or its medical staff about the federal program. (leave blank if not a Medicaid provider)	☐	☐	☐
b) This agency has found the HIT extension center(s) to be useful. (The two centers are NYC REACH and NY eHealth Collaborative)	☐	☐	☐
c) This agency is aware of the federal Beacon and other federal demonstration projects.	☐	☐	☐
d) Staff from this agency have attended briefings on the EHR initiative	☐	☐	☐
e) This agency learned about the federal EHR Initiative from the trade literature or other sources.	☐	☐	☐

7. Federal EHR assistance of up to $63,750 is available to substance use disorder providers for each physician, nurse practitioner and psychiatrist employed or contracted where at least 30% of their patients are Medicaid clients. Indicate the number of eligible medical staff that meets this 30% threshold? Include staffing at primary and behavioral health programs operated by your agency.
   - ☐ a) 6 or more eligible medical staff
   - ☐ b) 4 to 5 eligible medical staff
   - ☐ c) 2 to 3 eligible medical staff
   - ☐ d) 1 eligible medical staff
   - ☐ e) No eligible medical staff or less than 1 full-time staff

8. Please provide the name and email address of the person within this agency that OASAS staff could talk to regarding Electronic Health Records.
   a) EHR Contact Name: ☐
   b) EHR Contact Email Address: ☐

9. Please provide any additional comments or questions you have regarding Electronic Health Records.
   ☐

Glossary Terms Associated with this Survey

Electronic Health Record (EHR): A computerized record of health information about individual patients which may include a whole range of data in comprehensive or summary form, including demographics, medical history, medication and allergies, immunization status, laboratory test results, radiology images, vital signs, personal stats like age and weight, and billing information.

Federal American Recovery and Reinvestment Act's Health Care Electronic Health Records Initiative: The Health Information Technology for Economic and Clinical Health (HITECH) Act provisions of the Recovery Act of 2009 provides an unprecedented investment in health information technology as an important part of healthcare reform aimed at improving health care practices and reducing costs. The Act provides more than $19 billion in monetary incentives within the Medicare and Medicaid programs to encourage the use electronic medical records by health care providers.

E. LGBT Special Population Survey (treatment providers)

OASAS is conducting this survey to address priorities identified by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) to take critical steps toward ensuring the collection of useful national data on minority groups, including lesbian, gay, bisexual and transgender (LGBT) populations. SAMHSA intends to address the disparities in access, quality, and outcomes of care for vulnerable

populations that historically have been underserved or inappropriately served by the behavioral health system. For additional information on treating this population, see SAMHSA's publication *A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals*.

OASAS currently does not collect information specific to the LGBT population through any existing client or program reporting systems. This survey seeks to establish baseline data regarding this population within the OASAS treatment system and to give programs an opportunity to share related knowledge and data collection recommendations with OASAS.

1. Did this program provide treatment services to LGBT individuals during the past 12 months?
   - ☐ a) Yes
   - ☐ b) No (go to #4)
   - ☐ c) Unknown (go to #4)

2. Please describe the information you collect that identifies an individual as LGBT?

   _____

3. Approximately what percentage of your program's admissions during the past 12 months would you estimate to be LGBT?
   - ☐ a) More than 20%
   - ☐ b) 16% to 20%
   - ☐ c) 11% to 15%
   - ☐ d) 6% to 10%
   - ☐ e) 1% to 5%
   - ☐ f) Less than 1%

4. Has this program taken steps to create a more open and welcoming environment to better serve LGBT individuals?
   - ☐ a) Yes
   - ☐ b) No (go to #6)

5. Please describe the steps this program has taken to better serve LGBT individuals?

   _____

6. Does this program have a formal staff policy for treating LGBT individuals?
   - ☐ a) Yes
   - ☐ b) No

7. Does this program employ staff trained in issues impacting LGBT individuals?
   - ☐ a) Yes
   - ☐ b) No

8. Does this program provide specialized services to LGBT individuals?
   - ☐ a) Yes
   - ☐ b) No (go to #10)

9. Please describe the specialized services provided to LGBT individuals.

   _____

10. Does this program make referrals to other programs that provide specialized services to LGBT individuals?
    - ☐ a) Yes
    - ☐ b) No

11. Would this program be interested in staff training and supports to better serve LGBT individuals?
    - ☐ a) Yes (go to #12)
    - ☐ b) No (End of survey)

12. Please describe the training and supports that would be most helpful to this program's ability to better serve LGBT individuals?

    _____

F. Evidence-based and Best Practice Interventions Survey (treatment programs)

It is an ongoing priority of OASAS to strengthen the field of prevention, treatment, and recovery by supporting the adoption of administrative, clinical, and programmatic practices that are supported by evidence and science-based research. In an effort to understand the extent to which evidence-based practices (EBPs) and established best practices are being utilized by OASAS-certified and funded treatment providers, the cooperation of all program units is being sought through the completion of an Evidence-Based Practices Survey as part of the 2013 local services planning process. In addition, to better understand how to increase the capacity of addiction outpatient programs to provide integrated clinical care for individuals with co-occurring substance use and mental disorders we have continued our collaboration with the Center for Excellence in Integrated Care (CEIC) to include survey questions specific to integrated care and the use of evidence-based practices in those settings. Those EBPs are ideally tailored to meet the needs of patients with co-occurring disorders with the intent of improving their health and well-being.

The New York State Health Foundation, in collaboration with OASAS and OMH, established the Center for Excellence in Integrated Care (CEIC) to function in partnership with other interested constituencies to increase the capacity of New York State's addiction and mental health outpatient clinics to provide integrated clinical care for people with co-occurring conditions. That would include but not be limited to the implementation and use of selected evidence-based practices (EBPs) for integrated treatment.

This year's survey is a follow-up to the evidence-based practices surveys that were completed by treatment programs in 2008 and 2010. Those bi-annual EBP surveys provided OASAS with baseline and comparative data in terms of programs' adoption of EBPs and their stage of implementation process. The primary objectives of this year's survey is to contrast and compare current responses with our two prior surveys, as well as identify trends that indicate, and are supportive of, programs implementation and sustaining of evidence-based practices. For our selected EBP practices, if you indicate that implementation in your program is at least at the **implementation stage**, which would include those EBPs tailored for individuals presenting with co-occurring disorders, you will be prompted to answer additional follow-up questions. Therefore, it is very important that this survey be completed by either the program director or the clinical director responsible for the treatment practices used by the program. In addition, OASAS

staff may contact a sample of programs to obtain additional detail about the implementation process for the specific EBPs identified.

For the purposes of this survey, the following terms should be used to evaluate and assess the program's stage of implementation of the EBP and/or best practice, (Fixsen, Naoom, Blasé, & Wallace, 2007). When considering the appropriate stage of implementation, it is important to remember that a decision to adopt a particular innovation cannot be considered implementation of that innovation.

