2020
Local Services Plan
For Mental Hygiene Services

St. Lawrence County Community Srvs Bd
September 6, 2019
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| St. Lawrence County Community Srvs Bd      | 70700/70700      | (Provider)      |
|   Health Coordination Survey               | Required         | Certified       |

| St. Lawrence CD Services OP                 | 70700/70700/50188 | (Treatment Program) |
|   Clinical Supervision Contact Information Survey | Required     | Certified       |
|   Program EHR and LGBTQ Survey             | Required         | Certified       |

| St. Lawrence CD Services OP 1               | 70700/70700/51417 | (Treatment Program) |
|   Clinical Supervision Contact Information Survey | Required     | Certified       |
|   Program EHR and LGBTQ Survey             | Required         | Certified       |
Mental Hygiene Goals and Objectives Form  
St. Lawrence County Community Srvs Bd (70700)  
Certified: Nicholas Hobson (9/4/19)

1. Overall Needs Assessment by Population (Required)

Please explain why or how the overall needs have changed and the results from those changes.

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

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

Please describe any unmet mental health service needs that have improved:

- Citizen Advocates opened an integrated satellite clinic (IOS) in Massena, serving children and adults. Massena has historically had one of the highest rates of ER usage for suicidal and self-injurious behavior for those under the age of 18. Many of the individuals currently being served had previously traveled to the Citizen Advocates Clinic in Malone.
- United Helpers opened a satellite Article 31 Clinic in Canton.
- St. Lawrence County (SLC) Mental Health Clinic has recently begun providing telepsychiatry.
- In addition to ongoing QPR and MHFA training, the County now offers Youth MHFA.
- The quality and quantity of SLC Child and Family Support Team services has greatly improved over the past six months
- Volunteer Transportation and SLC Public Transit have created new routes, fully launched the First Mile Last Mile program, and received grant money through St. Lawrence Health Systems to provide free transportation to address social determinants of health.

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

- Similar to last year, there continues to be unmet mental health needs in SLC as evidenced by continued high rates of emergency room visits and subsequent inpatient psychiatric admissions when indicated, particularly with children and youth. This high need prompted Claxton Hepburn Hospital to receive approval and funding to open a children’s inpatient unit.
- The County continues to experience workforce recruitment and retention issues, particularly psychiatric prescribers and licensed therapists.
- County-wide crisis services do not fully comply with NYS Behavioral Health Crisis Response System guidance.
- There is an ongoing need for safe and affordable housing. Approximately 80 people are on a wait list for supported housing.
- Youth and Family peer supports are lacking.
- HARP only respite services are being under utilized.
- SLC does not have providers for all adult HCBS services, while lacking referrals.
- SLC Does not have a HCBS provider for the OPWDD children's population.
- There remains a critical need for mental health school-based services.

Please describe any unmet mental health service needs that have worsened:

- Staff recruitment and retention. The same staff are changing employers within the county; agencies struggle with drawing in additional staff from outside of the region.
- There is a lack of CFTSS and children's HCBS services, given the increasing demand.
- The HCBS enrollment process for non-medicaid children is cumbersome at best.
- Health Home Care Coordinators are saddled with increasing amounts of paperwork and high caseloads, leaving less time for client contact.

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

Please describe any unmet SUD service needs that have improved:

- Gouverneur Hospital opened an Article 32 clinic.
- Citizen Advocates opened an integrated clinic, which provides MAT.
- There has been a significant increase in the number of individuals trained in Opioid Overdose Prevention.
- Implementation of a Vivitrol program coupled with a case manager/peer placed in the County Jail has enhanced existing forensic services.
- St. Lawrence County Chemical Depedency Clinic began providing MAT via telemedicine.
- St. Joseph Addiction Treatment Center opened McCauley Manor, a four-unit family housing facility.
- New Hope Transformation House Ministries opened Grace House, an uncertified six-bed supportive-living house for women struggling with addiction.
- Seaway Valley Prevention Council received a $350,000 grant to open a Recovery Community Center in Ogdensburg.
- St. Lawrence County enhanced co-location services with DSS by placing another Chemical Dependency Case Aid within CPS. This allows for additional care planning for infants that are born drug positive.
- Rose Hill enhanced services with the addition of two licensed mental health therapists.

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

- In spite of increases, there remains a shortage of data waiver providers across the County, particularly within the local hospitals' emergency rooms.
- The SLC opioid analgesics prescription rate is significantly higher than the overall NYS rate.
Please describe any unmet SUD service needs that have worsened:

- The number of SLC children being placed in foster care rose 21% in less than two years. The Deputy DSS Commissioner reports that many of these families are struggling with addiction.
- There is a lack of timely transportation to ensure emergency detox and SUD inpatient admissions.

c) Indicate how the level of unmet needs of the developmentally disabled population, overall, has changed in the past year: ☐ Improved ☐ Stayed the Same ☐ Worsened

Please describe any unmet developmentally disability service needs that have improved:

- Jefferson Rehabilitation Center, the surviving entity, successfully merged with St. Lawrence NYSARC without disrupting continuity of care. Previously existing sheltered workshops have been closed.
- The number of individuals participating in supportive employment and self-directed services has increased.

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

- Providers are hesitant to develop respite beds due to low reimbursement rates. Lack of access to respite places additional strain on families, family care homes, and residential facilities.

Please describe any unmet developmentally disability service needs that have worsened:

- OPWDD reportedly does not fund emergency respite services causing avoidable, extended-stay, I/DD emergency department encounters.
- Direct care staff for residences who are being underpaid are seeking employment with CCO’s/CMA’s, if qualified; forcing the consolidation of IRA’s due to staff/client ratio requirements. Justice Center incident management causes prospective employees apprehension.
- Reportedly, job coaches are seeking employment elsewhere upon the realization that the I/DD individual they are mentoring is receiving higher earnings.

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

2. Goals Based On Local Needs

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<tr>
<th>Issue Category</th>
<th>Applicable State Agenc(ies)</th>
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<tr>
<td>a) Housing</td>
<td>OASAS OMH OPWDD</td>
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<td>b) Transportation</td>
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<td>c) Crisis Services</td>
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<td>d) Workforce Recruitment and Retention (service system)</td>
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<td>e) Employment/ Job Opportunities (clients)</td>
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<td>g) Inpatient Treatment Services</td>
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<td>h) Recovery and Support Services</td>
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<td>i) Reducing Stigma</td>
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<td>j) SUD Outpatient Services</td>
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<td>m) Coordination/Integration with Other Systems for SUD clients</td>
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<td>o) Other Mental Health Outpatient Services (non-clinic)</td>
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<td>p) Mental Health Care Coordination</td>
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<td>q) Developmental Disability Clinical Services</td>
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r) Developmental Disability Children Services
s) Developmental Disability Student/Transition Services
t) Developmental Disability Respite Services
u) Developmental Disability Family Supports
v) Developmental Disability Self-Directed Services
w) Autism Services
x) Developmental Disability Front Door
y) Developmental Disability Care Coordination
z) Other Need 1 (Specify in Background Information)

2) Other Need 2 (Specify in Background Information) (NEW)

ab) Problem Gambling (NEW)

ac) Adverse Childhood Experiences (ACEs) (NEW)

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

2a. Housing - Background Information

The New York State Office of Mental Health CAIRS Residential Program Indicators Report reflects the number of admissions and length of stay for housing programs located within St. Lawrence County. Data from April 1, 2018 to March 31, 2019 is indicated below. St. Lawrence County’s Apartment Treatment program located in Ogdensburg, which services a total of 16 individuals at a given time, admitted a total of 11 individuals during that time period. The average length of stay was 201 days. A total of 63.6% of these admissions were priority admits. The State Operated Community Residence located in Ogdensburg, which serves 26 individuals at one time, admitted a total of 27 individuals and the average length of stay was 214 days. Of their admissions 55.6% were considered a priority admission. The Non-Specialty Congregate Community Residence located in Gouverneur, which serves 12 individuals at one time, admitted a total of 3 individuals and the average length of stay was 469 days. Of their admissions 33.3% were priority admissions.

The Residential Program Indicators Report also reflects the number of admissions to Supported Housing Community Services, which includes Supported Housing Case Management, Long Term Stay and RCE services. St. Lawrence County has a total of 7 Long Term Stay slots. A total of 4 individuals were admitted during the timeframe. St. Lawrence County has a total of 30 RCE slots available. A total of 2 individuals were admitted during this time frame. There are a total of 70 regular Supported Housing Case Management slots available in the county. For the time period 26 individuals were admitted. St. Lawrence County currently has a Supported Housing Case Management waiting list of approximately 80 individuals; there also is a servere need for permanent supportive housing.

NCTLS is planning construction of additional SRO's for males in Ogdensburg. St. Joseph's is applying for an ESHI grant to fund permanant supportive housing. A Homeless Housing & Assistance Program application is being submitted by Step by Step. The North County Housing Council, who operates the County-Wide Housing Rehabilitation Program will continue the execution of a NYS Community Development Block Grant until January 2020, aimed at providing financial support to home owners for necessary repairs and improvements.

The North Country Health Compass "Severe Housing Problem" indicator rates St. Lawrence County as the most severe in the Tug Hill Region at 16.2%, compared to Jefferson and Lewis Counties at 15.1% and 13.9 respectively. This indicator measures the percentage of households with at least one of the following four housing problems: overcrowding, high housing costs, lack of kitchen, or lack of plumbing facilities. More than 5% of occupied housing units in the County lack either complete plumbing, kitchens or phones. Households in the St. Lawrence County are more likely than statewide to use higher-cost heating fuels, including LP gas (7.4% vs 3.3%); electricity (11.7% vs 9.8%); fuel oil (30.9% vs 27.5%). Over 14% of households in the County use wood as a primary heat source, compared to 2.0% statewide. The deindustrialization within the County resulting in increased poverty may account for the housing problems.

