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New York State Office of Alcoholism and Substance Abuse Services

Statewide Comprehensive Plan

2012-2016

OASAS
Improving Lives.

October 1, 2012

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Chapter I: Background and Context

OASAS Mission

To improve the lives of all New Yorkers by leading a premier system of addiction services through prevention, treatment, and recovery.

Background

The New York State Office of Alcoholism and Substance Abuse Services (OASAS) estimates that 12 percent, or 1.9 million, state residents age 12 and older (including 153,000 adolescents ages 12-17) experience a substance use disorder (substance dependence or abuse) annually. These figures do not fully depict the widespread impact of addiction in New York because of the millions of other individuals whose lives are also affected: children, spouses, and extended families. The cost to society is compounded by the consequences of addiction, which impact public safety, health, welfare, and education throughout the state.

OASAS oversees an addiction treatment service system that provides a full array of services to a large and culturally diverse population of approximately 254,000 unique individuals each year. In addition, over 480,000 youth receive recurring prevention services annually. Treatment services are provided in inpatient, outpatient, and residential settings. New York State's service continuum also includes school- and community-based prevention services as well as intervention, support, crisis, and recovery services.

As the addiction system moves forward with implementing health care reform, OASAS is working to ensure that substance use disorder (SUD), mental health, and physical health care are all part of an integrated services continuum. In order to achieve this goal, OASAS will examine new models that provide increased emphasis on care management and cost containment to better define the quality of our services. The system's future is about contracting services aligned to performance.

OASAS, counties, and providers collect and analyze significant amounts of information, which informs all aspects of service delivery. These data support policy development, planning, funding decisions, and performance monitoring. As OASAS enhances the use of outcomes management and encourages providers to adopt evidence-based programs and practices to achieve the best possible results, the use of data becomes even more critical to providing quality services.

Mental Hygiene Law Changes

During 2012, changes to Mental Hygiene Law were enacted covering the requirements for developing the Statewide Comprehensive Plan and Interim Report. Section 5.06 of Mental Hygiene Law established the Behavioral Health Services Advisory Council (BHSAC), which will assume the responsibilities of the Office of Mental Health (OMH) Mental Health Services Advisory Council and the OASAS Advisory Council on Alcoholism and Substance Abuse Services. The BHSAC will advise OASAS and OMH on matters relating to the provision of

behavioral health services. The OASAS and OMH commissioners are non-voting members of the BHSAC. The Chair of the Conference of the Local Mental Hygiene Directors (CLMHD) will serve on the BHSAC. The BHSAC will include a Chair designated by the Governor and 28 members appointed by the Governor and approved by the State Senate.

Amendments to Section 5.07 of Mental Hygiene Law authorize OASAS and OMH to develop joint Statewide Comprehensive Plans and Interim Reports. The legislation also moves the date for submission of the Statewide Comprehensive Plan from October 1 to November 1 and the Interim Report from February 15 to March 15. These changes do not take effect until the OASAS and OMH commissioners certify that that the BHSAC has sufficient confirmed membership to perform its functions, processes, and duties. OASAS is working closely with OMH to implement changes in the statewide comprehensive planning process.

Statewide Comprehensive Plan

The OASAS *Statewide Comprehensive Plan 2012-2016* informs counties, providers, people in recovery, their families, other state agencies, the federal government, and other interested parties about major priorities and future directions. Although planning documents are produced and released on regular cycles, as set by Mental Hygiene Law, OASAS views planning as a year-round process that informs policy development, budgeting, and the development and delivery of services at the state, local, and provider levels. Our collaborative planning efforts with counties, providers, state, and federal agencies will guide future efforts and have the flexibility to respond to changing conditions. OASAS seeks feedback on the use and usefulness of the *Statewide Comprehensive Plan*. To provide feedback on the Plan, please e-mail 5YearPlan@oasas.ny.gov.

Public Hearing

On September 6, 2012, OASAS and OMH held the first-ever joint public hearing on their statewide comprehensive plans. The hearing was conducted by videoconference among seven locations: Albany, Buffalo, Long Island, Manhattan, Staten Island, Syracuse, and Rochester. Commissioners González-Sánchez and Hogan gathered input for consideration in the development of their respective plans, anticipated integration of statewide planning efforts in the future, and ongoing planning initiatives. More information on the hearing is available in *Chapter II: OASAS-OMH Common Chapter*.

OASAS will consider testimony presented during the hearing along with information submitted by Local Governmental Units (LGUs) and providers in their Local Services Plans as it develops the 2013 Outcomes Dashboard.

Planning for Local Mental Hygiene Services

The local services planning process for mental hygiene services is a collaborative effort among the three New York State Department of Mental Hygiene agencies - OASAS, OMH, and the Office for People With Developmental Disabilities (OPWDD). Over the past five years, local services plan guidelines have reflected an integrated planning approach that fully meets the requirements of the three separate state agencies. Previously, a separate annual plan was

completed for each disability. Now, local governmental units (each county and the City of New York) need only complete a single integrated plan.

An integrated local planning approach facilitates greater cross-disability planning at the local level. It allows for planning to be more person-centered with a greater ability to focus on individuals with multiple disabilities who need services from multiple systems. This approach also strongly encourages collaboration with other local systems in which persons with a mental hygiene disability may also be involved.

Mental Hygiene Planning Committee

The local services planning process is guided by the Mental Hygiene Planning Committee, which was formed in 2007 to explore opportunities for collaborative mental hygiene service planning. The committee represents a partnership among the three state mental hygiene agencies, the NYS Conference of Local Mental Hygiene Directors (CLMHD), and Local Governmental Units (LGUs). It includes planning staff from the three state agencies, the CLMHD, and several counties.

The Mental Hygiene Planning Committee meets regularly throughout the year and is focused on integrating local planning for all mental hygiene services and developing planning resources that support and facilitate local planning and needs assessment. The committee has two workgroups which are led by county planners. The Data Needs Workgroup collaborates with state agency staff to develop data resources that are most useful to county planners. The Community of Practice for Local Planners (CPLP) is a peer run workgroup that develops and shares planning tools and conducts several training webinars throughout the year designed to enhance local planning efforts.

Local Services Plan Guidelines

State Mental Hygiene Law requires that OASAS, OMH, and OPWDD guide and facilitate the local planning process. It also requires each LGU to develop and annually submit to each state mental hygiene agency a local services plan that establishes long-range goals and objectives, which are consistent with statewide goals and objectives. In addition, the law requires that state goals and objectives embody the partnership between the state and LGUs, and for each agency's statewide comprehensive plan to be formulated from the local services plans.

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

Today, counties benefit from a more integrated mental hygiene local planning process that is guided by the state and carried out at the county level. More attention is focused on enabling counties to address cross-system issues that affect persons with co-occurring disorders and improve the quality of services and supports. In the five years since the formation of the Mental

Hygiene Planning Committee, the local planning process has more effectively focused on problems and needs that affect all three disability systems.

The Online County Planning System (CPS)

OASAS developed the online County Planning System (CPS) in 2004 and implemented it statewide in 2005 to enable counties and their service providers to complete and submit required annual local planning forms to the state electronically. CPS quickly became a state-of-the-art platform where counties could access significant and timely data resources for conducting their needs assessment and planning activities, complete required planning forms, and submit their entire plan to OASAS via the Internet. In recent years, a number of other tools were added to CPS to assist counties, including the ability to communicate directly with their addiction service providers and manage the completion and certification of all required planning forms.

In 2007, OASAS agreed to collect county mental health priorities through CPS. The following year, county developmental disability priorities were incorporated, thereby creating the first ever fully integrated mental hygiene local services planning process in New York State. For the first time, counties had the ability to develop and submit a single integrated mental hygiene local services plan to all three state agencies at once. Today, there are more than 2,400 individuals with a CPS user account in one or more of 18 separate user roles, mostly associated with an OASAS service provider or an LGU.

Each year, enhancements are made to CPS based on experience gained and feedback received from its users. These changes continually improve the system to ensure that it is a useful tool for everyone. CPS is a valuable resource for counties when carrying out their local planning and needs assessment responsibilities and developing and submitting their annual local services plan to the state.

Outcomes Management

OASAS Outcomes Dashboard

OASAS recognizes how critically important addiction services are to individuals, families, and communities. One of OASAS' overarching goals is to ensure that New York has the nation's premier and most fiscally responsible system for prevention, treatment, and recovery. On June 20, 2012, OASAS issued its *2012 Outcomes Dashboard* (See Chapter III), which serves as a roadmap for achieving the agency's mission of addressing the prevention, treatment, and recovery needs of New Yorkers. The Dashboard is the foundation for the OASAS statewide comprehensive planning process and part of an ongoing effort to integrate outcomes management into the operations of the agency and the addiction field. It identifies the five core destinations, 12 key metrics, and 43 sub-metrics used to measure progress by OASAS staff and the field. 2012 marks the fifth year that OASAS has issued the Dashboard, which is also available on the agency's website at:
http://www.oasas.ny.gov/pio/oasas/documents/2012dashboard.pdf.

OASAS will report on *2012 Outcomes Dashboard* results in its *2013 Interim Report on the Statewide Comprehensive Plan*. OASAS reported on *2011 Outcomes Dashboard* results in the *2012 Interim Report on the Statewide Comprehensive Plan*, which is available at: http://www.oasas.ny.gov/pio/commissioner/documents/5YPIntReport2012.pdf
and in the *OASAS 2011 Dashboard Results Report at:*
http://www.oasas.ny.gov/pio/oasas/documents/Metrics_2011Results.pdf.

The 2011 results showed that 42 percent of the metrics/sub-metrics were fully achieved, 28 percent were partially achieved, 20 percent were deferred to 2012, and 10 percent were not achieved.

Treatment Program Scorecards

On July 20, 2012, OASAS released the 2012 Treatment Program Scorecards. This is the second year that OASAS has issued treatment scorecards for use by the general public, LGUs, and providers. The scorecards are posted on the OASAS website and accessible to the public via the Provider Directory Search function at http://www.oasas.ny.gov/providerDirectory/index.cfm.