For each of the practices or approaches below, please indicate the stage of implementation within this program. If this program has not yet considered implementation of a particular practice, you must indicate "Not Applicable". Sections III, IV and VI are specific to practices for persons with co-occurring psychiatric conditions. These are person-centered approaches for improving access to treatment that have been demonstrated to be effective for this population. If you move your curser over a term or phrase that is hyperlinked, you will see a definition. Additional information about this survey, including helpful links and the complete glossary of terms and phrases used in this survey are also included in the local services plan guidelines and are accessible through the link above.

Specific questions related to the completion of this survey should be directed to Henri Williams at 518-485-0504 or HenriWilliams@oasas.ny.gov and/or Susan Brandau at 518-457-6129 or SusanBrandau@oasas.ny.gov.

Evidence-Based and Best Practice Interventions Survey (Treatment Programs)

		Implementation Stage					
		Exploration	Installation	Implementation	Innovation	Sustainability	N/A
I.	**Screening and Assessment:**						
A.	Screening for Co-Occurring Disorders	☐	☐	☐	☐	☐	☐
B.	Assessment for Co-Occurring Disorders	☐	☐	☐	☐	☐	☐
C.	Other (Specify):	☐	☐	☐	☐	☐	☐
II.	**Clinical Practices and Interventions:**						
D.	Motivational Interviewing (MI)	☐	☐	☐	☐	☐	☐
E.	Cognitive-Behavioral Therapy (CBT)	☐	☐	☐	☐	☐	☐
F.	Contingency Management (CM)	☐	☐	☐	☐	☐	☐
G.	Behavioral Couples Therapy (BCT)	☐	☐	☐	☐	☐	☐
H.	Brief Intervention Therapy	☐	☐	☐	☐	☐	☐
I.	Twelve-Step Facilitation (TSF)	☐	☐	☐	☐	☐	☐
J.	Anger Management	☐	☐	☐	☐	☐	☐
K.	Relapse Prevention	☐	☐	☐	☐	☐	☐
L.	Trauma-Related Counseling	☐	☐	☐	☐	☐	☐
M.	Matrix Model	☐	☐	☐	☐	☐	☐
N.	Rational Emotive Behavioral Therapy	☐	☐	☐	☐	☐	☐
O.	Other (Specify):	☐	☐	☐	☐	☐	☐

III. Clinical Practices and Interventions Specific to Treating Patients with Co-occurring Disorders:

P. Motivational Interviewing (MI)	☐	☐	☐	☐	☐	☐
Q. Cognitive-Behavioral Therapy (CBT)	☐	☐	☐	☐	☐	☐
R. Contingency Management (CM)	☐	☐	☐	☐	☐	☐
S. Behavioral Couples Therapy (BCT)	☐	☐	☐	☐	☐	☐
T. Mutual Self-Help Groups	☐	☐	☐	☐	☐	☐
U. Other (Specify):	☐	☐	☐	☐	☐	☐

IV. Achieving Integrated Care/Services for Treating Patients with Co-occurring Disorders:

V. Achieving Integrated Care/Services	☐	☐	☐	☐	☐	☐

V. Medication Assisted Therapy (Pharmacotherapy):

W. Buprenorphine (Subutex®/Suboxone®)	☐	☐	☐	☐	☐	☐
X. Methadone	☐	☐	☐	☐	☐	☐
Y. Naltrexone (oral) and Vivitrol® (injectible Naltrexone)	☐	☐	☐	☐	☐	☐
Z. Acamprosate (Campral®)	☐	☐	☐	☐	☐	☐
AA. Nicotine Replacement Therapies	☐	☐	☐	☐	☐	☐
BB. Disulfiram/Antabuse	☐	☐	☐	☐	☐	☐
CC. Other (Specify):	☐	☐	☐	☐	☐	☐

VI. Psychotropic Medication for Treating Patients:

DD. Psychotropic Medication for Treating Patients with Co-occurring Disorders	☐	☐	☐	☐	☐	☐

VII. Process Improvement Administrative Practices:

EE. Process Improvement	☐	☐	☐	☐	☐	☐
FF. Other Process Improvement Practice (Specify):	☐	☐	☐	☐	☐	☐

<u>Follow-up Questions to "Screening for Co-Occurring Disorders" (Question A)</u>

2a. Does this program have a documented implementation plan for **Screening for Co-Occurring Disorders**?
☐ Yes
☐ No

2b. Does this program have written policy and procedures related to the implementation of this EBP?
☐ Yes
☐ No

2c. Has this program received staff training by an OASAS-approved education and training provider on this screening process/instrument?
☐ Yes
☐ No

2d. Are positive screen findings incorporated into the treatment plans?
☐ Yes
☐ No

2e. Does this program have documented service agreements (e.g., a Memorandum of Understanding, contract, etc.) with Mental Health service providers?
☐ Yes
☐ No

Follow-up Questions to "Motivational Interviewing" (Question D)

3a. Does this program have a documented implementation plan for **Motivational Interviewing**?
☐ Yes
☐ No

3b. Has staff from this program received training on **Motivational Interviewing**?
☐ Yes
☐ No

3c. Has this program revised its assessment and treatment plan instruments to reflect the integration of **Motivational Interviewing**?
☐ Yes
☐ No

3d. Does this program provide periodic observation of staff utilizing **Motivational Interviewing**?
☐ Yes
☐ No

If "Yes" to 3d:

3e. Does this program provide feedback to staff for the purpose of improving the proficiency of their skills used in **Motivational Interviewing**?
☐ Yes
☐ No

Follow-up Questions to "Cognitive-Behavioral Therapy" (Question E)

4a. Does this program have a documented implementation plan for **Cognitive-Behavioral Therapy**?
☐ Yes
☐ No

4b. Has staff from this program received training on **Cognitive-Behavioral Therapy**?
☐ Yes
☐ No

4c. Has this program revised its assessment and treatment plan instruments to reflect the integration of **Cognitive-Behavioral Therapy**?
☐ Yes
☐ No

4d. Does this program provide periodic observation of staff utilizing **Cognitive-Behavioral Therapy**?
☐ Yes
☐ No

If "Yes" to 4d:

4e. Does this program provide feedback to staff for the purpose of improving the proficiency of their skills used in **Cognitive-Behavioral Therapy**?
☐ Yes
☐ No

Follow-up Questions to "Medication Assisted Therapies" (Questions W through CC)

5a. Are at least half of this program's clinical staff trained in **Medication Assisted Therapy**?
☐ Yes
☐ No

5b. For each patient, is the appropriateness for **Medication Assisted Therapy** incorporated into the assessment process and assessment instrument?
☐ Yes
☐ No

5c. Are there ongoing mechanisms to monitor medication response and potential side-effects?
☐ Yes
☐ No

Follow-up to Question W:

5d. Does this program's attending physician have a license to prescribe Buprenorphine?
☐ Yes
☐ No

If "No" to 5d:

5e. Has this program's attending physician applied for a license to prescribe Buprenorphine?
☐ Yes
☐ No

Follow-up to Question X:

5f. Does this program's attending physician have a license to prescribe Methadone?
☐ Yes
☐ No

If "No" to 5f:

5g. Has this program's attending physician applied for a license to prescribe Methadone?
☐ Yes
☐ No

Follow-up Questions to "Process Improvement" (Question EE)