Significant scientific evidence gained in the past decade has shown that various aspects of the home environment can have profound, direct measurable effects on both physical and mental health outcomes, particularly adding to the burden of physical illness (and mental illness) among low-income communities (Envisron Health 2005: May 113 (5): A310 -A317). Poor housing conditions are associated with a wide range of health conditions, including respiratory infections, asthma, lead poisoning, injuries, and mental health. Addressing housing issues offers us an opportunity to address an important social determinant of health (Am J Public Health. 2002 May; 92(5): 758-768).

Do you have a Goal related to addressing this need? Yes No

Goal Statement- Is this Goal a priority goal (Maximum 5 Objectives per goal)? Yes No

Provide safe and affordable housing with neccessary community-based supports for all populations.

Objective Statement

Objective 1: Facilitate the collaboration with State and local partners to increase the stock of affordable housing as funding opportunities are made available.

Applicable State Agency: (check all that apply): [ ] OASAS [ ] OMH [ ] OPWDD

Change Over Past 12 Months (Optional)

2b. Transportation - Background Information

St. Lawrence County is large and predominantly rural, making transportation difficult and costly for many when trying to access services. Data
reveals that approximately 10% of this County's population do not own a vehicle and 38% have one vehicle. Currently Volunteer Transportation, SLC Public Transit, The Arc of Jefferson and St. Lawrence, STEP by STEP, United Helpers, and MAS are providing transportation services in St. Lawrence County.

The St. Lawrence County Mobility Manager has significantly increased public transit routes and has successfully launched the First Mile Last Mile project. Additionally, the mobility manager communicates with the Medicaid transportation provider, MAS, to resolve complaints about denials, cancellations, and no-shows. There is a meeting with Volunteer Transportation, SLC Public Transit, community stakeholders, the Vice President of MAS, and a Medicaid Field Liaison scheduled later this summer to further address MAS transportation inconsistencies. The LGU will continue to support the Mobility Manager's efforts. (See Attachments)

Do you have a Goal related to addressing this need?  Yes  No

Goal Statement- Is this Goal a priority goal (Maximum 5 Objectives per goal)?  Yes  No

Ensure transportation is available to St. Lawrence County residents for access to services, employment, and recreational opportunities.

Objective Statement
Objective 1: Provide timely transportation to ensure emergency detox and inpatient admissions, as well as access to job sites and other social correlates of health activities.

   Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Change Over Past 12 Months (Optional)

2c. Crisis Services - Background Information
St. Lawrence County continues to have high rates of emergency department utilization. 2014 -2016 SPARCS Data from FDRHPO North Country Health Compass asserts the SLC age-adjusted emergency room visit adolescent rate due to suicide or intentional self-inflicted behavior per 10,000 was 119.2. Massena had the highest adolescent rate at 183.1. The State average was 48.2 per 10,000.

On the adult side, 18+ years, for this same indicator; the SLC ER rate was 126.1 per 10,000, while the State average was 108.9. Claxton-Hepburn Medical Center is too often on diversion resulting in patients spending long hours, sometimes days, waiting for inpatient psychiatric care, in spite of having in-County adult and children units.

The NYS Opioid Data Dashboard reports emergency department visits involving opioid overdose for SLC was 60.0 per 100,000, while the State Rate was slightly lower at 56.9. For emergency department visits due to heroin overdose the SLC rate of 29.1 was under the State average of 35.0 per 100,000.

County-wide crisis services do not fully comply with NYS Behavioral Health Crisis Response System guidance. Currently, Reachout provides a mobile crisis response from 9:00 am to 11:00 pm and 24/7 telephonic response. St. Lawrence County does not have a crisis and recovery center. There is a need for more comprehensive crisis intervention services and emergency department diversion strategies/programming.

Do you have a Goal related to addressing this need?  Yes  No

Goal Statement- Is this Goal a priority goal (Maximum 5 Objectives per goal)?  Yes  No

St. Lawrence County LGU will develop County-wide crisis intervention services to reduce avoidable emergency department encounters.

Objective Statement
Objective 1: The LGU, Reachout, and/or Citizen Advocates will develop and implement a County-wide crisis plan that complies with NYS Behavioral Health Crisis Response System guidance.

   Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 2: St. Lawrence County Probation, St. Lawrence Community Services, and SLPC are partnering with Columbia University Center for the Promotion of Mental Health and will develop and implement the e-Connect program to provide assessment and treatment linkage to at risk youth involved with the Juvenile Justice System.

   Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Objective 3: The LGU will explore embedding a behavioral health crisis and stabilization center in a local hospital.

   Applicable State Agency: (check all that apply):  OASAS  OMH  OPWDD

Change Over Past 12 Months (Optional)
2d. Workforce Recruitment and Retention (service system) - Background Information

Workforce recruitment and retention continues to be a salient concern as evidenced by County surveys, discussions with the CSB, Subcommittee members and local providers. St. Lawrence County is a designated health professional shortage area, allowing providers to apply to become a Health Services Corp (HRSA) agency that offers a loan forgiveness program.

There is a shortage of direct care staff. When posed with the choice of working as a direct care staff for an OPWDD agency where at risk of being the subject of a Justice Center report, versus working for a non-human services company for similar pay; many are choosing the latter.

Do you have a Goal related to addressing this need? Yes No

Goal Statement- Is this Goal a priority goal (Maximum 5 Objectives per goal)? Yes No

Develop strategies to assist providers in recruitment and retention of professional staff.

Objective Statement

Objective 1: Encourage providers to explore and implement the use of telehealth when indicated.
Applicable State Agency: (check all that apply): OASAS OMH OPWDD

Objective 2: SLC will utilize State Opioid Response funds to hire additional professional staff and/or peers.
Applicable State Agency: (check all that apply): OASAS OMH OPWDD

Objective 3: Encourage agencies to enroll in college loan repayment programs (e.g. HRSA).
Applicable State Agency: (check all that apply): OASAS OMH OPWDD

2g. Inpatient Treatment Services - Background Information

St. Lawrence County has the highest rates of children being admitted to inpatient psychiatric services in the region. In 2016 SLC’s average daily census for child inpatient admission was 10.39 per 10,000. The surrounding regional average was 5.71 per 10,000. Claxton Hepburn Medical Center has received funding from DOH and support from OMH to open a children's inpatient unit.

Do you have a Goal related to addressing this need? Yes No

If "No", Please discuss any challenges that have precluded the development of a goal (e.g. external barriers):
The LGU supports CHMC’s efforts to open a child inpatient unit, while concomitantly being charged with the task of increasing community based services to reduce the number of emergency room encounters and subsequent inpatient admissions for both children and adults.

Change Over Past 12 Months (Optional)

The inability of St. Lawrence County Providers to recruit psychiatric prescribers (with or without data waivers), CASAC’s, and licensed mental health therapists prohibits the expansion of existing services.

2h. Recovery and Support Services - Background Information

Although formal, clinical supports can be instrumental in guiding the recovery process, such services tend to inadvertently focus on the pathology of the illness and are often difficult for those struggling with behavioral health circumstances to remain engaged. Peer supports have the flexibility to promote sustained engagement and a more steadfast road to recovery and hope.

Seaway Valley Prevention Council opened The Valley Recovery Center in Ogdensburg that has two peer support staff on-site. St. Lawrence Chemical Dependency has recently hired two staff that are eligible for OASAS peer certification, one being jail-based and the other at clinic. The Community Center of the North Country, a FQHC, houses an OASAS peer to perform screening and referrals.

SLPC has one family peer advocate housed at the Children and Youth Clinic. They aslo contract with STEP by STEP to provide adult peer services for inpatient and outpatient services. St. Lawrence County LGU has one OMH family peer support staff embeded in the Child and Family Support Team.

The LGU is aware the 1650 OMH funds for Family Peer Support Services are currently being used to support services modeled after Health Home Care Coordination. In 2017, there was a program proposal approved by the SLC CSB to provide OASAS peer support services to local hospital emergency departments that has yet to be fully implemented. Notwithstanding, there is also a global lack of peer support services in St. Lawrence County of which the LGU has an interest of increasing.

Do you have a Goal related to addressing this need? Yes No

Goal Statement- Is this Goal a priority goal (Maximum 5 Objectives per goal)? Yes No
2i. Reducing Stigma - Background Information

The SLC Chemical Dependency administration participates on the St. Lawrence County Opioid Task Force Advisory Board which created St. Lawrence County Partners 4 Substance Use Prevention. One goal of the Task Force workplan is to increase awareness of the disease of addiction and decrease the stigma. The Task Force contracted with Fort Drum Regional Health Care Planning Organization (FDRHPO) to collect data, hold community forums, and interview key informants.

With regard to stigma FDRHPO reported:

- Of the gaps and barriers discussed (with key informants), stigma was mentioned in conversation the most. Participant responses indicated a thorough understanding and recognition of consequences that result from the stigma of substance use disorder and mental illness. The majority of informants acknowledged that addicted individuals are often accused of causing their own addiction. They are generally perceived as having significant character flaws or a skewed moral compass. They are seen as self-destructive, weak-willed, and ultimately to blame for their illness. Social isolation, joblessness, and a negative self-image are some of the common consequences of this type of discrimination. As one key informant said, “It’s common for individuals with an opioid use disorder to hide their addiction opting not to seek treatment for fear of being fired, losing family and friends, or even their freedom.”