Scorecards for each of the more than 900 treatment programs across the state present information across five domains: access, quality, patient outcomes, efficiency, and regulatory compliance, for the particular program and comparison data for similar programs across the state using a five star system. Program scorecards are a centerpiece of OASAS outcomes management efforts, which encourage and support exemplary performance by service providers and high-quality outcomes for patients. LGUs, providers, referral sources, and members of the public are able to search for a chemical dependence treatment program and review data about program performance, patient outcomes, and other useful descriptive information about the program and the people it serves.

Chapter II: OASAS-OMH Common Chapter

This common chapter, contained within both the OASAS and OMH Statewide Comprehensive Plans for 2012-2016, is just one of many efforts underway to improve coordination and collaboration between OASAS and OMH. This represents an initial step to integrating the OASAS and OMH statewide planning processes and reflects a strategic effort to bring about integration while recognizing that such efforts must be implemented carefully and wisely in order to avoid unintended consequences that could negatively affect access to care for vulnerable people. In bringing these processes together, there are a few themes that embody the commonalities between the OASAS and OMH systems.

The first is integration. Individuals receiving mental health or substance use disorder services should have access to such care regardless of a program's primary focus or license. Much has been done to improve this – through clinic reform, establishment of clinic guidelines for high quality care, and now through efforts to improve the integration of licensure requirements. For those individuals with more well-established mental health and substance use disorder needs, the movement toward Health Homes will help develop community networks that pull together medical, mental health, and substance use disorder services to provide a more person-centered, holistic form of care.

Secondly, the concept of "recovery" has now become common sense – no longer a radical or novel concept. While there are perhaps slightly different meanings of the word in mental health and substance use disorder services, they share the following principles: 1) individuals are the primary agent of their own healing and recovery process; 2) recovery no longer equates exclusively to the receipt of services, but is a process that takes advantage of services and includes family and natural supports in an explicit and meaningful way, wherever possible; 3) improved outcomes are possible for people, regardless of their circumstances; and, 4) peers play an important role in the recovery process. These common visions of recovery also include an understanding that more than health care or specialty health care is necessary – that securing employment or otherwise making a meaningful contribution to the community can dramatically improve one's well-being. Both fields also recognize that safe and affordable housing is a critical component in the recovery journey.

Lastly, OASAS and OMH are both moving toward care management for all individuals they serve. No longer shall services be absent some degree of care management to help people achieve positive outcomes in their life and reduce costs. Care management is not to be confused or mistaken for traditional managed care, which is too linear and too narrow to incorporate the full range of needs that must be addressed in a care management environment for people receiving mental health and substance use disorder services. The efforts of OASAS and OMH to develop a care management approach set us on a path to advance the integration of care, but recognizes that care management must be driven by those with specialty behavioral health care expertise. OMH and OASAS will need to work very closely to help direct this new care management approach.

The two state agencies, local governments, and providers are operating in a health care environment where an expansion of benefits is occurring at the same time as initiatives move to

control costs. The OASAS-OMH approach to integration is in its early stages. While care management is necessary, the leadership of both state agencies understands that this is a new and unfamiliar territory, necessitating our increased collaboration to move forward together from a position of strength. All of this is taking place within the framework of recovery, which recognizes that housing, supports, and meaningful community participation are all essential to achieving wellness and improving the quality of life for individuals, families, and communities throughout New York State.

OASAS and OMH are collaborating on a number of initiatives to address the needs of individuals with mental health and substance use disorders – many of whom who have co-occurring disorders. The overarching goal of these initiatives is to provide more integrated patient-centered care that meets the needs of the whole patient, regardless of disability or primary diagnosis. A number of the most prominent initiatives in which OASAS and OMH are collaborating are discussed in this chapter. These initiatives include:

- State and Local Planning Process
- Behavioral Health Organizations (BHOs)
- Health Homes
- Behavioral Health Services Advisory Council (BHSAC)
- Integrated Licensure
- New York State Clinical Records Initiative (NYSCRI)
- Integration of the Federal Block Grant

State and Local Planning Process

Section 5.07 of Mental Hygiene Law requires OMH, Office for People With Developmental Disabilities (OPWDD), and OASAS to develop Statewide Comprehensive Plans for the provision of services to their respective populations. These plans are to be formulated from local services plans submitted by each local governmental unit (LGU) (57 counties and New York City), with participation from stakeholders.

The local planning process begins in March with the posting of planning guidelines from the Department of Mental Hygiene agencies outlining the agencies' directions for the submission of local services plans. Utilizing the OASAS-operated County Planning System (CPS), LGUs develop their local services plans, taking into consideration input from stakeholders at the local level, submitting their final local services plans by the end of June.

This year's public hearing was the first ever conducted jointly by OASAS and OMH, in which stakeholders from both systems were invited to jointly submit testimony to the two agencies. . The hearing was part of a larger integration effort between OASAS and OMH that began with the integration of local planning and continued with the changes in the Mental Hygiene statute affecting statewide comprehensive planning authorized as part of the 2012-13 NYS Budget. The statute change authorized OASAS and OMH to begin working toward the future development of a joint OASAS-OMH Statewide Comprehensive Plan. However, the future development of such a plan is just one factor in the current evolution of the planning process taking place at the state and local levels.

Responding to the intensified pace and quantity of changes in the mental hygiene system, OASAS, OMH, OPWDD, and the Conference of Local Mental Hygiene Directors (CLMHD) have explored and implemented enhancements to planning processes. The goal of these efforts is to increase the ability of the state and LGUs to respond more quickly to emerging issues. As part of the ongoing collaboration between CLMHD and the Department of Mental Hygiene agencies, CLMHD initiated an experimental process to enhance the traditional planning process. This involved the rapid solicitation and collection of information from LGUs on a pertinent topic under consideration at the state level, with rapid analysis and dissemination of the analysis to the relevant state agencies. The subject of the first survey process, conducted over the summer, was Behavioral Health Organizations (BHOs).

Seneca County Director of Community Services and CLMHD Planning Committee Chair Scott LaVigne articulated details about the process particularly well in an email to the CLMHD members in August 2012:

"The Mental Hygiene Committee is seeking to create more opportunities for local input to be gathered and shared with leaders within state agencies at points in time when policy and practice changes are being contemplated. This survey was a pilot designed to be a complement to the annual planning process. … The survey was broken out into three sections and asked for demographic information, perceptions of the BHO experience to date and considerations for the next phase. …(T)he results of this pilot survey were (then) presented to … (an) OMH/OASAS … workgroup … comprised of senior staff from both state agencies that meet … to discuss relevant items that impact the implementation and development of RBHOs. The presentation prompted a good dialogue between LGU representatives and agency staff. Workgroup members were interested in the fact that the survey confirmed many of their conceptions of how BHOs are functioning statewide. Further discussion explored how the BROTs (BHO Regional Oversight Teams) were functioning, how Health Homes are rolling out and implications for non-Medicaid populations. The Mental Hygiene Planning Committee is encouraged by this feedback and will apply the same process to other policy and practice changes over the next several months. We believe that the 'rapid response' data which can be obtained in this process can provide an important perspective on the expertise and systems knowledge that resides at the local level."

An overview of the CLMHD "rapid-cycle" survey results on BHOs is available at http://www.clmhd.org/img/uploads/file/LGU_BHO_Survey_No_Detail_12992627481185320 6.pdf.

Moving forward, OMH, OASAS, and OPWDD will continue to collaborate with CLMHD to refine this "rapid-cycle" response survey process and pursue additional opportunities to increase the usefulness of planning in shaping the future direction of mental hygiene services.

OASAS-OMH Public Hearing

On September 6, 2012, OASAS and OMH held the first-ever joint public hearing on their statewide comprehensive plans. The hearing was conducted by videoconference among seven locations: Albany, Buffalo, Long Island, Manhattan, Staten Island, Syracuse, and Rochester.

Commissioners González-Sánchez and Hogan gathered input for consideration in the development of their respective plans, anticipated integration of statewide planning efforts in the future, and ongoing planning initiatives. Recent changes in Mental Hygiene Law give OASAS and OMH the authority to develop a joint Statewide Comprehensive Plan and Interim Report. The joint public hearing was a significant step in moving the addictions and mental health systems toward the delivery of more integrated services and the potential development of a single Statewide Comprehensive Plan for both agencies in the future.

A total of 255 representatives from local governments, advocacy organizations, providers, family members, and recipients of services attended the hearing with 30 individuals presenting testimony. Other stakeholders who were unable to attend the hearing submitted testimony by e-mail. Those presenting testimony came from all parts of New York State and reflected a broad diversity of perspectives.

The importance of integrating services to meet the need of individuals with co-occurring substance use and mental health disorders was a significant theme of the hearing. As one stakeholder put it, "Integrated treatment for co-occurring disorders is a best practice." Another stakeholder praised the steps that OASAS, OMH, and DOH have taken to coordinate services. There was support for integrating licensing and acknowledgement that family support services have increasingly become cross-systems efforts. However, the need for continued improvement in these areas was also discussed in the hearing testimony received. Two parents, each of whom lost a child to suicide after struggling with addiction issues, spoke movingly about the shortcomings in the continuum of care for adolescents and young adults, and the need for improved integration between OASAS and OMH.

Relatedly, a variety of perspectives were expressed regarding a potential future merger of OASAS and OMH. Most individuals who expressed an opinion supported the concept, as it would assist the efforts to integrate and improve coordination; at least one other individual expressed opposition to the concept. Some participants proposed quickly merging the two agencies into one behavioral health care state agency. Others advocated a more measured approach, recommending that the agencies move slowly toward a potential merger, with incremental steps to eliminate silos, provide more holistic care, and avoid allowing people to fall through the cracks during such a transition.