6a. Does this program have a "Change Team"?
☐ Yes
☐ No

If "Yes" to 6a:

Does the change team include?
6a1. Executive Sponsor
☐ Yes
☐ No
6a2. Change Leader
☐ Yes
☐ No
6a3. Data Coordinator
☐ Yes
☐ No

6b. Does this program routinely collect data regarding retention and engagement rates?
☐ Yes
☐ No

6c. Does the program use **Plan-Do-Study-Act** cycles to test improvements specific to Process Improvement?
☐ Yes
☐ No

Follow-up Questions to "Assessment for Co-Occurring Disorders" (Question B)

7a. Is there a distinct section in the assessment tool that identifies the presence of a mental health condition?
☐ Yes
☐ No

7b. Does a formal mental health assessment, if necessary, typically occur for each patient?
☐ Yes
☐ No

7c. Is there a licensed or certified health professional on staff that can conduct the mental health assessment?
☐ Yes
☐ No

7d. Does the mental health assessment typically lead to the formulation and recording of a mental health diagnosis in the clinical record?
☐ Yes
☐ No

7e. Are changes in mental health status routinely documented in the clinical record during the course of treatment?

☐ Yes
☐ No

7f. Is the interaction of the patient's mental health condition with his or her substance use documented in the assessment?

☐ Yes
☐ No

7g. Does this program provide feedback to staff for the purpose of improving the proficiency of their skills used in **assessing** patients who have a co-occurring mental health condition?

☐ Yes
☐ No

7h. Are there Quality Assurance systems in place to monitor the Assessment of Mental Health Conditions?

☐ Yes
☐ No

Follow-up Questions to "Motivational Interviewing (COD)" (Question P)

8a. Does this program utilize **motivational interviewing** to help patients resolve ambivalence about engaging in mental health treatment or taking psychotropic medication for their mental disorder?

☐ Yes
☐ No

8b. Does this program have a documented implementation plan for the utilization of **motivational interviewing** for patients who have a co-occurring mental health condition?

☐ Yes
☐ No

8c. Has staff from this program received training on applying **motivational interviewing** with patients to address their co-occurring mental health condition or the interaction between their mental health and substance use issues?

☐ Yes
☐ No

8d. Do the assessment and treatment plan sections of COD patients' clinical record reflect the use of **motivational Interviewing**?

☐ Yes
☐ No

8e. Does this program provide feedback to staff to improve their skills in applying **motivational Interviewing** with patients who have a co-occurring mental health condition?

☐ Yes
☐ No

8f. Are there Quality Assurance systems to monitor the use of **motivational interviewing** with co-occurring patients?

☐ Yes
☐ No

Follow-up Questions to "Cognitive Behavioral Therapy (COD)" (Question Q)

9a. Does this program utilize **cognitive-behavioral therapy** to treat a variety of mental health problems including for example, distortions in thinking or psychiatric symptoms, mood, anxiety, depression, personality, or psychotic disorders?

☐ Yes
☐ No

9b. Does this program have a documented implementation plan for **cognitive-behavioral therapy** that is to be applied with patients who have a co-occurring mental health condition?

☐ Yes
☐ No

9c. Has staff from this program received training on the application of **cognitive-behavioral therapy** with patients who have a co-occurring mental health condition?

☐ Yes
☐ No

9d. Do the assessment and treatment plan sections of COD patients' clinical record reflect the use of **cognitive-behavioral therapy**?

☐ Yes
☐ No

9e. Does this program provide feedback to staff to improve their skills in providing **cognitive-behavioral therapy** to patients who have a co-occurring mental health condition?

☐ Yes
☐ No

9f. Are there opportunities to document patient feedback about this treatment approach in the clinical record?

☐ Yes
☐ No

9g. Are there Quality Assurance systems in place to monitor the use of **Cognitive Behavioral Therapy**?

☐ Yes
☐ No

Follow-up Questions to "Contingency Management (COD)" (Question R)

10a. Does this program utilize **Contingency Management** techniques for patients with a co-occurring mental health condition to encourage participation in treatment or compliance with psychotropic medication?

☐ Yes

☐ No

10b. Does this program have a documented implementation plan for **Contingency Management** that is to be applied with patients that have a co-occurring mental health condition?
☐ Yes
☐ No

10c. Has staff from this program received training on the application of **Contingency Management** with patients that have a co-occurring mental health condition?
☐ Yes
☐ No

10d. Do treatment plan instruments of COD patients reflect the integration of **Contingency Management**?
☐ Yes
☐ No

10e. Does this program provide feedback to staff to improve their skills in **Contingency Management** with patients that have a co-occurring mental health condition?
☐ Yes
☐ No

10f. Are there Quality Assurance systems to monitor the use of **Contingency Management** for co-occurring patients?
☐ Yes
☐ No

Follow-up Questions to "Mutual Self-Help Groups (COD)" (Question T)

11a. Are there mutual self-help groups facilitated **on-site** for substance abuse such as NA/AA that welcome people with a co-occurring mental health condition?
☐ Yes
☐ No

11b. Are there mutual self-help groups facilitated **off-site** for substance abuse such as NA/AA to which clinicians typically refer that welcome patients with a co-occurring mental health condition?
☐ Yes
☐ No

11c. Are there mutual self-help groups facilitated **on-site** for co-occurring disorders such as Double Trouble in Recovery (DTR) or Dual Recovery Anonymous (DRA)?
☐ Yes
☐ No

11d. Are there mutual self-help groups facilitated **off-site** for co-occurring disorders (e.g. DTR, DRA) to which clinicians typically refer co-occurring patients during the course of treatment?
☐ Yes
☐ No

11e. Does the program maintain the involvement of alumni with co-occurring conditions to facilitate peer support onsite or ensure connections to peer recovery supports in the community?

☐ Yes
☐ No

Follow-up Questions to "Achieving Integrated Care/Services (COD)" (V)

12a. Does the agency join together with an external consortium to create a program that will serve the population of patients with both conditions?

☐ Yes
☐ No

12b. Do treatment staff use a program model (e.g., Relapse Prevention or Assertive Community Treatment) that integrates care?

☐ Yes
☐ No

12c. Do treatment staff coordinate a variety of substance use and mental health efforts in an individual treatment plan and deliver care that integrates the needed services?

☐ Yes
☐ No

12d. Do treatment staff consult with mental health specialists and integrate that consultation into the care provided?

☐ Yes
☐ No

12e. Do two or more treatment staff work together to provide substance abuse and mental health services to the same patient?

☐ Yes
☐ No

12f. Do treatment staff deliver a variety of substance abuse and mental health services to the same individual?

☐ Yes
☐ No

Follow-up Questions to "Psychotropic Medications (COD)" (Question DD)

13a. Does this program have documented policies and procedures to evaluate and monitor patients' need for **psychotropic medications**?

☐ Yes
☐ No

13b. For each patient, is the need for **psychotropic medication** routinely determined as part of the comprehensive assessment?

☐ Yes
☐ No

13c. Is at least half the program's clinical staff cross-trained on **psychotropic medications** and their interaction with substance use and addictive medications (e.g. benzodiazepines)?