- The sources of stigma mentioned by informants were family members, friends, community members, co-workers, providers, and law enforcement. The most pernicious form of stigma, according to a number of informants, is one that is self-imposed. For these reasons, stigma was considered to be a significant barrier to seeking and receiving treatment and support. A few informants offered a word of caution noting that, by understanding the science of addiction, working to reduce stigma, and addressing the effects of discrimination, one should grow in empathy and awareness, not to justify an individual surrendering to their symptoms or accepting things as they are, but to encourage and embolden an individual to seek help and develop strategies toward healing. Stigma surrounding mental illness was mentioned as a secondary contributing factor to opioid addiction. Some individuals with mental illness, to avoid discrimination, have chosen to self-medicate attempting to alleviate the symptoms of their mental illness while avoiding potential discrimination.

Do you have a Goal related to addressing this need? Yes No

Goal Statement - Is this Goal a priority goal (Maximum 5 Objectives per goal)? Yes No

St. Lawrence County Partners 4 Substance Use Prevention, SLC Community Services, Seaway Valley Prevention Council, Northern Tier Providers Coalition, and other local partners will work towards eliminating stigma associated with substance use disorders.

Objective Statement

Objective 1: Provide community events to provide education on stigma and the science of addiction.

Applicable State Agency: (check all that apply): OASAS OMH OPWDD

Objective 2: Educate healthcare professionals on culturally competent treatment approaches free from discrimination.

Applicable State Agency: (check all that apply): OASAS OMH OPWDD

Objective 3: Promote and support Northern Tier Providers Coalition’s stigma campaign.

Applicable State Agency: (check all that apply): OASAS OMH OPWDD

Change Over Past 12 Months (Optional)
St. Lawrence County LGU distributed a survey tool which included the list of issues/needs in the 2020 LSP Guidelines. The survey was distributed to Community Services Board, Subcommittee members and key stakeholders. Results were ranked by highest number of unmet needs. Community Services Board discussed areas of unmet needs and brainstormed resolution strategies. Survey results and information, subcommittee discussions, service delivery reports and discussions with local providers were used to identify goals and objectives.

Fort Drum Regional Health Planning Organization found:
In 2017, 4% of St. Lawrence County adults (nearly 4,400 people) said they or someone in their household had been affected by problem opioid use or addiction. During this year, our County lost 17 citizens to drug-induced death, following 18 deaths in 2016. The 35 lives lost in these two years alone are more than double that of any year prior to 2007.

Moreover, there were 27 emergency department visits for opioid overdoses in St. Lawrence County in 2017, of which 15 involved opioid pain relievers and 12 involved heroin. In this same year, EMS providers, law enforcement, and other agencies reported 83 naloxone administrations in response to overdoses throughout the county.

The SLC opioid analgescis prescription rate of 641.7 per 1,000 in 2017 is significantly higher than the overall NYS rate of 361.3.

Do you have a Goal related to addressing this need? 

**Goal Statement**
Is this Goal a priority goal (Maximum 5 Objectives per goal)?

Reduce the impact of opiate/opioid use disorders through supports to individuals, families and local communities.

**Objective Statement**
Objective 1: The LGU will consider using additional State Opioid Response funding slated to be released later this year to promote a mobile clinic with peer support and equipped with telemedicine capability.

Applicable State Agency: (check all that apply): OASAS OMH OPWDD

Objective 2: The LGU will explore the need and feasibility of an OTP based in SLC.

Applicable State Agency: (check all that apply): OASAS OMH OPWDD

Objective 3: St. Lawrence County Chemical Dependency Clinic will participate in the Massena Drug Free Community Coalition and support requests for outside funding.

Applicable State Agency: (check all that apply): OASAS OMH OPWDD

Objective 4: SLC Community Service and the Public Health Task Force will campaign to educate medical providers on the DOH recommended guidelines of opioid prescribing and alternatives to pain management.

Applicable State Agency: (check all that apply): OASAS OMH OPWDD

Objective 5: St. Lawrence County Community Services, who operates a Opioid Overdose Prevention Program, and Public Health have begun strategically planning Narcan trainings across the County.

Applicable State Agency: (check all that apply): OASAS OMH OPWDD

**Change Over Past 12 Months (Optional)**

**2n. Mental Health Clinic - Background Information**

Eleven St. Lawrence County Central School districts, who responded to a survey last year, indicated they would welcome additional mental health support from community providers. Citizen Advocates has recently expressed an interest in providing school-based services.

Additionally there are conflicting reports on wait times to receive clinic services.

Do you have a Goal related to addressing this need? 

**Goal Statement**
Is this Goal a priority goal (Maximum 5 Objectives per goal)?

Provide timely access to residents in St. Lawrence County who are seeking mental health services.

**Objective Statement**
Objective 1: Establish real-time clinic waiting lists based on standardized criteria/definitions so as to assess County gaps in clinic services.

Applicable State Agency: (check all that apply): OASAS OMH OPWDD

Objective 2: Create a County-wide dashboard of clinic wait times.

Applicable State Agency: (check all that apply): OASAS OMH OPWDD
Objective 3: The LGU will support Gouverneur Hospital’s plan to open a hospital-based Article 31 clinic for children and adults.

Applicable State Agency: (check all that apply): ☐ OASAS ☑ OMH ☑ OPWDD

Objective 4: The LGU will encourage Article 31 clinics to establish school-based satellite clinics.

Applicable State Agency: (check all that apply): ☐ OASAS ☑ OMH ☑ OPWDD

Objective 5: The LGU will continue to collect and assess data to determine the need for additional clinic services.

Applicable State Agency: (check all that apply): ☑ OASAS ☑ OMH ☑ OPWDD

Change Over Past 12 Months (Optional)

2o. Other Mental Health Outpatient Services (non-clinic) - Background Information

Three new Child and Family Treatment and Support Services (CFTSS) launched January 1, 2019 for children receiving Medicaid and meeting medical necessity criteria. These three services are Other Licensed Practitioner (OLP), Community Psychiatric Supports and Treatment (CPST) and Psychosocial Rehabilitation (PSR). On July 1, 2019 Family Peer Support and Services also launched. St. Lawrence County currently has 4 state designated providers of these services for the Mental Health population that are not in Foster Care and 3 state designated providers of these services for the Mental Health population that are in Foster Care. A third of the providers serving the non foster care population are already at capacity based on the staff available to provide the services and are not accepting new referrals. Finding qualified staff to provide the CFTSS services has been a challenge for the designated providers.

Six different Waiver services combined on April 1, 2019 to comprise the new Home and Community Based Services (HCBS). St. Lawrence County currently has 6 state designated providers of these services. Some of these providers are located outside of the county. As with the CFTSS services, a third of the providers are at capacity with the staff they have and are not accepting referrals at this time. Finding qualified staff to provide the HCBS services has also been a challenge for some designated providers. There are currently no state designated providers to serve the HCBS OPWDD population within St. Lawrence County.

Referents have expressed a lack of understanding of the services as well as how to refer a child to the services. In addition if a child does not have Medicaid the referral process for HCBS services is completed by an agency, C-Yes, which is located in the New York City area. More education is needed for referents and potential children and families receiving these services.

There has been recent discussions/collaboration with STEP by STEP, St. Lawrence Psychiatric Center, and OMH aimed at exploring the feasibility of a PROS program.

Do you have a Goal related to addressing this need? ☑ Yes ☐ No

Goal Statement- Is this Goal a priority goal (Maximum 5 Objectives per goal)? ☑ Yes ☐ No

Increase the number of CFTSS and HCBS state designated providers to serve high needs children in St. Lawrence County, while increase understanding and knowledge of the new services.

Objective Statement

Objective 1: St. Lawrence County LGU will assist interested agencies in becoming a state designated agency.

Applicable State Agency: (check all that apply): ☐ OASAS ☑ OMH ☑ OPWDD

Objective 2: St. Lawrence County LGU’s Mental Health Services Coordinator will continue to provide information and conduct presentations with community partner agencies to promote education and understanding of the new CFTSS and HCBS services.

Applicable State Agency: (check all that apply): ☐ OASAS ☑ OMH ☑ OPWDD

Objective 3: The LGU will continue to consider a PROS program.

Applicable State Agency: (check all that apply): ☐ OASAS ☑ OMH ☑ OPWDD

Change Over Past 12 Months (Optional)

2t. Developmental Disability Respite Services - Background Information

There is a gap in existing SLC I/DD services. When a DD child or youth undergoes a crisis evaluation in the local 9.39 hospital emergency room and is deemed not appropriate for inpatient admission; the assigned caregiver often refuses to allow the DD individual to return to their home or residential setting. This can lead to extended stays in the emergency department after the crisis is abated. Repites service are also needed to divert the number of avoidable I/DD emergency room visits.

Do you have a Goal related to addressing this need? ☑ Yes ☐ No

Goal Statement- Is this Goal a priority goal (Maximum 5 Objectives per goal)? ☑ Yes ☐ No

Increase opportunities for I/DD individuals to receive respite services, including crisis and/or intensive site-based services.

Objective Statement

Objective 1: SLC CSB OPWDD Subcommittee and key stakeholders/providers will form a work group to identify needs and address challenges in creating respite opportunities.

Applicable State Agency: (check all that apply): ☐ OASAS ☐ OMH ☑ OPWDD
Objective 2: Invite OPWDD DDRO Region 2 Leadership to attend I/DD Subcommittee to discuss respite opportunities.

Applicable State Agency: (check all that apply): ☐ OASAS ☐ OMH ☑ OPWDD

Objective 3: The LGU and its Subcommittees will collaborate with local OPWDD providers to implement financially sustainable I/DD respite services.