In addition, a number of other topics were discussed by individuals who testified. These included, but were not limited to the following:

- Behavioral Health Organization (BHO) implementation and the movement toward care management
- Health Home implementation and the conversion of case management services
- Importance of culturally competent evidence-based services for special populations, including veterans, children, adolescents, young adults, seniors, and those involved with the criminal justice system
- Need for safe and affordable supportive housing
- How children fit into the new care management environment
- Importance of peer-based services and family involvement

- Value of family support services
- Importance of Prevention Resource Centers
- Limitations on information access to parents with children in care
- Promoting movement toward electronic health records
- Reinvestment of system savings into community-based services
- Need to streamline funding mechanisms
- Review data collection for appropriateness and usefulness
- Importance of outcome/performances measures, and the use of data to drive performance
- Increasing screening for substance use disorder and mental health concerns
- Challenges related to transportation, particularly in rural areas
- Problem gambling
- Empowering people to move to less intensive services/care
- Research
- Helping primary care physicians address addiction and mental health issues
- Importance of not allowing managed care to dictate the terms of the treatment in the new care management environment

OASAS and OMH will continue to review the comments and testimony received from the September 6, 2012 public hearing. The two agencies will incorporate this input into their ongoing planning and service integration initiatives, and publish a more comprehensive analysis as part of a common chapter in the respective OASAS and OMH 2013 Interim Reports on their Statewide Comprehensive Plans in February 2013.

Behavioral Health Organizations (BHOs)

In 2011, Governor Cuomo's Medicaid Redesign Team (MRT) was constituted and charged with finding ways to reduce costs, and increase quality and efficiency in NYS' Medicaid program. Among the major elements of the MRT's initial work was a finding that "unmanaged" care was no longer satisfactory for individuals with mental illness and substance use disorders, as illustrated through high Medicaid costs and a lack of coordination of services, which resulted in poor outcomes. Therefore the MRT recommended moving all Medicaid beneficiaries (including people with mental illnesses and substance use disorders, previously exempted from such requirements) into a managed behavioral health model, bringing fee-for-service payment arrangements to an end. Unfortunately, Medicaid managed care organizations have limited experience overseeing services for individuals with serious mental illnesses. Therefore, the MRT's recommendation for people with serious mental illnesses and substance use disorders was to phase-in their transition over a three-year period. This resulted in the two-phase implementation of Behavioral Health Organizations (BHOs).

BHO Phase I

The first phase of the BHO initiative (BHO Phase I) is designed to improve care coordination for individuals with serious mental illness and substance use disorders, and provide OMH and OASAS the opportunity to learn more about what constitutes quality managed care for individuals with serious mental illness and substance use disorders, prior to moving into the

managed care environment in the second phase (BHO Phase II). After the recommendations of the Behavioral Health Reform Workgroup of the MRT were submitted in November 2011, OMH and OASAS jointly entered into contractual agreements with specialty managed care entities (known as Behavioral Health Organizations) to assist with preparing the fields of mental health and substance use disorder services to transition from fee-for-service to care management, paying particular attention to helping develop techniques to improve coordination of services and thereby improve health outcomes. This first step resulted in five regional BHOs being selected:

- New York City Region: OptumHealth
- Hudson River Region: Community Care Behavioral Health
- Central Region: Magellan Behavioral Health
- Western Region: New York Care Coordination Program
- Long Island Region: Long Island Behavioral Health Management

These five BHOs are responsible for:

1. Monitoring, reviewing and assessing the use of behavioral health inpatient care. This includes conducting concurrent reviews of inpatient behavioral health services, sharing prior service history from Medicaid claims data to inpatient clinical staff, and monitoring hospital discharge planning.
2. Monitoring and tracking outpatient services for children with serious emotional disorders (SED).
3. Profiling the system of care to identify service gaps, barriers, and high-performing providers. In collaboration with OASAS and OMH, each BHO hosts quarterly stakeholder meetings to share profile data and review systems issues with providers.
4. Facilitating cross-system linkages to improve engagement, re-engagement, continuity of care, accountability and service integration across behavioral and physical health care services.

Contracted BHOs in Phase I are utilizing their tools and expertise, as well as collecting and submitting data, to help OMH and OASAS learn how to improve care in preparation for the transition to a care management environment in Phase II. Phase I also will help identify where improvements can be made in relation to: inpatient discharge planning; ambulatory engagement/ continuity of care; and, utilization of Medicaid data to inform treatment and care planning. Lastly, Phase I will provide the opportunity to test and develop dynamic, useful metrics for monitoring behavioral health system performance.

BHO Outcomes Vignette #1

Helping with a complicated linkage to housing services

A provider from a residential treatment facility (RTF) contacted the BHO care manager for advice regarding a young man with schizophrenia who was aging out of the system. This consumer had no family support, was an immigrant with green card status, and had lived in the RTF for the prior 2 years. The RTF provider submitted a housing application but was told that the consumer was not eligible for services. The RTF provider explained to the BHO care manager that the only alternative was to discharge the consumer to a shelter. *The BHO care manager contacted the local Single Point Of Access (SPOA), reviewed the consumer's situation, and arranged for the SPOA representative to communicate with the RTF.* Within a few days, the consumer's application for housing was processed successfully. The BHO care manager received an email from the provider expressing appreciation for the assistance.

The Phase I population focus includes the following Medicaid fee-for-service beneficiaries (excluding Medicare dual eligibles):

- Admissions to OMH-licensed psychiatric units (all ages) in general hospitals (Article 28 hospitals)
- Children and youth admitted to OMH-licensed psychiatric hospitals (Article 31 hospitals)
- Children and youth direct admissions (i.e., not transfers) to OMH State-operated children's psychiatric centers or children's units of psychiatric centers
- Children with a SED diagnosis covered by Medicaid and receiving care in and OMH-designated specialty clinic
- Individuals in OASAS-certified hospitals (Article 28/32) or freestanding (Article 32 only) Part 818 Chemical Dependence Inpatient Rehabilitation Services
- Individuals in OASAS-certified Part 816 Inpatient Detoxification Services (Article 28/32)

Data collected by BHOs is intended to help provide a more complete picture of the factors taking place concerning people with mental illness and substance use disorders, focusing primarily on inpatient utilization and connections to care after inpatient care. BHOs are collecting data and sharing all profiles with individual providers. In addition, BHOs are sharing aggregated data with all other providers and interested stakeholders. By August 2012, each of the BHOs had produced both a first and second quarter report, containing such data. Data collected by the BHOs complements the Medicaid claims data available to OMH and OASAS from the Department of Health, much of which will be made available in aggregate via the new BHO portal http://www.omh.ny.gov/omhweb/news/2012/bho_portal.html.

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Each BHO is responsible for conducting regular meetings with stakeholders from their respective regions in an effort to establish a level of dialogue that will keep stakeholders informed and help the BHO gather valuable input regarding the experience of recipients, family members, advocates, and providers impacted by the BHOs' efforts and activities. Among these meetings are the BHO Evaluation and System Transformation (BEST) meetings, intended to serve as a forum in which the BHOs can present data they have collected, discuss possible modifications to their operations/functions, and engage stakeholders in discussions about preparedness for Phase II. Among the topics discussed at the BEST meetings are: reasons for inpatient admission and the types of discharge planning activities being utilized; the value of prior service history data and mechanisms for providers to gain access to such information, including through the use of the Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) database; and, care coordination strategies to improve engagement in care.

BHO Phase II

In 2013, BHO reform will begin moving to Phase II, involving contracting with specialty managed care plans that will bear financial and clinical risk for establishing and managing systems that address the needs of individuals whose benefits have been "carved out," in integrated plan arrangements.

Principles for Behavioral Health Services in a Managed Care Environment
Recommendations from the MRT Behavioral Health Reform Work Group

- There should be mechanisms at multiple levels for connecting and coordinating all of the different participants, including healthcare providers, payers, and care managers. The delivery of clinical care should be coordinated and efficient.
- Payment for services should be tied to patient/consumer outcomes.
- Patient/Consumer input and choice is critical.
- Attention should be paid to social factors that influence individual behavior and outcomes, such as employment and financial status.
- Housing resources need to be available directly for timely use to avoid lengthy or repeat admissions, and to provide stability for patients/consumers in the community.
- Money saved should be reinvested smartly to improve services for behavioral health populations.
- Distinction in design and operation must be made to address the unique needs of children and their families.
- The needs of older adults are unique and require special attention.
- Regulatory burden should be minimized.
- The diversity of NYS' communities should be taken into account.
- Key outcomes should include factors at individual, provider, and system levels.

Complete listing at
http://www.health.ny.gov/health_care/medicaid/redesign/docs/mrt_behavioral_health_reform_recommend.pdf

The MRT Behavioral Health Reform Work Group, co-chaired by OMH Commissioner Hogan and NYC Deputy Mayor for Health and Human Services, Linda Gibbs, developed parameters to guide the state agencies through this transition. This work group consisted of representatives of individuals receiving services, advocates, service providers, and health insurers in the mental health and substance use disorder fields. The Behavioral Health Reform Work Group submitted final recommendations to the MRT in November 2011, which were then accepted by the MRT and incorporated into the MRT's final report in 2012. Their recommendations included a set of principles (see insert) that should apply to the delivery of behavioral health services in a managed care environment in Phase II, regardless of the specific delivery design (e.g. full-benefit Special Needs Plans [SNPs], provider-based Integrated Delivery Systems [IDS], or behavioral health benefit carve-out BHOs).

In addition, and perhaps more importantly, the BH Reform Work Group submitted a number of specific recommendations in the areas of finance and contracting with plans; eligibility; performance metrics/evaluation; peer services; Health Homes implementation; as well as some issues that were considered important for the Behavioral Health Reform Work Group to provide recommendations on, but that were outside the scope of the Work Group's mission. A few overarching concepts from the work group's recommendations include:

- Establish risk-bearing managed care approaches/entities - either as SNPs, IDSs or BHOs.
- Invest or reinvest into community-based systems of care in order to create the strong, well-functioning system of care necessary to meet the needs of individuals no longer

utilizing inpatient care. Such investments are needed in care coordination, affordable housing, health information exchanges and other non-clinical services and supports.

- Risk-bearing managed care approaches should bear responsibility to pay for inpatient care at OMH Psychiatric Centers and to coordinate discharge planning from these facilities, and other inpatient settings. As downsizing of these facilities continues, such resources would be reinvested into the community-based services mentioned above.
- Advance the core principle that managed care approaches for people with behavioral health care needs should assist enrollees in recovery and in functioning in meaningful life roles.
- Ensure access to front-line services/benefits to prevent, screen and treat behavioral health disorders by identifying the core elements of the benefit package, including those specific to children.
- Develop outcome measurements and standards to review performance that are meaningful, easy to measure, validated and readily available, and easy to use – for both adult and children's behavioral health services.