☐ Yes
☐ No

13d. Are there Quality Assurance systems in place to monitor the use of **psychotropic medications**?

☐ Yes
☐ No

13e. Is there a person on staff who is licensed or certified (e.g. psychiatrist) to prescribe **psychotropic medications**?

☐ Yes
☐ No

If "No" to 13e:

13f. Does this program have access to a psychiatrist or another qualified health professional (e.g. nurse practitioner) on or off-site (e.g. part-time consultant) who can prescribe medication?

☐ Yes
☐ No

Glossary Terms Associated with this Survey

Stages of Implementation (Fixsen, Naoom, Blasé, & Wallace, 2007):

Exploration Stage: The exploration stage involves information collection, analysis and its dissemination. Frequently there will be a need to formulate an implementation team. Information sharing in various formats is essential to increasing awareness of innovations and can prompt program professionals and other staff to consider the need to make changes in current practices and services that will anticipate and support the subsequent introduction of a new practice.

Installation Stage: The installation stage ideally begins with the decision to implement an innovation and ends when the innovation is initially used with the first individual or program cohort. Starting or adopting any innovation requires time and resources, and the lack of planning for those costs and program changes can interfere with attempted implementation of an EBP.

Implementation Stage: During the initial implementation stage, program staff and others involved in the innovation must learn how to carry out and relate to the new practice(s) and intervention processes. It is called the initial implementation stage to acknowledge that staff, supervisors, and administrators in the provider organization are not always likely to be adept in their new roles and/or tasks at the beginning of the implementation process. Full implementation of an innovation is reached when at least 50% of the currently employed staff/clinicians concurrently perform the new practice/intervention and its functions/activities acceptably. The achievement of full implementation in your program should also include measurable fidelity to the original innovation, in the replication of the EBP or best practice intervention.

Innovation Stage: Efficacious and useful innovation(s) normally happens only after full implementation has occurred. Generally, that involves learning the intervention, learning how to do it with fidelity, maintaining the intervention long enough to learn the nuances of its applications/tasks, and then strategically planning to improve the intervention via adaptations that

would be applicable to your programs' uniqueness. Nonetheless, innovation and change should be based on data obtained from attempts to implement the EBP and its interventions with fidelity. As a result, adaptations in the innovation stage are based on solid data that demonstrate improved benefits and better outcomes.

Sustainability Stage: Sustainable and effective implementation efforts are firmly rooted in the activities that occur during the exploration stage and must be integrated into every stage of the implementation process. Sustainability is achieved when the program has, (1) developed and maintained ongoing quality assurance systems and measures, and (2) maintained continued fidelity of the EBP or best practice intervention.

I. Screening and Assessment:

Screening for Co-Occurring Disorders: Screening for co-occurring disorders is a formal process of administering a formal tool to determine whether an individual warrants further attention for a particular mental health disorder. The screening process and its instruments generally include dichotomous questions, which ask for a "yes/no" response to questions like, "Does the individual being screened show signs of a possible mental health problem that requires a comprehensive mental health assessment by a licensed practitioner." An example of a valid screening instrument for co-occurring disorders is the Modified Mini Screen (MMS).

- The MMS is a 22-item scale designed to identify individuals in need of a complete mental health assessment in the domains of Mood Disorders, Anxiety Disorders, and Psychotic Disorders. The questions are common to many screening, diagnostic and assessment tools, including the Diagnostic and Statistical Manual IV (DSM-IV), the Structured Clinical Interview for Diagnosis (SCID) and the Mini International Neuropsychiatric Interview (MINI).

Assessment for Co-Occurring Disorders: Consists of gathering key information and engaging in a process with the patient that enables the counselor to understand the patient's co-occurring disorder, readiness for change, problem areas, co-occurring disorders diagnosis(es), disabilities, and strengths. Information should be gathered on 12 domains: presenting problem(s), current symptoms & functioning, background, individual history, substance use, mental health, medical history, mental status examination, patient perception(s), cultural and linguistic considerations, supports & strengths, and diagnostic impressions on 5 DSM-IV Axes.

II. Clinical Practices and Interventions:

Motivational Interviewing (MI): A patient-centered approach for initiating behavior change by helping individuals resolve ambivalence about engaging in treatment and stopping drug use. It helps an individual develop a schema about the positive and negative effects of drug use to facilitate readiness for treatment and drug use reduction and/or cessation. MI techniques include reflective listening, delivering individual feedback, summarizing, decisional balancing, and developing change plans.

Cognitive-Behavioral Therapy (CBT): A short-term, focused approach to helping drug dependent individuals become abstinent from cocaine and other drugs. CBT posits that the same learning processes involved in the acquisition of drug using behavior can be used to help individuals reduce their drug use and become abstinent. Two critical components include an individual functional analysis of the role substances play in an individual's life and teaching individuals positive coping skills.

Contingency Management (CM): Sometimes called Motivational Incentives, CM is based upon principles of behavior modification. The intervention involves the opportunities for selected patients to earn immediate tangible rewards once they demonstrate achievement of concrete targeted behaviors such as the submission of negative urine toxicology. The process is for the

individual to initially receive some form of extrinsic motivation to cease drug use and then develop over time internal motivation to reach their targeted goals as stated on their treatment plan.

Behavioral Couples Therapy (BCT): Is a structured, skill- based intervention designed to build support for abstinence and to improve relationship functioning among married or cohabitating partners seeking help for addiction once a domestic violence assessment has been completed. The theoretical rationale for the effects of BCT on chemical dependency is that certain dyadic interactions function as inadvertent reinforcement triggers for the use of substances. BCT involves teaching and promoting methods to resolve problems and conflicts appropriately as they arise and encourages participation in relationship enhancement exercises.

Brief Intervention Therapy: A short-term intervention, usually one to five sessions, for substance abusers who are not yet dependent. The intervention generally focuses on solutions to the individual's problems rather than on causes of the problems, or emotional responses to the problems. The therapist uses respectful curiosity to invite the individual to explore and envision their preferred future and then develop a plan to work towards attaining that vision in small incremental steps. The rationale is that if an individual has the capacity to identify/describe something as a problem, that individual also has the capacity to identify/describe how their life could be improved, to include, articulating what are the necessary resources to make that change happen.

Twelve-Step Facilitation (TSF): Twelve-Step Facilitation (TSF) consists of a brief, structured, and manual-driven approach to facilitating early recovery from alcohol abuse/alcoholism and other drug abuse/addiction. It is intended to be implemented on an individual basis in 12 to 15 sessions and is based in behavioral, spiritual, and cognitive principles that form the core of 12-step fellowships such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA). It is suitable for problem drinkers and other drug users and for those who are alcohol or other drug dependent. (NIDA, 2003)

Anger Management: Generally, anger is a feeling or emotion that ranges from mild irritation to intense rage. Substance use, abuse, and dependence often coexist with anger and violence. Anger and its related behaviors can have a causal role in the initiation of drug and alcohol use, relapse, and can be a consequence of substance abuse/dependence. In addition, individuals who experience traumatic events often experience anger. Ideal objectives of anger management are to: (1) learn to manage anger effectively, (2) stop violence/threat of violence, and (3) the development of self-management skills.