Applicable State Agency: (check all that apply): ☐ OASAS ☐ OMH ☑ OPWDD

Change Over Past 12 Months (Optional)

2ac. Adverse Childhood Experiences (ACES) (NEW) - Background Information

St. Lawrence County LGU distributed a survey tool which included the list of issues/needs in the 2020 LSP Guidelines. The survey was distributed to Community Services Board, Subcommittee members and key stakeholders. 75% of the respondents indicated there was a need for ACES training. Community Services Board discussed areas of unmet needs and brainstormed resolution strategies. Survey results and information subcommittee discussions, service delivery reports and discussions with local providers were used to identify goals and objectives.

Do you have a Goal related to addressing this need? ☑ Yes ☐ No

Goal Statement - Is this Goal a priority goal (Maximum 5 Objectives per goal)? ☑ Yes ☐ No

Promote coordinated trainings and implementation of county-wide trauma informed care practices.

Objective Statement

Objective 1: The SLC CSB Integrated Subcommittee will form a workgroup to identify local, regional, and State-wide ACES training resources.

Applicable State Agency: (check all that apply): ☑ OASAS ☑ OMH ☑ OPWDD

Objective 2: Facilitate provider participation with SLC DSS who received grant funding to receive ACE’s training from the University of Buffalo.

Applicable State Agency: (check all that apply): ☑ OASAS ☑ OMH ☑ OPWDD

Change Over Past 12 Months (Optional)

<table>
<thead>
<tr>
<th>Attachments</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 2018 FMLM 2018.pdf</td>
</tr>
<tr>
<td>• Public Transportation.pdf</td>
</tr>
</tbody>
</table>
The following survey is intended to promote alignment with the NYS Prevention Agenda for 2019-2024 as part of local services plan development.

All inquiries regarding this survey should be directed to oasasplanning@oasas.ny.gov.

**Background**

The New York State Prevention Agenda for 2019-2024 aims to make New York State the Healthiest State in the Nation for People of All Ages. The Prevention Agenda's overarching strategy is to implement public health approaches that improve the health and well-being of entire populations and eliminate health inequities. This strategy includes an emphasis on social determinants of health - the social, cultural and environmental factors that influence health status, and are root causes of poor health and adverse outcomes. An agenda that focuses on social determinants necessitates cross-cutting policy development and support for local implementation.

As part of the Prevention Agenda, counties are required to submit Community Health Assessment and Community Health Improvement Plans to the Department of Health. LGUs responsible for mental hygiene services have often been active partners in the development and implementation of these plans that align with the statewide prevention agenda. The 2019-2024 Prevention Agenda includes goals and interventions specific to behavioral health, and overall health and well-being. Within the Prevention Agenda, available here, please review the Healthy Women, Infants, and Children Action Plan (pgs. 97-153) and the Promote Well-Being and Prevent Mental and Substance Use Disorders Action Plan (pgs. 154-171).

To reach the statewide prevention goals, future local service planning should include implementation of identified or other evidence-based interventions. Localities will need to create or identify metrics and data collection methods to determine impact. In some cases, data or metrics may not exist. Therefore, data collection will need to occur at the county/provider levels. These activities will require the support of all stakeholders.

**Questions**

1. Has your LGU developed a plan that aligns with the Statewide Prevention Agenda?
   - [ ] No
   - [x] Yes, please explain:

   The DCS and CD Program Director participate on the St. Lawrence County Opioid Task Force Advisory Board which created St. Lawrence County Partners 4 Substance Use Prevention. The 2019 workplan of this coalition includes: 1. Engage providers to improve local availability of MAT. 2. Determine use, trends, and opportunities to improve access to/coordination of care, education and support, based on county-wide assessment. 3. Engage and empower the SLC Community in understanding the current opioid resources. 4. To increase awareness of the disease of addiction and decrease stigma. Additionally, the 2020 plan will include goals and objectives that compliment the Prevention Agenda.

2. Each of the eight goals in the "Promote Well-Being" focus area and "Prevent Mental and Substance Use Disorders" focus area, have an associated intervention. Please select which of the following interventions you have begun or will begin implementing:

**Focus Area 1: Promote Well-Being**

<table>
<thead>
<tr>
<th>Goal 1.1: Strengthen opportunities to build well-being and resilience across the lifespan</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 a) Build community wealth</td>
</tr>
<tr>
<td>1.1 b) Support housing improvement, affordability and stability through approaches such as housing improvement, community land trusts and using a &quot;whole person&quot; approach in medical care</td>
</tr>
<tr>
<td>1.1 c) Create and sustain inclusive, healthy public spaces</td>
</tr>
<tr>
<td>1.1 d) Integrate social and emotional approaches across the lifespan and establish support programs that establish caring and trusting relationships with older people. Examples include the Village Model, Intergenerational Community, Integrating social emotional learning in schools, Community Schools, parenting education.</td>
</tr>
<tr>
<td>1.1 e) Enable resilience for people living with chronic illness by increasing protective factors such as independence, social support, positive explanatory styles, self-care, self-esteem, and reduced anxiety.</td>
</tr>
<tr>
<td>1.1 f) Implement evidence-based home visiting programs</td>
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<tr>
<td>1.1 g) Other</td>
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</tbody>
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<thead>
<tr>
<th>Goal 1.2 Facilitate supportive environments that promote respect and dignity for people of all ages</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.2 a) Implement Mental Health First Aid</td>
</tr>
<tr>
<td>1.2 b) Implement policy and program interventions that promote inclusion, integration and competence</td>
</tr>
<tr>
<td>1.2 c) Use thoughtful messaging on mental illness and substance use</td>
</tr>
<tr>
<td>1.2 d) Other</td>
</tr>
</tbody>
</table>

**Focus Area 2: Mental and Substance Use Disorders Prevention**

<table>
<thead>
<tr>
<th>Goal 2.1: Prevent underage drinking and excessive alcohol consumption by adults</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1 a) Implement environmental approaches, including reducing alcohol access, implementing responsible beverage services, reducing risk of drinking and driving, and underage alcohol access</td>
</tr>
<tr>
<td>2.1 b) Implement/Expand School-Based Prevention and School-Based Prevention Services</td>
</tr>
<tr>
<td>2.1 c) Implement Screening, Brief Intervention, and Referral to Treatment (SBIRT) using electronic screening and brief interventions (e-SBI) with electronic devices (e.g., computers, telephones, or mobile devices) to facilitate delivery of key elements of traditional SBI</td>
</tr>
</tbody>
</table>
2.1 d) Integrate trauma-informed approaches into prevention programs by training staff, developing protocols and engaging in cross-system collaboration

2.1 e) Other

<table>
<thead>
<tr>
<th><strong>Goal 2.2 Prevent opioid overdose deaths</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>2.2 a) Increase availability of/access and linkages to medication-assisted treatment (MAT) including Buprenorphine</td>
</tr>
<tr>
<td>2.2 b) Increase availability of/access to overdose reversal (Naloxone) trainings to prescribers, pharmacists and consumers.</td>
</tr>
<tr>
<td>2.2 c) Promote and encourage prescriber education and familiarity with opioid prescribing guidelines and limits as imposed by NYS statutes and regulations.</td>
</tr>
<tr>
<td>2.2 d) Build support systems to care for opioid users or those at risk of an overdose</td>
</tr>
<tr>
<td>2.2 e) Establish additional permanent safe disposal sites for prescription drugs and organized take-back days</td>
</tr>
<tr>
<td>2.2 f) Integrate trauma informed approaches in training staff and implementing program and policy</td>
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<tr>
<td>2.2 g) Other</td>
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<thead>
<tr>
<th><strong>Goal 2.3 Prevent and address adverse childhood experiences (ACES)</strong></th>
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</thead>
<tbody>
<tr>
<td>2.3 a) Address Adverse Childhood Experiences and other types of trauma in the primary care setting</td>
</tr>
<tr>
<td>2.3 b) Grow resilient communities through education, engagement, activation/mobilization and celebration</td>
</tr>
<tr>
<td>2.3 c) Implement evidence-based home visiting programs</td>
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<tr>
<td>2.3 d) Other</td>
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<tr>
<th><strong>Goal 2.4 Reduce the prevalence of major depressive disorders</strong></th>
</tr>
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<tbody>
<tr>
<td>2.4 a) Strengthen resources for families and caregivers</td>
</tr>
<tr>
<td>2.4 b) Implement an evidence-based cognitive behavioral approach such as Peter Lewinsohn's Coping with Depression course, Gregory Clarke's Cognitive-Behavioral Prevention Intervention</td>
</tr>
<tr>
<td>2.4 c) Implement the Combined Parent-Child Cognitive-Behavioral Therapy (CPC_CBT)</td>
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<tr>
<td>2.4 d) Other</td>
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<table>
<thead>
<tr>
<th><strong>Goal 2.5 Prevent suicides</strong></th>
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<tbody>
<tr>
<td>2.5 a) Strengthen economic supports: strengthen household financial security, and policies that stabilize housing</td>
</tr>
<tr>
<td>2.5 b) Strengthen access and delivery of suicide care â€“ Zero Suicide (a commitment to comprehensive suicide safer care in health and behavioral health care systems)</td>
</tr>
<tr>
<td>2.5 c) Create protective environments: reduce access to lethal means among persons at risk of suicide; integrate trauma informed approaches; reduce excessive alcohol use</td>
</tr>
<tr>
<td>2.5 d) Promote connectedness, coping and problem-solving skills: social emotional learning, parenting and family relationship programs, peer norm program</td>
</tr>
<tr>
<td>2.5 f) Other</td>
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<tr>
<th><strong>Goal 2.6 Reduce the mortality gap between those living with serious mental illnesses and the general population</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>2.6 a) Implement a multilevel intervention model that focuses at the individual, health systems, community and policy-levels. This model describes a comprehensive framework that may be useful for designing, implementing and evaluating interventions and programs to reduce excess mortality in persons with SMD.</td>
</tr>
<tr>
<td>2.6 b) Implement integrated treatment including concurrent therapy for mental illness and nicotine addiction</td>
</tr>
<tr>
<td>2.6 c) Support and strengthen licensing requirement to include improved screening and treatment of tobacco dependence by mental health providers</td>
</tr>
<tr>
<td>2.6 d) Other</td>
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</tbody>
</table>