BHO Outcomes Vignette #2

Care coordination to break the cycle of multiple detox admissions

A 38 year-old woman with co-occurring substance dependence and mental illness was admitted to an inpatient detoxification unit. The provider was unaware of the consumer's 3 inpatient detoxification admissions in the prior 3 weeks. *The BHO care manager provided recent service use history and noted that the consumer had a 4-year period of sustained engagement in outpatient services that ended 7 months prior to the current admission. The BHO care manager suggested transfer to an inpatient co-occurring unit for continued treatment.* Following transfer, *the BHO care manager organized a case conference* with the consumer and inpatient staff. Several discharge planning options were formulated and the consumer agreed to a plan including OMH's Assertive Community Treatment program and outpatient substance abuse services. Follow-up indicated the consumer successfully engaged in community-based services.

Given the unprecedented nature of this transition to managed care for individuals receiving mental health and substance use disorder services that are paid for by Medicaid, NYS is reaching out to other entities with similar experience to help determine the tasks necessary to successfully implement this initiative. These factors/tasks include background research on how BHOs/ SNPs have been implemented in other places, State Plan Amendment (SPA)/ waiver requirements that must be addressed to achieve program design goals, model payment approaches, and model the financial impact of the redesign initiative.

Moving into Phase II, contracted entities will indeed bear risk, be responsible, and be held accountable for the behavioral health services delivered through their network. OMH and OASAS, in consultation with DOH, will establish the behavioral health service delivery requirements and performance standards under Medicaid care management. These agencies will also jointly oversee and monitor contract performance related to care to people with mental illness and substance use disorders in the Medicaid program.

The BHO initiative is a transformational reform that provides a platform to address other areas where change is needed, including: reinvestment of inpatient savings into much needed targeted community supports and affordable housing; prioritizing recovery through reorientation of

support programs; and, enhancing use of information to improve care coordination, performance, and development of an electronic medical record.

Health Homes

Among the population of Medicaid recipients are those with complex and/or chronic conditions, including those with mental health and substance use disorders, developmental disabilities, those in long-term care, and those with conditions such as asthma, diabetes, heart disease, HIV/AIDS and obesity. Together, these populations total nearly $26 billion in costs in NYS's Medicaid program annually, with nearly $6.3 billion accounting for services to 400,000 individuals with complex/serious mental illness and/or substance use disorders.

To improve coordination among the various medical, behavioral and long-term care needs of these populations – and thereby reduce costs – New York State is establishing Health Homes, as is authorized under the federal Patient Protection and Affordable Care Act (ACA), enacted in 2010. "A Health Home is a care management service model whereby all of an individual's caregivers communicate with one another so that all of a patient's needs are addressed in a comprehensive manner."[1] Health Homes will consist of a network of organizations that provide a variety of services, all working together to meet the needs of the individuals they serve. These services include: "comprehensive care management; care coordination and health promotion; comprehensive transitional care from inpatient to other settings, including appropriate follow-up; individual and family support, which includes authorized representatives; referral to community and social support services, if relevant; and, the use of health information technology to link services, as feasible and appropriate. The use of the health home service delivery model will result in lower rates of emergency room use, reduction in hospital admissions and re-admissions, reduction in health care costs, less reliance on long-term care facilities, and improved experience of care and quality of care outcomes for the individual."[2]

In essence, Health Homes are responsible for coordinating the various aspects of a Medicaid recipient's health care needs, paid through Medicaid managed care or fee-for-service Medicaid (until BHO Phase II is implemented), and promoting communication among caregivers. Health Homes will be responsible for directly providing or contracting for services to identify eligible beneficiaries. These services include comprehensive care management, health promotion, transitional care including appropriate follow-up from inpatient to other settings, patient and family support, referral to community and social support services, and use of health information technology to link services. It is expected that Health Homes will develop networks with primary, medical, specialty and mental health providers, substance abuse service providers, community based organizations, managed care plans and others to provide enrollees access to needed services.

The Health Home will assign each individual enrollee one dedicated care manager who is responsible for overall management of the enrollee's plan of care. The enrollee's care manager will be clearly identified in the clinical record and have overall responsibility and accountability for coordinating all aspects of the individual's care. The Health Home will assure that

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

communication is fostered between the dedicated care manager and treating clinicians to discuss as needed enrollee's care needs, conflicting treatments, changes in condition, etc., which may necessitate treatment change (i.e., written orders and/or prescriptions).

Health Homes are being developed, in part, through "conversion" of OMH's current Targeted Case Management (TCM) program and the OASAS Managed Addiction Treatment Services (MATS) program. This will allow Health Homes to utilize the extensive expertise of former TCM providers in engaging and reaching out to people in the mental health system, but includes responsibility for coordinating all medical, behavioral and long-term care needs. Likewise, MATS case managers will lend their expertise in working with individuals in the treatment system and coordinating all aspects of care. This more comprehensive care coordination approach is anticipated to significantly benefit individuals with mental illnesses and substance use disorders by providing more integrated health and behavioral health service delivery. More information on this conversion is available at:
http://www.omh.ny.gov/omhweb/adults/health_homes/.

Health Homes will also be required to have policies and procedures in place with local government units, local practitioners, health facilities including emergency rooms, hospitals, and residential/rehabilitation settings, providers and community-based services to ensure coordinated, and safe transition in care for individuals who require transfer to/from sites of care. They will be required to develop and have a systematic follow-up protocol in place to assure timely access to follow-up care post discharge. Also, they will be an active participant in all phases of care transition, including: discharge planning and follow-up to assure that enrollees received follow up care and services and re-engagement of individuals who have become lost to care.

Peer supports, support groups, and self-care programs will be utilized by Health Homes to increase individuals' and caregivers' knowledge about the individual's medical conditions, promote the enrollee's engagement and self management capabilities, and help the enrollee improve adherence to their prescribed treatment.

Health Homes will also need to identify available community-based resources and manage appropriate referrals, access to care, engagement with other community and social supports, coordinate services and follow-up post engagement with services. To accomplish this, they must develop policies, procedures and accountabilities (through contractual agreements) to support effective collaboration with community-based resources, that clearly define the roles and responsibilities of the participants. The plan of care will include community-based and other social support services, appropriate and ancillary healthcare services that address and respond to the individual's needs and preferences, and contribute to achieving the recipient's goals.

Health Home providers must meet Health Information Technology (HIT) standards and provide a plan to achieve the final HIT standards within 18 months of program initiation in order to be approved as a health home provider. To the extent possible, Health Homes will be encouraged to utilize regional health information organizations or qualified entities to access patient data and to develop partnerships that maximize the use of HIT across providers (i.e., hospitals, TCMs). Health Homes will also be encouraged to utilize HIT as feasible to create, document, execute and

update a plan of care that is accessible to the interdisciplinary team of providers for every patient. Lastly, Health Homes will be encouraged to utilize HIT as feasible to process and follow up on individual testing, treatments, community based services and provider referrals.

It is important to note that Health Home care managers will be required to make sure that individuals (or their guardian) enrolled in their Health Home play a central and active part in the development and execution of their plan of care, and that they are in agreement with the goals, interventions and time frames contained in the plan. Family members and other supports involved in the individual's care should be identified and included in the plan and execution of care as requested by the individual. The care plan must also include outreach and engagement activities, which will support engaging the individual in their own care and promote continuity of care.

After receiving more than 150 applications to become a Health Home from around the state, DOH established a three phase process for the Health Homes roll-out, with an increasing number of counties moving to the Health Home model in each phase. There are 10 counties included in Phase 1 (Bronx, Clinton, Essex, Franklin, Hamilton, Kings, Nassau, Schenectady, Warren, and Washington), which had an implementation date of January 1, 2012. Phase 2 includes 13 counties (Dutchess, Erie, Monroe, New York, Orange, Putnam, Queens, Richmond, Rockland, Suffolk, Sullivan, Ulster, and Westchester) and has an implementation date of April 1; however, the Medicaid State Plan Amendment (SPA) authorizing these counties has not yet been approved by the Centers for Medicare and Medicaid Services (CMS). Over the summer, DOH designated a number of contingent Health Homes for the remaining counties participating in Phase 3 (Albany, Allegany, Broome, Cattaraugus, Cayuga, Chautauqua, Chemung, Chenango, Columbia, Cortland, Delaware, Fulton, Genesee, Greene, Herkimer, Jefferson, Lewis, Livingston, Madison, Montgomery, Niagara, Oneida, Onondaga, Ontario, Orleans, Oswego, Otsego, Rensselaer, Saratoga, Schoharie, Schuyler, Seneca, St. Lawrence, Steuben, Tioga, Tompkins, Wayne, Wyoming, and Yates), with additional designations anticipated soon after. However, as with Phase 2, the SPA for these counties has not yet been approved by CMS, despite the planned implementation date of July 1, 2012.

Community-based providers, including mental health organizations, have been strongly encouraged either to take the lead in establishing a Health Home or to partner with an organization taking the lead in establishing a Health Home network in their region. DOH has posted all the designated Health Homes on their website.

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

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

The State has provided each managed care plan with a Health Home eligible list of individuals sorted from highest to lowest predictive risk. The State is working on the development of Patient Rosters that take the factors above into priority consideration for initial health home assignment. The goal is to assign and outreach to the highest risk (based on a predictive model) and highest cost members with the lowest primary and ambulatory care connectivity in each health home area. Once those members have been assigned and enrolled then the State and health plans will move down the list using provider loyalty and geography as markers for initial health home assignment. The details of this algorithm will be approved by all the State partners (DOH, OMH, AIDS Institute and OASAS) and will be recommended to health plans as one means of distributing members through intelligent assignment to each of the State approved health homes."[3] Once individuals have been assigned to a Health Home, they will have the option to choose a different Health Home provider or opt out of Health Home enrollment altogether.