Relapse Prevention: Relapse is the act of taking a drink or drug after being clean and sober, and is generally caused by a combination of factors. It helps to view relapse as a process that begins well in advance of that act of using alcohol and drugs. Relapse prevention is the pedagogy of educating people in recovery on how to identify the warning signs and behavioral cues that may lead to a lapse in their abstinence, and the development of strategies that would enable taking positive steps to stay clean and sober.

Trauma-Related Counseling: Trauma-related counseling includes screening and a trauma-informed system of services that have been assessed and developed with regard to how trauma may have played a part in the lives of patients requesting substance use and mental health treatment services, (SAMHSA webpage http://www.samhsa.gov/nctic/trauma.asp#care In addition, trauma-informed services are designed to consider and adjust to potential vulnerabilities a traumatized patient may have, taking into consideration service delivery constructs and approaches that will be supportive and not continue, or re-traumatize the patient, (Harris, M., & Fallot, R.D., 2001). For informational and educational purposes only, the following are a few examples of some trauma-specific interventions that have been used extensively in public system settings. Moreover, additional information regarding trauma-informed care can be obtained at the National Center for Trauma-Informed Care. (http://www.samhsa.gov/nctic/)

- Addiction and Trauma Recovery Integration Model (ATRIUM)
- Essence of Being Real
- Risking Connection
- Sanctuary Model
- Seeking Safety
- Trauma, Addictions, Mental Health, and Recovery (TAMAR) Model
- Trauma Affect Regulation: Guide for Education and Therapy (TARGET)
- Trauma Recovery and Empowerment Model (TREM and M-TREM)

Matrix Model: The Matrix Model is a multi-element collection of therapeutic strategies that complement each other and combine to produce an integrated outpatient treatment experience. It is a set of evidence-based practices delivered in a clinically coordinated manner as a "program." The therapist fosters a positive relationship with the patient and uses that relationship to reinforce positive behavior change. The Model and its strategies are derived from clinical research literature that includes cognitive behavioral therapy, research on relapse prevention, motivational interviewing strategies, psycho-educational information, and 12-Step program involvement. Guiding principles of the Model are:

- Establishing a positive and collaborative relationship with the client
- Creating explicit structure and expectations
- Teaching psycho-educational information, i.e., brain chemistry and other relevant research findings
- Application of cognitive-behavioral concepts
- Positively reinforcing desired behavioral change
- Educating family members regarding the expected course of recovery
- Introducing and encouraging self-help participation
- Monitoring drug use through the use of urinalyses

Additional information regarding the Matrix Model can be obtained at NREPP SAMHSA's National Registry of Evidence-Based Programs and Practices.
http://nrepp.samhsa.gov/ViewIntervention.aspx?id=87

Rational Emotive Behavioral Therapy (REBT): Rational emotive behavior therapy is a comprehensive, humanistic, and action-oriented approach to emotional growth. REBT is a philosophically and empirically based psychotherapy which focuses on resolving emotional and behavioral problems and disturbances. REBT emphasizes individuals' capacity for creating emotions; the ability to change and overcome the past by focusing on the present; and the power to choose and implement satisfying alternatives to current ineffective behavior patterns.

III. Clinical Practices and Interventions Specific to Treating Patients with Co-Occurring Disorders:

Motivational Interviewing (MI): A client-centered method for enhancing intrinsic motivation to change by exploring and resolving client ambivalence. For example, does this program utilize motivational interviewing to help patients with co-occurring disorders resolve ambivalence about engaging in mental health treatment or taking psychotropic medication for their mental disorder?

Cognitive–Behavioral Therapy (CBT): A therapeutic approach that seeks to modify negative or self-defeating thoughts and behavior. Cognitive–Behavioral Therapy is aimed at both thought and behavior change—that is, coping by thinking differently, and coping by acting differently. In the context of co-occurring disorders or conditions, does this program utilize cognitive behavioral approaches to address distortions in thinking or psychiatric symptoms?

Contingency Management (CM): An approach to treatment that maintains that the form or frequency of behavior can be altered through a planned and organized system of positive and negative consequences. The key concept in contingency management is frequent monitoring and the provision of tangible, positive reinforcement whenever a patient demonstrates specific targeted behavior as per their treatment plan goals. The objective is to encourage and reward pro-recovery behaviors and attitudes for patients in treatment or considering behavior change in relation to their mental health in the context of co-occurring disorders (or conditions). Target behaviors for mental health treatment would include (1) treatment attendance, (2) medication compliance, and (3) treatment goal accomplishments.

Behavioral Couples Therapy (BCT): A structured, skill-based intervention designed to build support and to improve relationship functioning among married or cohabitating partners once a domestic violence assessment has been completed. BCT involves teaching and promoting methods to resolve problems and conflicts appropriately as they arise and encourages participation in relationship enhancement exercises. The purpose of BCT is to restore a better level of functioning in couples who experience relationship distress. The reasons for distress can include a broad spectrum of issues such as domestic violence, alcoholism, depression, anxiety, and schizophrenia. The focus of BCT is to identify the presence of dissatisfaction in the relationship, and to devise and implement a treatment plan with objectives designed to improve the presenting symptoms and restore the relationship to a better and healthier level of functioning.

Mutual Self-Help Groups: Mutual support is a process by which people who share their experience, strength and hope about dual recovery voluntarily come together to help each other address common problems. This peer-to-peer approach offers social, emotional, or instrumental support that is mutually provided by persons with similar mental health conditions. Examples may include many mental health consumer non-profits and social groups such as Double Trouble in Recovery, Dual Diagnosis Anonymous, Dual Disorders Anonymous, and Dual Recovery Anonymous.

IV. Achieving Integrated Care/Services for Treating Patients with Co-occurring Disorders:

Achieving Integrated Care/Services: Integrated Care/Services involves the *joint* provision of both mental health and addiction care and services. A patient receives care at a single agency from a single *cross-trained* staff member or a treatment team who assess both conditions, develops a single treatment plan to address both conditions, and combines interventions for both conditions *into a single or series of session(s) or interaction(s).* Care for both disorders may also be coordinated across agencies. There is no one-way of providing integrated care/services; rather there exist a variety of techniques or methods for supplying integrated services to patients. All of these recognize the equal importance of both the mental health and substance abuse problems and the need for treatment to address both conditions.

V. Medication Assisted Therapy (Pharmacotherapy):

Buprenorphine: Is a partial opiate agonist (with agonist and antagonist properties). Buprenorphine behaves like a full agonist (activates the opiate receptor) at low dose and behaves like an agonist or antagonist (blocks the opiate receptor) at high dose. It can be used for detoxification from opiates or for maintenance treatment; however, the individual should always be linked to chemical dependence treatment. There are two forms of the medication, available in 2 mg and 8 mg sublingual tablets, (under the tongue):

- **Subutex®** – Buprenorphine alone
- **Suboxone®** – Buprenorphine combined with Naloxone in a 4:1 ratio. This combination form prevents intravenous use of the tablet after crushing, in which the user would get an antagonist effect of the Naloxone, or at the least, a diminished opiate effect.