Please describe your efforts implementing the interventions selected above (if any). Also, if you selected an "other" category from any set of interventions above, please describe it here:

2.1d, 2.2f Information from the community survey indicates a need for trauma informed care and treatment for services providers. This will be included in the 2020 Plan. 22a Earlier this year, Citizen Advocates opened an integrated clinic in Massena that provides MAT; Gouverneur Hospital opened an Article 32 clinic. St. Joseph’s is applying for an Article 32 satellite clinic in Massena. Approximately eleven additional prescribers are in the process of obtaining their Data Waiver. 22b St. Lawrence County Community Services and Public Health are strategically planning Narcan trainings across the County; to be included in the LSP. 22c SLC has high rates of analgesic opioid prescription disseminating and use. Medical prescriber detailing will promote prescriber education and familiarity with opioid prescribing guidelines. 22d Seaway Valley Prevention Council received grant money to develop a recovery community center, scheduled to open this year. St Lawrence County Community Services added two peer support positions.

3. Have you engaged any local or regional partners in implementing actions related to the New York State Prevention Agenda (e.g., Local Health Department, hospital or hospital system, substance use disorder prevention coalition)?

- [ ] No
- [ ] Yes, please explain:

  Community Services and other local agencies have partnered with Public Health to create a drug task force.

4. As data and metrics related to the Prevention Agenda's behavioral health interventions may not exist, has your LGU considered how to track
progress of implementation?

- No
- Yes, please explain:
  FDRHCPO is working with the task force to track data. OD Map is being initiated. The CLMHD also provides an extensive data portal.

5. Has your LGU identified statewide policies that assist or impede implementation of Prevention Agenda interventions?

- No
- Yes, please explain:

6. Is your LGU planning for Prevention Agenda alignment by Article 31 and 32 clinics via implementation of evidence-based practices? If so, please describe, and include relevant details on any LGU support of data protocols that would assist clinics in determining outcomes.

- No
- Yes, please explain:
  Other than trauma informed care trainings.

7. Are the Prevention Agenda's cross-cutting goals and priorities (e.g., environmental concerns, chronic illness reduction) addressed in your health department's Community Health Assessment and Community Health Improvement Plan? If so, how will your LGU support these cross-cutting goals and priorities?

- No
- Yes, please explain:

8. DSRIP funding has advanced many projects related to the overall improvement of behavioral health and well-being. Of these projects supported by DSRIP, are there local prevention opportunities that your LGU could build upon and sustain?

- No
- Yes, please explain:
  Promote early prevention/identification strategies for physical and behavioral health needs among all health care providers. Embedded Behavioral Health in PCP and hospital settings are being launched as staffing permits.

9. Aside from Prevention Agenda activities, please identify any of the following social determinants of mental health that you are addressing in your community:

- [ ] Un/Underemployment and Job Insecurity
- [ ] Food Insecurity
- [ ] Adverse Features of the Built Environment
- [ ] Housing Instability or Poor Housing Quality
- [ ] Discrimination/Social Exclusion
- [ ] Poor Education
- [ ] Poverty/Income Inequality
- [ ] Adverse Early Life Experiences
- [ ] Poor Access to Transportation
- [ ] Other

Please describe your efforts in addressing the selections above:

NCTLS is planning construction of additional SRO's for males in Ogdensburg. St Joseph's is applying for an ESHI grant to fund permanent supportive housing. A Homeless Housing & Assistance Program and ESHI application is being submitted by Step by Step. The North County Housing Council, who operates the County-Wide Housing Rehabilitation Program will continue the execution of a NYS Community Development Block Grant until January 2020, aimed at providing financial support to home owners for necessary repairs and improvements. Community surveys supported the need for training of trauma-informed approaches to treatment for mental health and substance use disorder providers; to be included on the 2010 local services plan. Currently Volunteer Transportation, SLC Public Transit, Step by Step, and MAS are providing transportation services in St. Lawrence County. The St. Lawrence County Mobility Manager has significantly increased public transit routes that now extend into Jefferson County and has successfully launched the First Mile Last Mile project. Additionally, the mobility manager communicates with the Medicaid transportation provider, MAS, to resolve complaints about denials, cancellations, and no-shows. There is a meeting with Volunteer Transportation, SLC Public Transit, community stakeholders, the Vice President of MAS, and a Medicaid Field Liaison scheduled later this summer to further address MAS transportation inconsistencies. The LGU will continue to support the Mobility Manager's efforts.

10. In your county, do you or your partners offer training related to strengthening resilience, trauma-informed or trauma-sensitive approaches?

a) [ ] No  [ ] Yes

b) If yes, please list

- Title of training(s):
  Bridges Out of Poverty Youth and Adult Mental Health First Aid.

- How many hours:
  16/8

- Target audience for training:
  Both professional and public

- Estimate number trained in one year:
  100-150
11. New to the 2019-2024 cycle of the Prevention Agenda is the incorporation of a Health-Across-all-Policies approach, initiated by New York State in 2017, which calls on all State agencies to identify and strengthen the ways that their policies and programs can have a positive impact on health. As part of this effort, New York State was designated as the first Age-Friendly State in the nation by the American Association of Retired Persons (AARP).

Does your LGU have policies and procedures in place to support the positive environmental, economic, and social factors that influence the health and well-being of all residents, especially older adults?

- [ ] No
- [ ] Yes, please provide examples:
The purpose of this survey is to promote continued and improved access to quality mental health services in Medicaid Reform (DSRIP/Value Based Payment). All questions regarding this survey should be directed to Melissa Staats, MA MSW, at 518-408-8533, or Melissa.Staats@omh.ny.gov

Background
On April 14, 2014, New York received a waiver from the federal government that allowed the state to reinvest $8 billion in federal savings generated by Medicaid Redesign Team (MRT) reforms and support the redesign of the health care delivery system. Of this, $6.42 billion is used to support Delivery System Reform Incentive Payments (DSRIP). The DSRIP program promotes community-level collaborations and focus on system reform, specifically a goal to achieve a 25 percent reduction in avoidable hospital use over five years. DSRIP projects focus on system transformation, clinical improvement and population health improvement. All DSRIP funds are based on performance linked to achievement of project milestones.

DSRIP serves as a bridge to value-based payment in New York State.

DOH website

DSRIP Performing Provider Systems (PPS)
Organizations responsible for implementing DSRIP goals via Project Plans are called Performing Provider Systems. Many counties report the value PPS brings to communities as they provide resources that support efforts currently not funded by Medicaid.

DSRIP Project Lists
New York State Delivery System Reform Incentive Payment Program Project Toolkit
DSRIP Performing Provider Systems (PPS Statewide)

Value Based Payment (VBP) - Reduce Costs/Improve Quality
The New York State Medicaid managed care system is transforming from one that pays for service volume to one that rewards value, as defined by the intersection of cost and quality. This transformation is detailed in the NYS VBP Roadmap for Medicaid Payment Reform.

New York State VBP Roadmap
Further details regarding VBP readiness and implementation can be found at: DSRIP - Value Based Payment Reform (VBP) and VBP for Providers

NYS Behavioral Health (BH) Value Based Payment (VBP) Readiness Program
The BH VBP Readiness Program provides funding over 3 years to selected BH provider networks that have formed a Behavioral Health Care Collaborative (BHCC), beginning in 2017. There are 19 BHCCs across the state receiving this funding. A BHCC is a network of providers delivering the entire spectrum of behavioral health services available in a natural service area. The BHCC includes, but is not limited to, all licensed/certified/designated OMH/OASAS/Adult BH HCBS programs and service types. The Readiness Program is designed to achieve two overarching goals:

1. Prepare behavioral health providers to engage in VBP arrangements by facilitating shared infrastructure and administrative capacity, collective quality management, and increased cost-effectiveness; and
2. Encourage VBP payors, including but not limited to MCOs, hospitals, and primary care practices, to work with BH providers who demonstrate their value as part of an integrated care system.

Value Based Payment Readiness for Behavioral Health Providers
New York State Behavioral Health Value Based Payment Readiness Program Overview
New York State's goal is to have the vast majority of total managed care payments tied to VBP arrangements by 2020. DSRIP funding to support BHCCs and PPS projects ends March 31, 2020.