Behavioral Health Services Advisory Council

As part of the 2012-13 NYS Budget enacted earlier this year[4], the OMH Mental Health Services Council and the OASAS Advisory Council on Alcoholism and Substance Abuse Services will be replaced by a newly created Behavioral Health Services Advisory Council (BHSAC), constituted of individuals nominated by the Governor and confirmed by the New York State Senate. The BHSAC will comprise 28 individuals with varying degrees of experience and expertise, including consumers of behavioral health services, family members, non-providers, providers of mental health and substance use disorder services, individuals with experience serving veterans with mental health and substance use disorders, state/local governmental agency representatives, and members of DOH's Public Health and Health Planning Council.

The BHSAC's responsibilities include advising the Commissioners of OMH and OASAS on matters related to behavioral health service delivery, financing of behavioral health services, integration of behavioral health services with primary health services, services to people with co-occurring disorders, prevention of behavioral health disorders, and improvements in care to people with served by the behavioral health system. In addition, the BHSAC will have responsibilities in relation to the annual comprehensive planning process, shall review applications seeking OASAS/OMH certification to provide behavioral health services, and review all proposed OASAS/OMH rules and regulations prior to enactment.

This initiative marks a significant step forward in enhancing the ability of the addictions and mental health systems to deliver more integrated services. This effort will have additional impacts down the road, through the BHSAC's development of statewide goals and objectives that will guide the respective OASAS and OMH planning processes and the potential merger of those separate planning processes into a single Statewide Comprehensive Plan for both agencies.

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

[4] Chapter 56 of the Laws of 2012, Part N

Integrated Licensure Project

Physical and behavioral health problems often occur simultaneously. Individuals with behavioral health disorders frequently suffer from chronic illnesses such as hypertension, diabetes, obesity, and cardiovascular disease. These illnesses can be prevented and are treatable. However, barriers to primary care, as well as the difficulty in navigating complex healthcare systems, present major obstacles.

In addition, individuals with serious mental illness and substance use disorders often receive regular care in specialized behavioral health settings, but many do not routinely access primary care or care for their chronic physical health conditions. When they do receive physical health care, it is often segregated from their behavioral health services. As a result, they experience poorer health status and higher rates of emergency room and inpatient hospitalization. By facilitating the co-location and integration of physical health and behavioral health services, NYS is seeking to reduce preventable hospital utilization among people with mental illness and substance use disorders, and improve their overall health status and quality of life.

OASAS, OMH, and DOH have been working on an Integrated Licensing Project pursuant to authorization contained in the 2012-13 NYS Budget.

Goals of the project:

1. To streamline the approval and oversight process for clinics interested in providing services from more than one agency (OMH, DOH, and OASAS) at one location:
    - Providing an efficient approval process to add new services to a site that is not licensed for those services
    - Establishing a single set of administrative standards and survey process under which providers will operate and be monitored
    - Providing single state agency oversight of compliance with administrative standards for providers offering multiple services at a single site

2. To improve the quality and coordination of care provided to people with multiple needs:
    - Ensuring that appropriate compliance with applicable federal and state requirements for confidentiality of records
    - Incorporating the evidence-based treatment approaches to integrated dual disorders treatment outlined in the OMH/OASAS 2008 clinical guidance to the field. This initiative is not meant to replace this guidance, but rather to support providers in their evolution toward service integration.
    - Building on the efforts of OASAS and OMH on the New York State Clinical Records Initiative (NYSCRI)
    - Ensuring that optimal clinical care and not revenue drive the program model.

Each agency (OMH, DOH, and OASAS) will work with a subgroup of pilot providers. The pilot will begin during fall 2012, and the interagency group will assess the progress and make a decision expanding the project beyond the initial participants.

New York State Clinical Records Initiative (NYSCRI)

Initially developed on Long Island in 2009, the New York State Clinical Records Initiative (NYSCRI) offers licensed OMH and OASAS community-based treatment providers an opportunity to standardize and streamline their clinical records. Developed collaboratively among OMH, OASAS, Nassau and Suffolk County Mental Hygiene Departments, the Long Island Coalition of Behavioral Health Providers, recipients and families, NYSCRI offers providers a standardized set of clinical case record forms designed to enhance compliance with state, federal, and accreditation requirements. NYSCRI also offers providers a number of other benefits, including technical assistance in the use of the records, support for documenting medical necessity, and more efficient use of clinician time. Perhaps most beneficial, however, is the compatibility opportunities NYSCRI offers as movement toward the establishment of electronic medical record (EMR) systems continues. This capacity allows EMR system vendors to develop an electronic record certified as compliant with the NYSCRI requirements, thereby allowing providers to use NYSCRI as a means of data entry into an EMR system.

NYSCRI is now available throughout New York State, offering the same opportunity to create efficiency at no-cost to providers and on a voluntary/non-mandatory basis. The NYSCRI project team welcomes feedback, which is reviewed by the implementation team for potential changes to the record set. An advisory group consisting of behavioral health leaders, government representatives, and recipient representatives also provides project feedback related to their particular constituencies. The record set is updated at least annually to assure all promulgated OMH and OASAS regulations and other accrediting bodies' standards are represented accurately. By fall 2012, an updated version is anticipated to be completed, making the NYSCRI records set even more streamlined, compliant, person-centered and user-friendly.

Integration of the Federal Block Grant Plan

The pending implementation of health care reform and affordable insurance exchanges has led the Substance Abuse and Mental Health Services Administration (SAMHSA) to encourage states to submit integrated mental health and substance use disorder Block Grant plans. In 2011, the OASAS Substance Abuse Prevention and Treatment (SAPT) Block Grant consisted of approximately $115 million coming into New York State and the OMH Mental Health Block Grant consisted of approximately $24 million.

OASAS and OMH have agreed to pursue this opportunity to integrate the respective Block Grant plans and subsequent reporting into one. To accomplish this, OASAS and OMH must have an integrated process for review and approval of the integrated Block Grant. Through the recently created Behavioral Health Services Advisory Council (BHSAC), OASAS and OMH have a mechanism for Block Grant integration. OASAS and OMH have agreed to create a subcommittee/subgroup of the BHSAC to review and approve the integrated Block Grant Plan prior to its submission to SAMHSA, as required.

For OMH, this will constitute a significant change, as the OMH Mental Health Planning Advisory Committee (MHPAC) currently has responsibility for review and approval of OMH's Mental Health Block Grant application to SAMHSA. Once the new BHSAC is constituted and

prepared to take on its responsibilities, including review and approval of the integrated Block Grant Application, the MHPAC will be dissolved.

Changes to Block Grant Requirements

The new integrated Block Grant Plan must reflect the following SAMHSA priorities:

- Primary health and behavioral health care should work together to support the individual. The use of health information technology and interoperable electronic health records are an indispensable tool to integrated care.
- SAMHSA has continued interest in understanding the evidence that supports the delivery of medical and specialty care (including care for substance use disorders and mental health disorders). OASAS and OMH fully support this direction. To determine which evidence-based practice will be most successful, SAMHSA promotes the use of the Strategic Prevention Framework (SPF), which uses a five-step process to assess the community needs, determine the capacity to meet the identified needs, plan to meet the needs, implement the plan, and evaluate the impact on the identified needs. Similar to primary health care, specialty health care for substance use disorders and mental health disorders must emphasize prevention and primary prevention, address health disparities, implement recovery-based approaches, address trauma, and ensure program integrity through quality services.
- SAMHSA encourages a "systems of care" approach to serving unique populations, particularly adolescents, criminal justice, juvenile justice, veterans and their families. This approach uses state and local interagency coordination centered on the unique needs of the individual and family being served.

Chapter III: Dashboard

OASAS 2012 Outcomes Dashboard

2012 marks the fifth year OASAS has issued a system-wide *Outcomes Dashboard* - a tool designed to focus staff across the agency and the prevention, treatment, and recovery system on the most important success indicators associated with mission achievement. The 2012 Outcomes Dashboard identifies the agency's five core destinations and the key metrics used to measure progress by OASAS staff and the field toward reaching those destinations. As part of an ongoing effort to integrate outcomes management into the operations of the agency and the field, the system-wide outcomes dashboard serves as a roadmap to guide efforts and achieve the agency's mission of addressing the prevention, treatment and recovery needs of New Yorkers.

The five destinations that organize the OASAS strategic map reflect a comprehensive look at system performance including:

- **Mission Outcomes** - To establish an effective, science-based system, which integrates prevention, treatment, and recovery.

- **Provider Engagement** - To develop a "Gold Standard" system of service provision.

- **Leadership** - To be the state resource on addiction and lead the nation in the field of chemical dependence and problem gambling prevention, treatment, and recovery.

- **Talent Management** - To become a "Profession of Choice" for attracting, selecting, and developing system-wide talent.

- **Financial Support** - To ensure a system with strong return on taxpayer investment and stewardship of resources.

The 12 metrics included in the 2012 Dashboard reflect the agency's priorities for the year while meeting the three M criteria of meaningful, measurable, and manageable. Each metric on the 2012 OASAS Dashboard is intended to be:

- Meaningful - generally accepted by those most familiar with the metric and connected to the agency mission;
- Measureable - valid, reliable, and associated with a readily available, regularly updated data source;
- Manageable - able to be affected through agency efforts and vertically integrated at the system, county, provider, and program levels.

OASAS marks progress towards accomplishing each of the 12 metrics through a series of milestones. The milestones are short-term goals that OASAS can achieve by the end of 2012. There are 43 milestones associated with the 12 metrics. **OASAS will report on 2012 Outcomes Dashboard results in the *2013 Interim Report on the Statewide Comprehensive Plan***.

Mission Outcomes

Metric 1: Strengthen addiction services through a comprehensive, integrated, culturally competent system that focuses on individual needs and accessibility.

1.1: Improve 90-day retention rates by 3 percent over a 36-month period for these two statewide service modalities: Intensive Residential *(baseline - 76%*) and Outpatient programs (*baseline - 72%*).

1.2: The 12 OASAS run Addiction Treatment Centers will increase one-week retention rates from 85.7 percent to 87.6 percent and maintain the overall occupancy rate above 90 percent.