- Doses for opioid dependence range from 2 mg to 32 mg.

Methadone: Methadone treatment provides services to persons dependent on opiates, such as heroin and morphine, so that they may develop productive lifestyles. These programs offer methadone as part of a range of medical procedures and services. Included in these services are supportive counseling, medical care, and other individualized services. Medically supervised withdrawal is a short-term (up to 30 days) or long-term (not more than 180 days) medical treatment protocol that utilizes methadone to alleviate withdrawal symptoms caused by the continued use of opiates. This protocol will be included in the array of services available in methadone programs.

Naltrexone (Oral) and Vivitrol® (Injectible Naltrexone): Is a narcotic antagonist that blocks the pleasurable effects of alcohol, reduces alcohol cravings after establishing abstinence, and can be utilized alone for long-term treatment of individuals with opioid addiction. Naltrexone is used for alcohol dependent individuals and can be used after medically supervised withdrawal from an opioid to prevent drug relapse in selected and well-motivated individuals.

Acamprosate (Campral®): Enhances abstinence and reduces drinking days through its effect on the neurotransmitters GABA and glutamate. Although its mode of action has not been clearly established, it may work by reducing symptoms of protracted abstinence such as insomnia, anxiety, and restlessness. Treatment usually starts between 2 to 7 days after the individual ceases alcohol consumption, and the medication does not have hepatic metabolism, which is an advantage in individuals who have inflamed livers due to alcohol use.

Nicotine Replacement Therapies: Designed to support the goal of tobacco abstinence and decrease withdrawal symptoms. A variety of products have been developed which include nicotine gum, nicotine transdermal patches, nicotine inhaler, nicotine spray, and nicotine lozenges.

- **Nicotine Transdermal Patch** - All patches deliver slow release of nicotine per hour. Temperature and circulation affect delivery.
- **Nicotine Lozenge** - Lozenges come in 2 mg and 4 mg doses with the recommended number being about nine (9) lozenges per day, in the first 6 weeks, with tapering thereafter.
- **Nicotine Gum** - available in 2 mg and 4 mg pieces (.86 mg absorbed from the 2 mg piece and 1.2 mg absorbed from the 4 mg piece). The "Park and Chew" technique is used and is affected by chewing rate and pH of the saliva.
- **Nicotine Inhaler** - Cigarette holder shape with replaceable cartridges each containing 10mg nicotine and 1 mg menthol (400 puffs per cartridge and 80 puffs equal one cigarette). One can use 4 to 6 inhalers per day and the delivery is affected by puff rate, temperature, and saliva pH.
- **Nicotine Spray** - One inhalation in each nostril equals a total dose of 1mg nicotine. The average use is 13- to 20 doses per day.
- **Chantix (Varenicline)** - Chantix comes in two doses: 0.5 mg and 1.0 mg. A steady-state level is usually achieved in about four days and is not affected by food or time of day dosing. Ninety-two (92%) percent of the medication is excreted unchanged in the urine, making this a safe medication for individuals with liver disease as there is no significant liver metabolism.
- **Bupropion (Zyban / Wellbutrin)** – Bupropion should be started when the individual is still smoking. Individuals should set a target quit date generally in the second week of treatment. Individuals can receive 150 mg/per day for the first three days, followed by a dose increase in most individuals to 150 mg twice a day (300 mg/day), no sooner than 3 days after beginning therapy. Treatment duration ranges from 7- to 12 weeks, longer in some cases.

Disulfiram/Antabuse®: Disulfiram (or antabuse) produces an unpleasant flushing reaction whenever the individual drinks alcohol, thus it produces a disincentive to drinking and provides some external controls on drinking behavior. It has been shown to be most effective when given in a monitored fashion, such as at a treatment program or by a spouse.

VI. Psychotropic Medication for Treating Patients:

Psychotropic Medications: Pharmacological interventions that can be prescribed for symptoms and behavior associated with mental disorders (or conditions).

VII. Process Improvement Administrative Practices:

Process Improvement: A practice that involves increasing treatment access and retention for individuals by making organizational changes that impact four treatment aims: (1) decrease wait times; (2) decrease no-shows; (3) increase admission rates; and (4) increase continuation and rates of treatment engagement. Five principles guide organizational improvement; (1) understand and involve the customer (e.g., conduct a walk-through to understand the individual perspective); (2) fix key problems; (3) use an internal and powerful change leader; (4) get ideas from outside the organization and/or field; and (5) use rapid cycle testing to make changes using a PDSA Cycle paradigm, i.e., Plan-Do-Study-Act.

G. Domestic Violence Assessment Survey (treatment programs)

Last year, we asked you if this program assessed and referred individuals to the domestic violence provider system, when appropriate. The results revealed that the vast majority of OASAS-certified treatment programs screen for domestic violence victimization (94%) and perpetration (80%) and that appropriate referrals to services are being made. As a follow-up to that survey we are seeking additional information that would allow us to better understand and address the needs of individuals affected by substance use and domestic/intimate partner violence (DV/IPV).

The following questions pertain to clients in your program that may have a history as a domestic violence victim or perpetrator. All questions regarding this survey should be directed to Brenda Bannon at 518-485-2123 or at BrendaBannon@oasas.ny.gov.

Domestic Violence Assessment Survey (Treatment Programs)

13. When does this program conduct DV/IPV victimization screening? (check all that apply)
    - ☐ a) At admission
    - ☐ b) At discharge
    - ☐ c) At any time during treatment
    - ☐ d) Other (specify): _____
    - ☐ e) We do not screen for DV/IPV victimization. (go to #4)

14. Does this program use a standardized assessment tool to screen for DV/IPV victimization?
    - ☐ a) Yes (go to #3)
    - ☐ b) No (go to #4)

15. What standardized assessment tool does this program use to screen for DV/IPV victimization? (check all that apply)
    - ☐ a) Questions included in psycho-social assessment
    - ☐ b) HITS Tool for Intimate Partner Violence Screening
    - ☐ c) Women Experience with Battering (WEB) Scale
    - ☐ d) Composite Abuse Scale (CAS)
    - ☐ e) Abusive Behavior Inventory
    - ☐ f) Revised Conflict Tactics Scale (CTS-2)
    - ☐ g) Other (specify): _____

16. When does this program conduct DV/IPV perpetration screening? (check all that apply)
    - ☐ a) At admission
    - ☐ b) At discharge
    - ☐ c) At any time during treatment
    - ☐ d) Other (specify): _____
    - ☐ e) We do not screen for DV/IPV perpetration. (go to #7)

17. Does this program use a standardized assessment tool to screen for DV/IPV perpetration?
    - ☐ a) Yes (go to #6)
    - ☐ b) No (go to #7)

18. What standardized assessment tool does this program use to screen for DV/IPV perpetration? (check all that apply)
    - ☐ a) Abuse within Intimate Relationships Scale
    - ☐ b) Abusive Behavior Inventory
    - ☐ c) Safe Dates
    - ☐ d) Partner Abuse Scale - Physical
    - ☐ e) Partner Abuse Scale - Non-Physical
    - ☐ f) Multidimensional Measure of Emotional Abuse
    - ☐ g) Other (specify): _____

19. What DV/IPV services does this program offer? (check all that apply)
    - ☐ a) Safety planning within program
    - ☐ b) Educational group within program
    - ☐ c) Individual DV/IPV counseling within program
    - ☐ d) Group DV/IPV counseling within program
    - ☐ e) Referral to local DV/IPV service providers
    - ☐ f) Referral to local mental health service providers
    - ☐ g) Other (specify): _____
    - ☐ h) We do not offer DV/IPV services.