Questions

1. Have the PPS supported your LGU and community? For example, support for efforts such as: addressing gaps in services, promoting evidence based and best practices, and facilitating clinical integration.
   a) Yes  b) No
   b) Please provide more information:
   2.a.i. – All regional PPS partners have been connected by secure DIRECT messaging to support a clinically integrated network. In order to ensure a compliant clinically integrated network, the PPS has funded a privacy and security management vendor for partners to utilize. 2.a.ii. – All participating PCPs in the region meet NCQA 2014 Level 3 PCMH accreditation. PPS is providing direct, hands-on support with in-house NCQA Certified Content Experts (CCE) to primary care partners. 2.a.iv. – Regional hospital has become a medical village, which is a “one-stop-shop” for the community; this helps to reduce excess bed capacity and results in in service integration. Medical villages are also platforms for primary care/behavioral health integration. 2.b.iv. – Regional partners, including SLCCS, have adopted care transitions protocols to strengthen community-based support for the patient for a 30 day transition period post-hospitalization. This includes access to care teams with resources including community health workers, behavioral health peer supports, tobacco treatment specialists, and certified diabetes educators. 2.d.i. – This project has identified uninsured patients as well as low and non-utilizers of primary care/prevention services and engaged these patients through coaching to utilize primary care/prevention services. 3.a.i. – County has two models of care to integrate mental health and substance abuse with primary care services and thus ensure coordination of care. The PPS has assisted with SLCCS’s Model 2 integration of mental health and substance abuse with primary care services to ensure coordination of care in the community. Through Model 2 integration, SLCCS is now able to offer primary care services on site for patients, which is an evidence based best practice. 3.b.i. - The PPS has implemented an annual blood pressure training for all participating providers as well as implemented standardized disease management policies for hypertension and cholesterol. The PPS has developed care teams with tobacco cessation services, CDEs, CHWs, and behavioral health peer supports for primary care practices to utilize. 3.c.i. – All PPS primary care partners have implemented standardized diabetes disease management policies. The PPS has developed care teams with tobacco cessation services, CDEs, CHWs, and behavioral health peer supports for primary care practices to utilize. 3.c.ii. – By aligning clinical & community priorities, the NCI PPS has created a holistic focus for chronic disease prevention in the region. Diabetes prevention and management classes have been established and are offered in the region. 4.a.iii. – The PPS has strengthened infrastructure for MEB health promotion and MEB disorder prevention through the creation of a customized MEB video and Public Service Announcements, as well as aligning goals with the regional prevention councils and suicide coalitions. 4.b.ii. - Smoking cessation services and Chronic Disease Self-Management Programs have been established across the county to address chronic disease in the community setting. The NCI PPS has also
supported community partners by providing funding for the following resources: recruitment and retention of providers, workforce training, diabetes prevention classes, chronic disease self-management programs, compliance and security support, BH Peer Supports, Community Health Workers, and tobacco cessation support.

2. Has your LGU planned for PPS project sustainability beyond March 31, 2020?
   a) Yes  No
   b) Please explain:
      NCI PPS has created an IPA as a structure to sign into value-based arrangements with payers. In addition, the PPS has conducted a Sustainability Survey with all partners and a Sustainability Retreat with essential partners to determine the areas in which to develop formal sustainability plans. The PPS Project Leads are currently drafting the formal plans for Board approval late Summer, early Fall.

3. Are there any behavioral health providers in your county in VBP arrangements?
   a) Yes  No
   b) Please explain (if "yes" include steps providers have taken to execute contracts):
      To my knowledge not yet. Tug Hill Seaway Valley BHCC BH providers are participating in the North Country IPA (Jefferson County) however the IPA has not yet negotiated agreeable terms with payers for PCP or BH providers. Northwinds Integrated Health Network is starting to have discussions with payers.

4. Is the LGU aware of the ways in which managed care organizations and mental health providers plan to leverage VBP resources to implement evidence and best practices like, but not limited to, Collaborative Care Model (CCM), Dual Diagnosis Integration, or Self-Help and Peer Support Services?
   a) Yes  No
   b) Please explain:
      The regional BH networks are working internally to more fully integrate BH services among local providers in effort to attract payers and facilitate an integrated whole health model.

5. Is the LGU aware of the development of In-Lieu of proposals?
   a) Yes  No
   b) Please explain:

6. Can your LGU support the BHCC planning process?
   a) Yes  No
   b) Please explain:
      St. Lawrence County Community Services participates with Northwinds as a network provider and with Tug Hill Seaway Valley BHCC as an affiliate provider.

7. Does your county have access to data and IT systems that will support further transformation to VBP and outcomes management?
   a) Yes  No
   b) Please explain:
      The Tug Hill Seaway Valley BHCC partners have access to resources to navigate PSYCKES data and have their data displayed in a custom data dashboard to reflect performance on 6 high-priority BH measures. Northwinds has also creating a network providers PSYCKES dashboard.
Community Service Board Roster  
St. Lawrence County Community Srvs Bd (70700)  
Certified: Sheena Smith (3/28/19)

Note:

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 particular community interest being represented. Members shall serve four-year staggered terms.

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Represents</th>
<th>Term Expires</th>
<th>Email Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mary Jones</td>
<td></td>
<td>Physician</td>
<td>Term Expires</td>
<td>Email Address</td>
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<tr>
<td>Robert Buffham</td>
<td></td>
<td>Retired from SLPC</td>
<td>Term Expires</td>
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<tr>
<td>Joann Chambers</td>
<td></td>
<td>Potsdam Central School</td>
<td>Term Expires</td>
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<tr>
<td>Frank Doldo</td>
<td></td>
<td>St. Lawrence County Public Transit</td>
<td>Term Expires</td>
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<td>Kimberly McKnight</td>
<td></td>
<td>Claxton Hepburn Medical Center</td>
<td>Term Expires</td>
<td>Email Address</td>
</tr>
<tr>
<td>Patricia Hogle</td>
<td></td>
<td>St. Lawrence County Health Initiative</td>
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<td>Kevin Acres</td>
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<tr>
<td>Kristin Weber</td>
<td></td>
<td>St. Lawrence Psychiatric Center</td>
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<tr>
<td>Sherri Hewitson</td>
<td></td>
<td>CP of the North Country</td>
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</tr>
<tr>
<td>Lee Scaggs</td>
<td></td>
<td>BOCES</td>
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<td>Email Address</td>
</tr>
<tr>
<td>David Bayne</td>
<td></td>
<td>Peer</td>
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</tbody>
</table>
Indicate the number of mental health CSB members who are or were consumers of mental health services: 0

Indicate the number of mental health CSB members who are parents or relatives of persons with mental illness: 0
Alcoholism and Substance Abuse Subcommittee Roster  
St. Lawrence County Community Svcs Bd (70700)  
Certified: Sheena Smith (3/28/19)

<table>
<thead>
<tr>
<th>Name</th>
<th>CSB Member:</th>
<th>Represents:</th>
<th>Email Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marilyn Beldock</td>
<td>Yes</td>
<td>St. Lawrence Addiction Treatment Center</td>
<td><a href="mailto:Marilyn.beldock@oasas.ny.gov">Marilyn.beldock@oasas.ny.gov</a></td>
</tr>
<tr>
<td>Kevin Beary</td>
<td>Yes</td>
<td>Retired</td>
<td><a href="mailto:kevinbeary@hotmail.com">kevinbeary@hotmail.com</a></td>
</tr>
<tr>
<td>Emily Marquart</td>
<td>Yes</td>
<td>Gouverneur Hospital</td>
<td><a href="mailto:emarquart@ephospital.org">emarquart@ephospital.org</a></td>
</tr>
<tr>
<td>Sean Vitali</td>
<td>Yes</td>
<td>North Country Freedom Homes</td>
<td><a href="mailto:svitali@ncfreedomhomes.org">svitali@ncfreedomhomes.org</a></td>
</tr>
<tr>
<td>Jennifer Barron</td>
<td>Yes</td>
<td>Rose Hill</td>
<td><a href="mailto:Jbarron@stjoestreatment.org">Jbarron@stjoestreatment.org</a></td>
</tr>
<tr>
<td>Larry Calkins</td>
<td>Yes</td>
<td>Seaway Valley Prevention Counsel</td>
<td><a href="mailto:lcalkins@svpc.net">lcalkins@svpc.net</a></td>
</tr>
</tbody>
</table>

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 Representitive", etc. to indicate the perspective the member brings to the subcommittee.
The subcommittee shall have no more than eleven members. Three subcommittee members must be members of the board; those members should be identified here.

New York State Mental Hygiene Law requires that "each subcommittee for mental health shall include at least two members who are or were consumers of mental health services, and at least two members who are parents or relatives of persons with mental illness."

Under item labeled "Represents", enter the name of the member's organization or enter "Consumer", "Family", "Public Representative", etc. to indicate the perspective the member brings to the subcommittee.