1.3: Improve services to individuals in treatment by achieving the following results:

- Expand the number of Opioid Treatment Program (OTP) slots by 50 from 43,962 to 44,012.
- Increasing the number of OASAS programs trained in Opioid Overdose Prevention by the Harm Reduction Coalition from 25 to 35 programs.
- Fifty percent of the 32 Pregnant and Parenting Women's programs will complete an assessment of cultural competence in delivering gender specific care to women.
- Compile baseline data for persons in treatment re: number of individuals with HIV, Hepatitis C and other communicable diseases.
- Improve services to veterans by conducting knowledge enhancement and skill building for 500 treatment provider staff who will advocate the adoption/ use of proven and effective therapeutic models at the provider level.
- Compile an inventory of universal screening and assessment instruments for adolescents and their families and make it available on the OASAS website.

1.4: Successfully implement Medicaid Redesign Team (MRT) recommendations to improve substance abuse and behavioral health program performance regarding Behavioral Health Organizations and Health Home initiatives by meeting milestones articulated in detailed interagency agreements.

1.5: Improve interagency integration between OASAS, OMH and DOH including the forming of **"**Futuring Teams" to implement these system changes:

- 2012-13 Article 7 law to combine the Governor's Advisory Councils at OASAS and OMH into a single entity
- Establish a process which will allow local programs with licenses from OASAS, OMH and/or DOH to operate under a single set of operating standards.
- Collaborate with OMH to implement mental hygiene law changes in statewide comprehensive planning.

1.6: The Addiction Screening, Brief Intervention & Referral to Treatment (SBIRT) project supported by an $8.3 million Federal grant will screen/prescreen 22,784 patients, provide brief intervention to 2,350 and refer 216 patients to treatment in the first year of its five-year time period.

Metric 2: Working in collaboration with NYS DMV, OASAS will increase utilization of evidence-based practices by Impaired Driver Services programs through implementation of a new online reporting/enrollment data systems. This will enable the reporting of recidivism; allow for improved enforcement of clinical screening/assessment standards and improve monitoring of the new evidence-based training curricula.

2.1: Establish baseline rates for delivery, referral and completion of Impaired Driving Services in NYS.

2.2: Fully implement an Impaired Driver Quality Assurance System by:

- Conducting 25 Impaired Driver Screening/Assessment addendum reviews of certified providers and
- Distributing a new self-assessment survey instrument to approximately 1,000 private screening/assessment practitioners and establish a new Impaired Driver Services complaint process and database.

Metric 3: Reduce rates of past 30-day substance use and reduce levels of substance abuse risk factors including: perception of risk, perception of parental disapproval, and percent of youth exposed to prevention messages in New York State.

3.1: The 62 counties implementing evidence-based prevention practices will increase their utilization of evidence-based prevention practices from 35 percent to 40 percent or more of the countywide prevention effort.

3.2: Administer a survey and develop a baseline of culturally competent evidence-based practices in the prevention provider community.

3.3: The 11 funded Strategic Prevention Framework State Incentive Grant communities will submit and have comprehensive strategic plans approved and fully implemented.

3.4. The implementation of planned evidence-based practices education class delivery will meet or exceed an 80 percent completion standard.

Metric 4: Recovery: Increase the number of persons successfully managing their addiction within a culturally competent, recovery-oriented system of care.

4.1: The five-year $13 million federally funded *Access to Recovery grant* will achieve its enrollment target of 3,875 by the end of 2012 grant year.

4.2: The permanent supportive housing portfolio for people in recovery across the state will be increased from 1,460 to 1,530 apartment units.

4.3: Increase the number of certified supportive living beds by 5 percent from 965 to 1013.

4.4: Implement MRT-Affordable Housing PSH programs statewide in SFY 2012-13 adding more than 400 units for single adults who are high cost, high frequency Medicaid users.

4.5: The number of Recovery Coaches trained in the *Connecticut Community for Addiction Recovery* (CCAR) model in NYS will be increased from 270 to 370 and the number of Recovery Coaches trained to disseminate CCAR curriculum in their communities will be increased from 51 to 100.

Provider Engagement

Metric 5: Implement increased program oversight and strengthen provider accountability to ensure culturally competent, quality services.

5.1: Implement an enhanced program monitoring system that will result in (25) focused reviews of at-risk programs, which will identify deficiencies requiring corrective action and implementation.

5.2 Establish a compliance baseline for programs under the revised Part 822 regulations (822-4 outpatient and 822-5 opioid treatment programs) beginning with recertification reviews conducted in January 2012.

5.3: Provide technical assistance to the estimated 70 programs that annually receive six month (non-compliance) or one-year (minimal compliance) conditional operating certificates. At least 80 percent of the programs receiving technical assistance will demonstrate improvement.

5.4: In conjunction with the Department of Corrections and Community Supervision, OASAS will certify six additional DOCCS addiction services programs adding to the four certified in 2011 for a total of 10 DOCCS programs.

5.5: Reports available in the statewide prevention data collection system, PARIS, will be modified to decrease work plan and data collection delinquencies by 10 percent.

Metric 6: Increase Provider engagement in the Gold Standard Initiative.

6.1: Based on an annual survey of providers, OASAS will increase from 2010 baselines the percentage of non-crisis programs (which total 677) adopting targeted evidence based practices (EBPs) as follows:

- Screening for Co-occurring Disorders (2010 Baseline 67%, Target 70.4%)
- Motivational Interviewing (Baseline 67%, Target 70.4%)
- Cognitive Behavioral Therapy (Baseline 60%, Target 63%)

- Medication Supported Recovery/Buprenorphine (Baseline 37%, Target 38.85%)
- Process Improvement (Baseline 32%, Target 34%)

6.2: Release the first prevention scorecard utilizing PARIS data with approval from the Gold Standard Outcomes Management Advisory Committee.

6.3: The OASAS Integrated Quality System (IQS) will conduct data integrity reviews of 100 percent of eligible programs. A Gold Standard application will be completed and the types and number of programs eligible for a four-year operating certificate will be analyzed to validate the methodology.

6.4: The number of programs with recurring management plans will be reduced from 31 percent to 29 percent and those with repeat deficiencies will be reduced from 22 percent to 20 percent.

6.5: Increase the number of patients served by providers with electronic health care systems as part of national health care reform. Establish a baseline by Spring 2012, with a survey of providers in their use of electronic health records and establish a goal for 2013.

Leadership

Metric 7: Utilize outcome management concepts that focus on performance measures and hold both OASAS and its providers accountable.

7.1: Increase use of Outcomes Management across the addictions system by:

- increasing the percentage (68% to 75%) of providers and local government units (48% to 50%) that report reviewing and acting on outcome focused data on a quarterly basis and
- increasing (by two, from four to six) the number of regional Outcomes Management Communities of Practice.

7.2: Launch at least two Lean/Six Sigma projects to eliminate waste and improve customer outcomes within OASAS.

Metric 8: Educate and partner with the community, government agencies and elected officials to advance the agency mission by increasing public awareness through positive media coverage and proactive communication strategies.

8.1: Support a statewide Recovery consumer movement by increasing the total number of stories to the *"Your Story Matters"* campaign at www.iamrecovery.com from 410 to 470.

8.2: Effectively articulate agency policy issues/initiatives and collaborate with federal and state government agencies, elected officials and affiliated organizations to support the OASAS mission.

Talent Management

Metric 9: Increase cross-systems training to support integrated, culturally competent behavioral health services.

9.1: Increase the number of OASAS programs that enroll staff and provide access to the online *Focus on Integrated Treatment* (FIT) modules, webinars and learning collaborative from 173 to 250. Increase by 50 percent (2,500 to 3,750) the number of FIT modules, webinars and learning collaborative sessions completed by provider staff.

9.2: Increase by 10 percent the proportion of OASAS providers that are determined to be dual diagnosis capable using the Dual Diagnosis Capability in Addiction Treatment (DDCAT) rating process.

Metric 10: Increase full knowledge, expertise and retention of a high-performing, diverse staff throughout the field.

10.1: Expand provider skills through training in the following areas:

- Provide fetal alcohol spectrum disorder training to a minimum of 350 provider staff from the addictions system and other service systems.
- Increase the number of providers receiving overdose prevention training by 10 percent from 27 to 30.
- Provide SBIRT training to 500 individuals in both OASAS and non-OASAS settings. Develop a12-hour training for non-licensed individuals and certify two additional training entities.
- Deliver Wellness Self-Management Plus training to 15 OASAS providers, reaching 100 participants.

10.2: Increase the number of addiction professionals across the state by five percent as follows:

- Credentialed Alcohol and Substance Abuse Counselors (CASAC) (7,085 to 7,439)
- CASAC Trainees (5,277 to 5,540)
- Certified Addictions Registered Nurses (CARNs) (87 to 92)
- American Board of Addiction Medicine (ABAM) Certified Physicians (214 to 225)
- Credentialed Prevention Professionals (CPPs) (333 to 350)

10.3: Work with Human Resource professionals in the field to develop an HR/Leadership Institute in 2012 and implement at least one *Best Places to Work* initiative.

Metric 11: Improve OASAS leadership capabilities and employee engagement in a culturally competent environment.

11.1: Seventy-five percent (2011 baseline - 67.8%) of staff will report that their supervisors conduct supervisory meetings at least monthly and discuss professional development opportunities and performance outcomes.

11.2: Managers and supervisors will ensure 100 percent (2011 baseline 73%) of performance programs for OASAS supervisors include a standard supervision performance task measure that rates quality assessments and timely submission of employee performance evaluations.

11.3: Supervisory skills will be enhanced through monthly group learning sessions with an average participation rate of 65 percent (2010 baseline 47.5%) and an average participant usefulness rating of 80 percent (2010 baseline 68%) as measured by surveying training participants.

11.4: A total of 20 percent of all OASAS staff will participate in cultural competency training with an overall "Good" satisfaction rate as measured by training evaluations.

Financial Support

Metric 12: Increase or stabilize funding resources while ensuring strong return on taxpayer investment.