Glossary Terms Associated with this Survey

Domestic Violence/Intimate Partner Violence (DV/IP): A pattern of coercive tactics, which can include physical, psychological, sexual, economic and/or emotional abuse, perpetrated by one person against an adult intimate partner, with the goal of establishing and maintaining power and control over the victim. An **Intimate Partner** includes persons legally married to one another; persons formerly married to one another; persons who have a child in common, regardless of whether such persons are married or have lived together at any time, couples who are in an "intimate relationship" including but not limited to couples who live together or have lived together,

or persons who are dating or who have dated in the past, including same sex couples. An **Abuser** is a person who perpetrates a pattern of coercive tactics which can include physical, psychological, sexual, economic, and emotional abuse against an adult intimate partner, with the goal of establishing and maintaining power and control over the victim. A **Victim** is the person against whom an abuser directs coercive and/or violent acts.

Victimization: To be or have been made a victim.

HITS Tool for Intimate Partner Violence Screening: HITS is a screening tool that is designed for outpatient clinical settings and consists of four questions based on the acronym for Hurt, Insult, Threaten, and Scream.

Women Experience with Battering (WEB) Scale: 10-item scale that measures prevalence of the battering of women.

Composite Abuse Scale (CAS): 30-item scale with 4 subscales that measure severe combined abuse, emotional abuse, physical abuse, and harassment. The physical abuse subscale includes 7 items. The emotional abuse subscale includes 11 items.

Abusive Behavior Inventory: 30-item scale with 2 subscales that measure the frequency of physical and psychological abusive behaviors. The physical abuse subscale includes 13 items (2 of which assess sexual abuse). The psychological abuse subscale includes 17 items.

Revised Conflict Tactics Scale (CTS-2): 78-item scale that assesses both victimization and perpetration. The 39-item victimization scale includes 5 subscales that measure physical assault, psychological aggression, sexual coercion, negotiation, and injury between partners. The psychological aggression subscale includes 8 items that assess verbal and symbolic acts that are intended to cause fear or psychological distress.

Perpetration: To be or have been an abuser.

Abuse within Intimate Relationships Scale: 26-item scale that measures perpetration of psychological and physical abuse. There are 5 subscales: emotional abuse, deception, verbal abuse, overt violence, and restrictive violence.

Partner Abuse Scale - Physical: 25-item scale that measures the magnitude of physical abuse.

Partner Abuse Scale - Non-Physical: 25-item scale that measures the magnitude of perceived non-physical abuse received from a spouse or partner; 2 of the items assess sexual abuse.

Multidimensional Measure of Emotional Abuse: 28-item scale (reduced from 54 items) that measures restrictive engulfment, hostile withdrawal, denigration, and dominance/intimidation.

H. Capital Funding Request Form - Schedule C (optional)

OASAS Bonded Capital Funding

Capital costs are defined as the acquisition of real property, design, construction, reconstruction, rehabilitation and improvement, original furnishings and equipment, site development, and appurtenances of the local facility. Capital costs do not include operating costs; payments of principal, interest, or other charges on obligations; or costs for which State Aid is claimed or paid under provisions of law other than the Mental Hygiene Law. For 2012, capacity expansions, new programs or existing programs that would require additional state aid will NOT be considered for capital funding.

Capital projects will be reviewed by OASAS staff to determine the priority that should be given to Schedule C requests and if they meet OASAS criteria for project development. For 2012, any new capital funding will be used primarily for preservation, relocation or purchase of existing sites. Preservation is not limited to projects which specifically address structural repairs, but rather any project that is necessary or advisable to allow the site to continue to serve as an acceptable space for the provision of services of the particular kind and to the particular populations served (i.e., capital funds may be requested for improvements in space layout, un-grandfather programs to meet current space regulations, improvement in the service environment, improved amenities, upgraded electrical, plumbing or HVAC systems, rearranged space and facilities to adapt to changing service requirements, etc.) OASAS recognizes that some facilities are in premises which cannot be economically preserved. In these circumstances, funding may be made available for relocation or reconstruction of programs.

MH Facilities Improvement Bond Program (MHFIBP), a bond-backed financing program, permits voluntary providers to borrow 100 percent of their capital project costs at fixed interest rates for 20-30 year periods. The loans made to providers for capital construction and acquisition of property secured by a mortgage on the property necessitates a first lien on the entire site. Debt service (payments for principal and interest on the borrowing) is repaid through the OASAS local assistance account.

To take advantage of the MHFIBP financing program, voluntary providers must be in good standing with the New York State Department of State, possess the powers to enter into the mortgage agreement in accordance with incorporation documents, and receive appropriate boards of directors' approvals. In addition, providers must have an effective notification from the Internal Revenue Service that qualifies the provider as a tax-exempt organization under Section 501(c) (3) of the Internal Revenue Code.

Providers will be expected to sign a waiver or assignment agreement authorizing OASAS to intercept local assistance payments otherwise due to providers for the purposes of paying debt service on the mortgage. OASAS will make debt service payments directly to the Dormitory Authority (DA) on a semi-annual or other agreed upon basis.

To be eligible for tax-exempt bond financing on leased property, the lease term must exceed the economic life of the building, must constitute the equivalent of tax

ownership, and must be at least 5 years longer than the term of the bond. Projects under $300,000 are generally considered too small to warrant the cost of bond issuance.

Other OASAS Capital Funding Available

Minor Maintenance

OASAS also has funding available to address capital needs for rehabilitation of existing facilities that do not qualify for the bond-backed mortgage program. If the estimated cost of a project is less than $100,000, a PAS-34 Minor Rehabilitation Request form should be completed and submitted directly to the Field Office. It should not be submitted in the local services plan. Minor maintenance project requests will be reviewed and approved on a continuous basis. The PAS-34 form is available on the OASAS Website.