<table>
<thead>
<tr>
<th>Name</th>
<th>CSB Member: Yes</th>
<th>Represents:</th>
<th>Email Address:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lindsay Newvine</td>
<td>Yes</td>
<td>St. Lawrence County</td>
<td><a href="mailto:Lnewvine@stlawco.org">Lnewvine@stlawco.org</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Community Services</td>
<td></td>
</tr>
<tr>
<td>Patrick Donahue</td>
<td>Yes</td>
<td>Catholic Charities</td>
<td><a href="mailto:pdonahue@rcdony.org">pdonahue@rcdony.org</a></td>
</tr>
<tr>
<td>Tammy Bush</td>
<td>Yes</td>
<td>STEP by STEP</td>
<td><a href="mailto:Tbrush@stepbystepinc.org">Tbrush@stepbystepinc.org</a></td>
</tr>
<tr>
<td>Sara Hutcheson</td>
<td>Yes</td>
<td>Reachout</td>
<td><a href="mailto:shutches@twcny.rr.com">shutches@twcny.rr.com</a></td>
</tr>
<tr>
<td>Kim McKnight</td>
<td>Yes</td>
<td>Claxton Hepburn Medical</td>
<td><a href="mailto:kmcknight@chmed.org">kmcknight@chmed.org</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Center</td>
<td></td>
</tr>
<tr>
<td>Colleen Aldridge</td>
<td>Yes</td>
<td>United Helpers</td>
<td><a href="mailto:csalridge@unitedhelpers.org">csalridge@unitedhelpers.org</a></td>
</tr>
<tr>
<td>Kristine Weber</td>
<td>Yes</td>
<td>Community Services Board</td>
<td><a href="mailto:kristne.weber@omh.ny.gov">kristne.weber@omh.ny.gov</a></td>
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</tr>
</thead>
<tbody>
<tr>
<td>Lee Scaggs</td>
<td>Yes</td>
<td>Community Services Board</td>
<td><a href="mailto:scaggs337@gmail.com">scaggs337@gmail.com</a></td>
</tr>
<tr>
<td>Sheri Hewitson</td>
<td>Yes</td>
<td>Cerebral Palsy of NNY</td>
<td><a href="mailto:Sherri@cpnorthcountry.org">Sherri@cpnorthcountry.org</a></td>
</tr>
<tr>
<td>John Mikolay</td>
<td>Yes</td>
<td>Transitional Living Services NNY</td>
<td><a href="mailto:jnikolay@tlsnny.com">jnikolay@tlsnny.com</a></td>
</tr>
<tr>
<td>Linda Scagel</td>
<td>Yes</td>
<td>Family</td>
<td><a href="mailto:311linny@gmail.com">311linny@gmail.com</a></td>
</tr>
<tr>
<td>Keith Mitchell</td>
<td>Yes</td>
<td>NRCIL</td>
<td><a href="mailto:keithdennismitchell@gmail.com">keithdennismitchell@gmail.com</a></td>
</tr>
<tr>
<td>Heather Wenzel</td>
<td>Yes</td>
<td>St. Lawrence County Department of Social Services</td>
<td><a href="mailto:Heather.Wenzel@dfa.state.ny.us">Heather.Wenzel@dfa.state.ny.us</a></td>
</tr>
<tr>
<td>Melissa Hale</td>
<td>Yes</td>
<td>Fostering Futures</td>
<td><a href="mailto:mhal@nnychildrenshome.com">mhal@nnychildrenshome.com</a></td>
</tr>
</tbody>
</table>

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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 2020 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 2020 Local Services planning process.
Under New York State regulations, providers certified under the following parts are required to "have a qualified individual designated as the Health Coordinator who will ensure the provision of education, risk reduction, counseling and referral services to all patients regarding HIV and AIDS, tuberculosis, hepatitis, sexually transmitted diseases, and other communicable diseases":

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

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

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

All questions on this form should be answered as they pertain to each program operated by this agency. The responses to this survey should be coordinated to ensure accuracy of responses across all programs within the agency. We are asking that the survey be completed by Monday, April 1, 2020. Any questions related to this survey should be directed to Matt Kawola by phone at 518-457-6129, or by e-mail at Matt.Kawola@oasas.ny.gov.

1. What is the overall average fringe benefit rate paid to employees by this agency? This number must be entered in number format as a percentage of salary, without the percent sign or symbols (example: 20.5).

50.88 %

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

<table>
<thead>
<tr>
<th>PRU</th>
<th>Program</th>
<th>Paid Staff</th>
<th>In-kind Services</th>
<th>Contracted Services</th>
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</tr>
<tr>
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<td>St. Lawrence CD Services OP 1</td>
<td>☑️</td>
<td>☐️</td>
<td>☐️</td>
</tr>
</tbody>
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3. Please provide the following information for each PRU where those paid staff and in-kind services services are provided. If multiple individuals provide these services at a single program, provide the total hours worked and the hourly pay rate for each individual. For hourly pay rate, use number format without a dollar sign or symbols (example: 37.5).

<table>
<thead>
<tr>
<th>PRU</th>
<th>Program</th>
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<th>Health Coordinator #2</th>
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<td>Services Provided</td>
<td>Hours per Week Worked as a Health Coordinator</td>
<td>Hourly Rate (dollars)</td>
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<td>50188</td>
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<td>St. Lawrence CD Services OP 1</td>
<td>☑️</td>
<td>☐️</td>
</tr>
</tbody>
</table>

4. Please provide the following information for each PRU where those contracted services are provided. If multiple contracted individuals provide these services at a single program, provide the total hours worked per week and the average hourly rate paid. For dollars paid, use number format without a dollar sign or symbols (example: 37.5).

<table>
<thead>
<tr>
<th>PRU</th>
<th>Program</th>
<th>Service Provided</th>
<th>Hours per Week Worked as a Health Coordinator</th>
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</table>
The OASAS Division of Practice Innovation and Care Management (PICM) maintains contact information on clinical supervisors in order to communicate on matters of interest and importance to the practice of clinical supervision. This form was developed to collect contact information on all clinical supervisors in OASAS-certified treatment programs. The information will be maintained in the County Planning System and will be required to be updated annually in the spring. This form can be updated at any time throughout the year by contacting the OASAS Planning Unit oasasplanning@oasas.ny.gov and requesting that the form be decertified so that the information can be revised.

To enter the contact information for a clinical supervisor, click on the “Add a Clinical Supervisor” link below. Click on the link again to enter contact information for additional clinical supervisors.

<table>
<thead>
<tr>
<th>Name</th>
<th>Sheena Smith</th>
<th>Name</th>
<th>Gidget RafusRousell</th>
</tr>
</thead>
<tbody>
<tr>
<td>Credentials</td>
<td>CASAC 2, CTRS</td>
<td>Credentials</td>
<td>CASAC 2, LMHC</td>
</tr>
<tr>
<td>Email Address</td>
<td><a href="mailto:shsmith@stlawco.org">shsmith@stlawco.org</a></td>
<td>Email Address</td>
<td><a href="mailto:Grafusrousell@stlawco.org">Grafusrousell@stlawco.org</a></td>
</tr>
<tr>
<td>Phone</td>
<td>3153862189</td>
<td>Phone</td>
<td>3153862189</td>
</tr>
</tbody>
</table>
The following survey is designed to provide OASAS with program-level information regarding two topics that are integral to ensuring that individuals with Substance Use Disorders (SUDs) receive the highest quality care. Part I asks about Electronic Health Record (EHR) usage and Part II collects information regarding the treatment of individuals identifying as lesbian, gay, bisexual, transgender or questioning (LGBTQ).

Questions related to this survey should be directed to Carmelita Cruz at Carmelita.Cruz@oasas.ny.gov.

**PART I - Electronic Health Record (EHR) Survey**

An Electronic Health Record (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 information 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.

The purpose of Part I of this survey is to assess your agency's status on the adoption of an EHR, and which EHRs are most commonly used by OASAS-certified programs.

1. Does your program use an electronic health record?
   - [ ] No
   - [ ] Yes, please provide the company and product names of your EHR below:

   **Company Name (e.g., Allscripts, Netsmart, Core Solutions, etc.):**
   IMA Serve

   **Product Name (e.g., Paragon, CareRecord, Cx360, etc.)**

**PART II - Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) Program Survey**

Research suggests that Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) individuals face health disparities linked to societal stigma, discrimination, and denial of their civil and human rights. OASAS recognizes that culturally sensitive treatment often results in more effective treatment. In order to protect the rights of LGBTQ individuals receiving Substance Use Disorder (SUD) treatment OASAS issued Local Services Bulletin (LSB) 2017-04 "Affirming Care for Lesbian, Gay, Bisexual, Transgender and Questioning Clients in OASAS Programs."

The purpose of Part II of this survey is to gather background information regarding the LGBTQ populations served by OASAS-certified SUD treatment programs so that OASAS may develop technical assistance for providers in order to deliver the best possible care to LGBTQ individuals.

2. Is your program aware of Local Services Bulletin (LSB) 2017-04 "Affirming Care for Lesbian, Gay, Bisexual, Transgender and Questioning Clients in OASAS Programs"?
   - [ ] No
   - [ ] Yes

3. In your opinion and not relying on data reported to OASAS, please estimate the percentage of total clients treated over the course of a year that identify as lesbian, gay, bisexual, transgender or questioning
   - [ ] \(8\%\)

4. Does your program require technical assistance to comply with the requirements of the LSB?
   - [ ] No
   - [ ] Yes, I need assistance with the following (check all that apply)
     - [ ] a) Developing policies and procedures
     - [ ] b) Staff training on affirming LGBTQ care
     - [ ] c) Staff training on evidence-based practices, such as delivering trauma informed care
     - [ ] d) Other, please describe:

   [26]
The OASAS Division of Practice Innovation and Care Management (PICM) maintains contact information on clinical supervisors in order to communicate on matters of interest and importance to the practice of clinical supervision. This form was developed to collect contact information on all clinical supervisors in OASAS-certified treatment programs. The information will be maintained in the County Planning System and will be required to be updated annually in the spring. This form can be updated at any time throughout the year by contacting the OASAS Planning Unit oasasplanning@oasas.ny.gov and requesting that the form be decertified so that the information can be revised.

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<td>Email Address</td>
<td><a href="mailto:Grafusrousell@stlawco.org">Grafusrousell@stlawco.org</a></td>
</tr>
<tr>
<td>Phone</td>
<td>3153862167</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name</th>
<th>Sheena Smith</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
<tr>
<td>Email Address</td>
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1. Does your program use an electronic health record?
   - No
   - Yes, please provide the company and product names of your EHR below:
     Company Name (e.g., Allscripts, Netsmart, Core Solutions, etc.):
     IMA Serve
     Product Name (e.g., Paragon, CareRecord, Cx360, etc.)