12.1: Maintain and/or increase federal or foundation financial support of agency priorities through supporting grant development, management and comment on proposed changes in funding sources.

12.2: The annual NYS Retailer Violation Rate for underage tobacco sales, which is required by the Federal Synar Amendment for states to receive Federal Block Grant Funds, will continue to be less than the weighted national average of 9.3 percent and remain close to recent NYS average of 5.8 percent.

12.3: Achieve Governor's Minority/Women Owned Business Enterprise goal of increasing state contracting to minority and women owned businesses to 20 percent.

Chapter IV: System Overview

National Outcome Measures (NOMs)

SAMHSA developed National Outcome Measures (NOMs) in collaboration with states to demonstrate and improve the effectiveness of the SAPT Block Grant and the corresponding Center for Mental Health Services (CMHS) Block Grant, as well as discretionary grant programs. The SAPT Block Grant provides approximately $115 million annually to prevention, treatment, and recovery services in New York.

The ten NOMs domains cut across mental health, substance use treatment, and substance abuse prevention services:

1. Reduced Morbidity (e.g., abstinence);
2. Increased Employment and Education;
3. Decreased Criminal Justice Involvement;
4. Stability in Housing;
5. Social Connectedness;
6. Access and Capacity;
7. Retention in Care;
8. Perception of Care;
9. Cost Effectiveness;
10. Use of Evidence-Based Practices.

These domains are intended to represent "meaningful, real life outcomes for people who are striving to attain and sustain recovery; build resilience; and live, work, learn, and participate fully in their communities."

For treatment services, many of the NOMs use before-and-after measures, specifically, changes in status from admission to discharge. While this may not be a strong design from a research perspective (e.g., no control group), it is an excellent design for managing outcomes and improving performance. In order to implement this measurement design, SAMHSA required states to enhance reporting of client admission and discharge data to the federal Treatment Episode Data Set (TEDS). OASAS began implementing new data items based on NOMs requirements in 2006 and will continue, as necessary, to augment its Client Data System (CDS). At the same time, OASAS continues to participate in SAMHSA's Technical Consultation Groups (TCGs) and the National Association of State Alcohol and Drug Abuse Directors (NASADAD) Performance Management Work Group. OASAS' purpose is to minimize the reporting burden on service providers while assuring that the measures developed are useful for performance management at the federal, state, county, and provider levels.

Table 4.1 presents statewide outcomes for chemical dependence treatment in four of the ten domains. In the table, "Net Improvement" is the percentage point difference between the before and after rates; SAMHSA refers to this as "absolute" change. While NOMs reported to SAMHSA are limited to outcomes for funded programs and exclude opiate treatment services, the statistics reported here include all non-crisis treatment services regardless of funding. The

NOMs in **Table 4.1** represent outcomes for the entire certified treatment system (excluding crisis services for which NOMs have not been developed).

Table 4.1 National Outcome Measures (NOMs) for Non-crisis Chemical Dependence Treatment Services* Based on Persons Discharged in Calendar Year 2011 ***

National Outcome Measure	At Admission	At Discharge	Net** Improvement
Abstinence in Past 30 Days			
From Alcohol	62.5%	86.1%	23.6%
From Other Drugs	46.2%	74.6%	28.4%
From Alcohol and Other Drugs	31.2%	68.9%	37.7%
Employed or Enrolled in School	27.1%	33.5%	6.4%
Stable Living Situation#	88.0%	90.6%	2.6%
Not Arrested in Past 6 months	75.2%	88.4%	13.2%
Social Connectedness	25.4%	39.7%	14.3%

* These figures include non-crisis outpatient services, inpatient rehabilitation, residential and methadone services.

** Net improvement is simply the percentage point difference between the admission and discharge measures.

***(The denominator) total discharges with valid data vary by measure: 202,364 for abstinence measures, 202,527 for employment/enrollment, 202,468 for living situation, 210,833 for arrest and 198,646 for social connectedness.

#Stable living situation includes congregate care residences, but excludes homeless shelters and unsheltered situations.

- Abstinence is measured as frequency of use in the past 30 days (i.e., zero frequency). SAMHSA measures abstinence separately for alcohol and other drugs while OASAS includes abstinence from alcohol and other drugs combined.

  - *Alcohol and Other Drugs* – Among persons discharged in 2011 from non-crisis treatment services, 31 percent had used neither alcohol nor drugs in the 30 days prior to admission while 69 percent had used neither alcohol nor drugs in the 30 days prior to discharge. Thus abstinence from alcohol and drugs increased by 38 percentage points, meaning that 77,000 more persons were alcohol and drug abstinent at discharge than at admission.
  - *Alcohol* – Among persons discharged in 2011 from non-crisis treatment services, 63 percent had not used alcohol in the 30 days prior to admission while 86 percent were not using alcohol in the 30 days prior to discharge. Abstinence from alcohol increased by 23 percentage points, meaning that 47,000 more persons were alcohol abstinent at discharge than at admission.
  - *Other Drugs* – Forty-six percent of persons discharged had not used other drugs in the 30 days prior to admission while 75 percent were not using other drugs in the 30 days prior to discharge. Abstinence from other drugs increased 29 percentage points, meaning that 59,000 more persons were abstinent from other drugs at discharge than at admission.

- Employment and Education – Among persons discharged in 2011 from non-crisis treatment services, 27 percent had been employed or enrolled in school at admission while 34 percent were employed or enrolled at discharge. This increase of 7 percentage points means that 14,000 more persons were employed or enrolled at discharge than at admission.
- Stability in Housing – Among persons discharged in 2011 from non-crisis treatment services, 88 percent had been in a stable housing situation at admission while 91 percent were in a stable housing situation at discharge. This increase of three percentage points in stable housing situation means that 6,000 fewer persons were homeless at discharge than at admission.
- Criminal Justice Involvement – Among persons discharged in 2011 from non-crisis treatment services, 75 percent had not been arrested in the six months prior to admission while 88 percent had not been arrested in the six months prior to discharge. This increase of 13 percentage points means that 27,000 fewer persons were arrested in the six months prior to discharge than had been arrested prior to admission.
- Social Connectedness – Among persons discharged in 2011 from non-crisis treatment services, 25 percent indicated that they had attended self-help groups at admission, which is used as a measure of social connectedness. Forty percent were socially connected at discharge. This increase of 15 percentage points means that 30,000 more persons were socially connected at discharge than at admission.

No additional information on NOMS or the status of client perception of care has been discussed with the states recently. However SAMHSA has included the concept of an annual Behavioral Health Barometer in an outline of current initiatives. States submitted ideas that have been compiled and are being reviewed. The ideas include current NOMS, data from prescription monitoring databases, and monitoring trends in emerging substances of abuse. OASAS will continue to participate in the dialogue and monitor proposals for their impact on New York's network of addiction providers.

For prevention NOMs, the first five domains are population-based and epidemiological in nature. Data for these indicators are taken from surveys or collected from administrative sources. Data for access/capacity, retention and use of evidence-based practices is collected in the OASAS Prevention Activities and Results Information System (PARIS). Cost-effectiveness measures are under development.

OASAS continues to analyze and review NOMs and other performance indicators at the state and regional levels to identify trends (See **Table 4.2**) and to develop policies and programs for improving the health and well-being of New Yorkers as well as supporting the recovery of individuals who have experienced substance use disorders. The agency will continue to enlist counties and providers in performance improvement efforts.

As New York's systems evolve and improve, NOMs are being integrated as appropriate. In most cases, improved performance on scorecard indicators and on Integrated Program Monitoring and Evaluation System (IPMES) indicators translate directly into improvement on NOMs indicators.

OASAS will not superimpose a new performance monitoring system on top of scorecards and IPMES, but rather will continue to integrate NOMS and these systems over time.

Table 4.2 Five-Year Trends of National Outcome Measures (NOMs) for Non-crisis Chemical Dependence Treatment Services Showing Net Improvement for Persons Discharged in Calendar Year 2011 ***

National Outcome Measure	Net** Improvement 2007	Net** Improvement 2008	Net** Improvement 2009	Net** Improvement 2010	Net** Improvement 2011
Abstinence in Past 30 Days From Alcohol From Other Drugs From Alcohol and Other Drugs	 26.6% 29.2% NA	 24.7% 28.4% 38.0%	 24.4% 28.0% 37.5%	 23.6% 28.1% 37.2%	 23.6% 28.4% 37.7%
Employed or Enrolled in School	7.1%	6.5%	5.5%	6.3%	6.4%
Homelessness	3.3%	NA	NA	NA	NA
Stable Living Situation#	NA	2.9%	2.2%	2.5%	2.6%
Arrested in Past 30 Days	29.0%	NA	NA	NA	NA
Not Arrested in Past 6 months	NA	11.5%	13.0%	13.9%	13.3%
Social Connectedness^	NA	NA	11.3%	13.8%	14.2%

* These figures include non-crisis outpatient services, inpatient rehabilitation, residential and methadone services
** Net improvement is simply the percentage point difference between the admission and discharge measures.
*** Total discharges with valid data (the denominator) varies by measure: 202,364 for abstinence measures, 202,527 for employment/enrollment, 202,468 for living situation, 210,833 for arrest and 198,646 for social connectedness.
# Stable living situation includes congregate care residences, but excludes homeless shelters and unsheltered situations.
^ Social Connectedness refers to attendance at self-help programs. Reporting of this measure began in 2009.

Needs Assessment

OASAS is required to assess the need for both prevention and treatment services as stipulated in Section 19.09 of Mental Hygiene Law. In addition, the SAPT Block Grant and the Center for Substance Abuse Prevention's (CSAP's) Strategic Prevention Framework State Incentive Grant (SPF SIG) require OASAS to address epidemiology and needs assessment. The first step in the SPF process is the assessment of population needs and resources, including development of baseline data against which progress and outcomes can be measured. Needs assessment informs prevention, treatment, and recovery policy making, planning, and program development at the state and local levels and ensures that OASAS is in compliance with the mandate stipulated by MHL 19.09 and federal grant requirements.