Capital Projects Costing $100,000 or More

For all other projects (i.e., those projects costing at least $100,000), **a completed Schedule C form must be submitted via the Online County Planning System**. Projects that will be considered for funding include:

- Program relocation
- Purchase of existing leased space
- Regulatory compliance
- Health and safety improvements
- Access for physically disabled
- General preservation

OASAS will review all projects proposed on a Schedule C form and submitted through the local services planning process based solely on the information provided. All project proposals that have a strong justification in relation to program, physical plant and community need, OASAS capital plans, their cost, the provider's ability to provide or arrange interim financing, and OASAS' anticipated capital funding authority will be considered. Staff will be assigned to arrange performance of feasibility studies and appraisals. The provider will have to complete an application for approval in accordance with Part 810 of OASAS regulations. OASAS will provide advice and assistance in completing the Schedule C form. After a capital request is approved and all detailed information about the project is submitted, a decision will be made by OASAS on whether the project will be funded or not. If OASAS approves the project, it will seek Division of the Budget (DOB) approval. After DOB approval, a capital contract will be executed with the provider. Upon obtaining a fully executed capital contract approval, project obligations and expenditures can commence. Only approved expenditures made during the capital contract period will be eligible for reimbursement.

Considering the routine state budget process, the Part 810 review process, and the time it takes to get DOB approval, major capital projects must be considered multi-year efforts. Even after a contract is executed, project design, other approvals, construction bidding, and construction will take two to three years or longer for very large projects. Thus, as OASAS reviews and approves projects for development, the agency will schedule the projects over a number of years. Therefore, funding will come from appropriations made over a number of years as well. Providers submitting proposals for major projects should be aware that regardless of the speed of the initial decision, the conduct of the approved project is a long-term effort.

Instructions for the Capital Project Funding Request Form - Schedule C

A Schedule C "OASAS Capital Project Funding Request Form" should be completed by any provider that wants to request capital funds as described above. The completed form must be completed and submitted in CPS. Each Schedule C will be reviewed and considered by OASAS on a case-by-case basis. Further information may be requested, as needed.

For the **2013 Local Services Plan,** a Schedule C should be completed for each project that meets the criteria for fundable capital projects. The focus of all capital funding will be on preservation of existing sites, with the highest priority being given to correction of code and regulatory violations, health and safety matters and maintenance of service delivery space. All provider and project site information at the top of the form must be completed. Specific instructions follow:

Question #1 - Project Purpose: Place an "X" in the box next to each purpose which applies to the project proposed.

a. **Relocation:** Check this box if the project is intended to physically relocate an existing program or site to a new location.
b. **Purchase of Existing Leased Space:** Check this box if the project involves the possible purchase of an existing program that is in leased space. For example: with skyrocketing lease costs, it may be more financially feasible to pay debt service on a mortgage as opposed to a lease with large escalator clauses.
c. **Regulatory Compliance:** Check this box if the project is intended to bring the program and/or its space into compliance with building, health or safety codes or OASAS regulatory requirements. These violations may be ones you have identified by outside inspectors including, but not limited to, OASAS inspectors.
d. **Health and Safety Improvements:** Check this box if the project is intended to improve health and safety of the space in ways not required by code or regulation. Examples might include rehabilitation of bathroom fixtures and plumbing, upgrading smoke detection and alarm systems, replacing kitchen floors and finishes, etc.
e. **Access for Physically Disabled**: Check this box if the project is to improve access to or use of all or part of the site by physically challenged persons. Examples include construction of wheelchair ramps at entrances, installations of lifts, handrails and grab bars, installation of special bathroom equipment, and acquisition and installation of calling devices for summoning assistance.
f. **General Preservation**: Check this box if the project is to preserve an existing facility. Projects in this category are intended to maintain or protect the use of an existing facility and do not materially extend the useful life or provide enhancement of the environment or program, for example, replacement of a deteriorated bathroom, replacement of heating system, roof, kitchen, driveway, etc.

Question #6: Provide a detailed statement of the need for the project and a justification for it. Describe the need/benefit to the program's operation, to the improvement of the physical plant and the need/benefit to the financial operation of the facility.

- ***Program need/benefit*** refers to correction/improvement of client safety, access, privacy, space layout and traffic flow, or number and types of spaces for patient services and staff activity, etc.
- ***Physical need/benefit*** refers to correction/improvement of inadequate functioning of building or mechanical systems (plumbing, electric, HVAC etc.), structural safety and adequacy, energy efficiency, building integrity (leaky roof windows etc.), building security or internal security of property, supplies, personnel, etc.
- ***Financial need/benefit*** refers to improved financial circumstances resulting from projects which increase energy efficiency, reduce property costs, allow more efficient use of space allowing reduced space use, or reduction of space and cost due to program reorganization or contraction, etc.

A sample of the Schedule C form appears on the following pages.

Schedule C – OASAS Capital Project Funding Request Form (Page 1)

Corporate Headquarters			Date:	
Provider Name (full legal name):			Provider Number:	
Street/P.O. Box:	City:		State:	Zip:
Project Site				
Street/P.O. Box:	City:		State:	Zip:
Service Category:		PRU:	County:	
Contact Person:		Title:		
Telephone:	E-mail:	Certified Capacity:		Funded Capacity:

1. Project Purpose:
   - ☐ a) Program Relocation
   - ☐ b) Purchase of Existing Leased Space
   - ☐ c) Regulatory Compliance
   - ☐ d) Health and Safety Improvements
   - ☐ e) Access for Physically Disabled
   - ☐ f) General Preservation

2. Estimated Project Cost: _____

   If the estimated cost is less than $100,000, a PAS-34 Minor Rehabilitation Request should be submitted separately to the Field Office.

3. Briefly describe the physical plant problem and corrective work required:

4. Indicate approximate square footage of space to be added or affected by the proposed capital project: _____ ft^2

5. Briefly describe the proposed scope of work in the project:

New York State Office of Alcoholism and Substance Abuse Services,SCHEDC2009

Schedule C – OASAS Capital Project Funding Request Form (Page 2)

Project Site		
Provider Name:	Provider Number:	PRU:

6. Provide a detailed statement of need for the proposed project that addresses programmatic, physical plant and financial need, as appropriate: (provide attachment, if necessary)

7. Complete if the project is for an EXISTING certified site:
   a) The site is: ☐ Leased ☐ Owned ☐ Provided as a gift
   b) If leased, is the lease an arms-length lease? ☐ Yes ☐ No
   c) If leased, what is the annual rent? $_____
   d) If owned, are there any liens on the site? ☐ Yes ☐ No
      e) If YES, what is the current market value of the site? $_____
      f) If YES, what is the total balance of all liens on the site? $_____
   g) Are you the sole occupant of the site? ☐ Yes ☐ No

8. Complete if the project is for a NEW site:
   a) Has a probable site been identified? ☐ Yes ☐ No
   b) How do you expect to acquire the site? ☐ Lease ☐ Purchase ☐ Other (attach explanation)
   c) Have you obtained an option on the site? ☐ Yes ☐ No
   d) If an appraisal or fair market rental study of the proposed site has been completed, forward a copy to the field office.

9. If a feasibility study has been completed for the project, forward a copy to the field office.

10. Planned project financing:
    a) Provider funds: $_____
    b) Commercial loans/debt: $_____
    c) Grants (other than OASAS): $_____
    d) OASAS: $_____

11. Has this financing plan been adopted by the governing authority? ☐ Yes ☐ No

Provider Official

Name: _____ Title: _____ Date: _____

New York State Office of Alcoholism and Substance Abuse Services,SCHEDC2009