PART II- Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) Policy and Technical Assistance Survey
Research suggests that Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) individuals face health disparities linked to societal stigma, discrimination, and denial of their civil and human rights. OASAS recognizes that culturally sensitive treatment often results in more effective treatment. In order to protect the rights of LGBTQ individuals receiving Substance Use Disorder (SUD) treatment OASAS issued Local Services Bulletin (LSB) 2017-04 "Affirming Care for Lesbian, Gay, Bisexual, Transgender and Questioning Clients in OASAS Programs."

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     a) Developing policies and procedures
     b) Staff training on affirming LGBTQ care
     c) Staff training on evidence-based practices, such as delivering trauma informed care
     d) Other, please describe:
Introduction to First Mile/Last Mile

• One of the greatest challenges many public transit providers face is getting riders from their home to the public stop. Many items can play a role—lack of personal transportation, poor walking conditions or inefficiency of the transit arrival/departure date and time in a particular area. St. Lawrence County New York is no different. According to the U.S. Census Bureau, the county has a total area of 2,821 square miles of which 2,680 square miles is land and 141 square miles is water. It is the largest county by area in New York. It is larger than the entire state of Rhode Island (1544.9 square miles) and the state of Delaware (2488.72 square miles).

• Because of the rural nature of the County individuals may use a number of modes of transport to complete the journey-- they may walk, drive, ride a bicycle, use volunteer transportation, take a bus or in many cases combine a number of modes. St. Lawrence County Public Transit typically provides bus service that may frame the core of such trips, but users must complete the first and last portion on their own; they must first walk, drive or roll themselves to the nearest bus stop. This is referred to as first last mile.

• Though the streets and infrastructure that comprise the first last mile fall outside the boundaries of St. Lawrence County Public Transit’s jurisdiction and control, they remain critical components of an effective public transportation system. Simply put, all St. Lawrence County Public Transit riders must contend with the first last mile challenge, and the easier it is to access the system, the more likely people are to use it.
First Mile/Last Mile Process
Book a ride with First Mile Last Mile
Call 315-386-2600

• **Call 48 hours ahead** to arrange transportation to the bus stop by calling St. Lawrence County Public Transit to request a ride.

• **Enjoy your ride** with a volunteer driver to the bus stop.

• **Connect to St. Lawrence County Public Transit** and enjoy your ride (cost is $2 each way).

• **Catch the bus**—When you are ready to go home take the bus back to a bus stop closest to your house.

• **Travel home**—a volunteer driver will pick you up at the closest bus stop and take you home.
What you need to know about First Mile/Last Mile

Q: Who can ride using FIRST MILE LAST MILE?
A: Any St. Lawrence County resident of any age; individuals or families can ride.

Q: Where can I ride with FIRST MILE LAST MILE?
A: From your home to the closest public bus stop and back again—ride to the doctor, work, shopping, entertainment, wherever you need to go in St. Lawrence County.

Q: When can I ride FIRST MILE LAST MILE?
A: Anytime public transportation (the bus) is available—Monday through Friday 4:30 am to 7 pm.

Q: Would trips be available to the general public without connecting to a public bus?
A: No, this is a connector service only.

Q: Can I use FIRST MILE LAST MILE one-way?
A: Yes

Q: How many times can I use the FIRST MILE LAST MILE program?
A: Rides are unlimited as long as program funding is available.

Q: Can a volunteer driver be flagged down by the public for a ride?
A: No, all trips must be booked through the public transit office.

Q: Are FIRST MILE LAST MILE rides wheelchair accessible?
A: Yes, arrangements can be made to accommodate all riders.
# First Mile Last Mile Age Group 2018

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>60+</td>
<td>6%</td>
</tr>
<tr>
<td>60-50</td>
<td>15%</td>
</tr>
<tr>
<td>50-40</td>
<td>12%</td>
</tr>
<tr>
<td>40-30</td>
<td>32%</td>
</tr>
<tr>
<td>30-21</td>
<td>31%</td>
</tr>
<tr>
<td>under 21</td>
<td>4%</td>
</tr>
</tbody>
</table>
First Mile Last Mile Trip Type 2018

<table>
<thead>
<tr>
<th>Type</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>3%</td>
</tr>
<tr>
<td>Visitation</td>
<td>10%</td>
</tr>
<tr>
<td>Education</td>
<td>21%</td>
</tr>
<tr>
<td>Grocery</td>
<td>0%</td>
</tr>
<tr>
<td>Employment</td>
<td>56%</td>
</tr>
<tr>
<td>Other</td>
<td>9%</td>
</tr>
</tbody>
</table>
## Total Number of Units and Miles 2018

<table>
<thead>
<tr>
<th>Month</th>
<th>Total Units</th>
<th>Total Miles</th>
<th>No-Show</th>
</tr>
</thead>
<tbody>
<tr>
<td>April</td>
<td>21</td>
<td>526</td>
<td>5</td>
</tr>
<tr>
<td>May</td>
<td>37</td>
<td>1,090</td>
<td>7</td>
</tr>
<tr>
<td>June</td>
<td>47</td>
<td>824</td>
<td>9</td>
</tr>
<tr>
<td>July</td>
<td>79</td>
<td>2,280</td>
<td>9</td>
</tr>
<tr>
<td>August</td>
<td>87</td>
<td>2,426</td>
<td>8</td>
</tr>
<tr>
<td>September</td>
<td>152</td>
<td>3,543</td>
<td>12</td>
</tr>
<tr>
<td>October</td>
<td>111</td>
<td>2,226</td>
<td>9</td>
</tr>
<tr>
<td>November</td>
<td>112</td>
<td>2,113</td>
<td>3</td>
</tr>
<tr>
<td>December</td>
<td>239</td>
<td>5,041</td>
<td>17</td>
</tr>
<tr>
<td>2018 - Total</td>
<td>885</td>
<td>20,069</td>
<td>79</td>
</tr>
</tbody>
</table>

Unit equals a one-way trip
Volunteer Transportation Center, Inc.

The Volunteer Transportation Center, Inc., is striving to provide essential transportation for North Country residents who have no other transportation alternatives.

### Quick Facts

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Years in Operation</strong></td>
<td>29 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Employees</strong></td>
<td></td>
<td><strong>Full-Time</strong></td>
<td><strong>Part-Time</strong></td>
</tr>
<tr>
<td><strong>Counties Served</strong></td>
<td>Jefferson County</td>
<td>Lewis County</td>
<td>St. Lawrence County</td>
</tr>
<tr>
<td><strong>Total Miles 2018</strong></td>
<td>5,749,065</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Trips 2018</strong></td>
<td>158,065 trips</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Volunteer Hours</strong></td>
<td>253,389 hours provided by 350 volunteers</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Charitable Facts (27,170 trips for 777,123 miles)

<table>
<thead>
<tr>
<th></th>
<th>Jefferson County</th>
<th>Lewis County</th>
<th>St. Lawrence County</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Trips Per year</strong></td>
<td>15,334</td>
<td>3,757</td>
<td>8,079</td>
</tr>
<tr>
<td><strong>Miles Per Year</strong></td>
<td>414,558</td>
<td>110,959</td>
<td>251,606</td>
</tr>
<tr>
<td><strong>Average Trip Length</strong></td>
<td>27.4 miles one-way</td>
<td>25 miles one-way</td>
<td>40.7 miles one-way</td>
</tr>
</tbody>
</table>
Become a Volunteer Driver
How to Become a Volunteer Driver

• Visit www.VolunteerTransportationCenter.org and download a new driver application. (you can also fill out a form online)

• Once the VTC receives a completed application they submit for a criminal background check, drug test and review the volunteers driving records. At the same time a car inspection is required.

• After the background check is approved an orientation is scheduled. We provide our drivers with all the tools needed to be successful.
Questions?

sam@volunteertransportation.org
(315) 755-2901 or 286-4510
OVERVIEW
The County’s Bus System operated 19 routes, most county routes run Mondays through Fridays, while four routes offer weekly or bi-weekly service.

The County’s Bus System provided 50,922 one-way trips to riders, up 75%.

Public Buses traveled a total of 583,192 miles.

Re-Branded Public Transit.

New Program First Mile/Last Mile was implemented on a soft opening.

Ogdensburg Intra City Shuttle was added as a new route.

Funding Stream is 80% Federal, 10% State and 10% covered by the ARC for Public Transit and Volunteer Transportation for Mobility Management.
Stats for 2018

Ridership for Public Transit:

- 2017 29,084
- 2018 50,922

First Mile/ Last Mile 885 units

- 56% Employment
- 21% Education

Ogdensburg Shuttle

- 2017- N/A
- 2018 2,631 units for 10 months
Clarkson University and SUNY Canton will be Public Routes.
College Connector will start to develop.
Coordinated Transportation Plan was adopted May 2019.
Massena Shuttle will be implemented.
Advertising Campaign will start in the Fall.
First Mile Last Mile Program continuation.
2 new 28 Passenger buses will be ordered.
5311 grant will be submitted for 2019-2020.
WIFI will be installed on all Public Transit Buses.
Ridership will increase due to new Public Routes.
Projected Stats for 2019-20

Ridership for Public Transit:
- 2018 50,922
- 2019 60,000
- 2020 75,000

First Mile/ Last Mile
- 2018 885 units 10 months
- 2019 4,000 units 12 months
- 2020 4,800 units 12 months

Ogdensburg Shuttle
- 2018 2,631 units for 10 months - average 263 per month
- 2019 3,800 units for 12 months – average of 317 per month
- 2020 4,200 units for 12 months – average of 350 per month
Questions?

Frank Doldo
Mobility Manager for St. Lawrence County
frank@slcpublictransit.org
315-405-5406