Assessing the nature and extent of substance use and its related consequences within various communities and population groups is accomplished through a program of surveys, indicator systems and ethnographic and qualitative studies. Three basic methodologies are used: (1) epidemiological surveys of household, school, and special populations conducted by state and federal agencies; (2) ethnographic studies, special investigations, and other qualitative methods; and (3) statistical indicators representing both substance use and related consequences. OASAS also uses information collected by the federal government and other state, county, and municipal agencies.

In addition to state level efforts, OASAS conducts a comprehensive annual local services planning process through which 57 counties and the City of New York are required to assess local chemical dependence problems and service needs and develop long range goals and intermediate range objectives to address those needs. Local planning and needs assessment is required by Mental Hygiene Law to be comprehensive and participatory, involving consumers, providers, other agencies, and interested stakeholders. Local needs assessments are updated on an annual basis and reported to OASAS in county Local Services Plans.

All OASAS-funded prevention programs complete a community-level needs assessment as part of their annual work plan. Community prevention development passes through a county-level review and approval as part of the county annual local services planning process. OASAS' state and local planning processes ensures inclusive, data-driven, and results-focused planning for local communities, counties, and the state.

OASAS seeks to improve needs assessment, planning, implementation, and monitoring efforts through the application of systematic, analytical thinking about the causes and consequences of substance use. This is done by collecting, analyzing, interpreting, and applying state and community level epidemiological data. Data-informed decision making necessitates the development of state monitoring systems for substance abuse, which can help inform assessment ("*What do substance use and related consequences look like in the State?")*, planning *("What are the current priorities that emerge after needs assessment?")*, and monitoring/evaluation activities *("How are we doing in our efforts to address these issues*?") to enhance substance abuse prevention and treatment services. CSAP has defined a series of activities to assist OASAS in developing an effective monitoring system by:

- Developing a key set of indicators to describe the magnitude and distribution of substance related consequences and consumption patterns across New York State;
- Collecting, analyzing, interpreting, and communicating these data through the development of various epidemiological reports;
- Establishing prevention priorities for New York State resources based on data analyzed and interpreted through the profiling process;
- Allocating resources to populations based on the established priorities;
- Developing a systematic, ongoing system of monitoring statewide substance related consumption patterns and consequences and tracking OASAS' progress in addressing prevention priorities, detecting trends, and using data to redirect resources if needed.

Epidemiological Reports

OASAS produces epidemiological reports documenting trends in risk and protective factors, substance use consumption patterns, and the resulting negative consequences of abuse as part of its needs assessment efforts, Measuring the magnitude and distribution of substance use within various communities and population groups through a key set of survey and archival indicators assists OASAS in assessing the need for prevention and treatment services.

OASAS monitoring efforts include the NOMs for prevention and treatment services, specific outcome measures that will be required of SAPT Block Grant and discretionary grant recipients, as specified by SAMHSA. These NOMs include the following domains: Abstinence from Alcohol and Other Drugs, Employment/Education, Crime and Criminal Justice, Access/Service Capacity, Retention, Social Support/Social Connectedness, Cost-Effectiveness, and Use of Evidence-Based Practices. These NOMs relate to youth ages 12 to 17 and to adults 18 and older.

Risk and Protective Factors

Research has demonstrated that lowering risk factors and increasing protective factors that drive substance abuse prevalence in individual, peer, family, school, and community domains leads to reductions in substance abuse. OASAS supports a strategic planning process that includes a local needs assessment and the selection and implementation of appropriate prevention services to address the risk and protective factors to prevent or reduce substance abuse in individuals, families, and communities.

Several Prevention NOMS that are risk and protective factors, including perception of risk from alcohol, cigarettes, marijuana, and age of first use of various substances are highlighted below. Perceived risk of harm from using alcohol, marijuana, and tobacco, especially heavy use is a deterrent to using these substances, especially among youth. Research demonstrates that respondents who believe great risk of harm results from using these substances were significantly less likely to use than those who thought there was little risk of harm.

The National Survey on Drug Use and Health (NSDUH) provided New York with the Prevention NOMS data for adults and youth from 2002-2003 to 2008-2009 (survey results are reported as two-year averages). According to the NSDUH, New York State experienced a statistically significant decline in the percent of residents ages 12 and older, who reported perceiving great risk in smoking marijuana once a month from 36.01 in 2007-2008 to 34.04 in 2008-2009. A decline of similar statistical significance occurred for the nation as a whole (from 37.87 to 36.06) during this same time period. Analysis of the New York State finding by age indicates that this decline was statistically significant for all age groups; however, among residents between the ages of 12 and 17 as well as residents 26 and older, the decline was significant at the .10 level. Trend analyses of earlier NSDUH surveys suggest that the decline in the percentage of New York State residents who perceive harm from using marijuana is a continuation of a trend that began in 2005-2006. A decline in perception of great risk in smoking marijuana once a month reverses the earlier trend of an increasing percentage of the state's residents who perceived harm from smoking marijuana between 2002-2003 and 2005-2006. In 2008-2009, less than one-third of adolescents perceived great risk from smoking marijuana once a month while less than one-quarter of young adults (ages 18-25) perceived great risk. Less than 40 percent of older adults (age 26 and older) perceived great risk from smoking marijuana once a month.

New York State experienced a statistically significant decline in the percent of residents aged 12 and older who reported perceiving great risk in smoking one or more packs of cigarettes a day from 79.61 in 2007-2008 to 77.85 in 2008-2009. A decline of similar statistical significance occurred for the nation as a whole (from 73.72 to 72.32) during this time period. Analysis of New York State's estimate by age indicates that the statistically significant declines were actually

limited to residents between the ages of 18 and 25 and, to a lesser extent, residents 26 years of age and older where a lower level of statistical significance ($p<.10$) was obtained. The decline in perception of risk reverses the long term trend of steadily increasing perception of great risk regarding smoking cigarettes seen from 2002-2003 to 2007-2008 among all three age groups. However, the percentage of New York State residents who perceived great risk in smoking cigarettes in 2008-2009 was still higher than any of the other states. Fewer than three-quarters of adolescents and three-quarters of young adults (ages 18-25) perceived great risk from smoking one or more packs of cigarettes a day, while four-in-five older adults (age 26 and older) perceived great risk from smoking one or more packs of cigarettes a day.

NSDUH found the percent of New York State residents who reported perceiving great risk from binge drinking (i.e., having five or more drinks of alcohol once a week or more) remained virtually unchanged, from 42.24 percent in 2007-2008 to 41.98 percent in 2008-2009. In fact, trend data indicate little change in the perception of great risk regarding binge drinking from 2002-03 to 2008-09. New York State estimates from the NSDUH for 2008-09 indicated that only about 40 percent of adolescents perceived great risk from binge drinking once or twice a week while less than one-third of young adults (ages 18-25) perceived great risk. Almost one-half of older adults (age 26 and older) perceive great risk from binge drinking once or twice a week.

OASAS, which monitors the age of first use of various substances, has found a decrease in proportion of students who used a substance before age 15. Based on the OASAS School Survey, between 1998 and 2006 the proportion of students in high school who smoked cigarettes before age 15 decreased by over 40 percent while the proportion who used marijuana before age 15 decreased by one-quarter and the proportion who used alcohol before age 15 decreased by about nine percent. The most recent statistics (2006) indicated that 59 percent of students in grades 9-12 used alcohol before age 15 while 28 percent used cigarettes and 24 percent used marijuana before age 15. OASAS has not conducted a school survey since 2006.

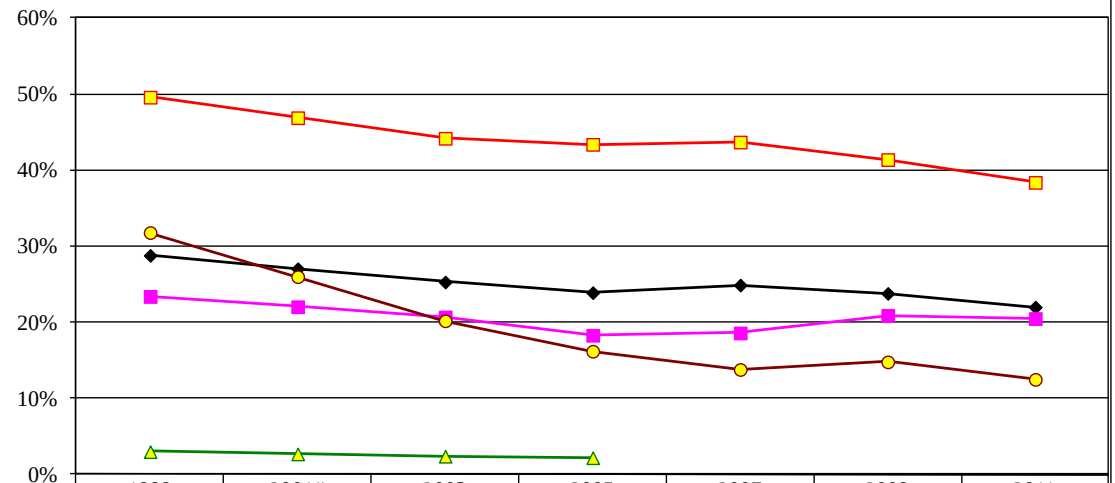
Consumption Patterns and Substance Use Behavior

OASAS monitors consumption patterns consistent with the Prevention NOMS by measuring the nature and extent of substance use within various communities and population groups. The Prevention NOMs include the consumption of alcohol, cigarettes, other tobacco products, marijuana, and use of other drugs other than marijuana in the general population, among adolescents 12-17, and adults 18 and older.

According to the 2011 Youth Risk Behavior Survey (YRBS), 22 percent of New York State high school students engaged in binge drinking in the last 30 days. The current binge drinking rate declined between 1999 and 2011 from 29 percent to 22 percent. One-in-five (21 percent) of high school students used marijuana in the last 30 days. The rate of current marijuana use declined about ten percent between 1999 and 2011 (from 23 percent to 21 percent). One-in-eight (12.5 percent) of high school students smoked cigarettes in the last 30 days. The rate of current cigarette use declined by more than 60 percent between 1999 and 2011 (from 32 percent to 13 percent). About two percent of high school students used cocaine or crack in the last 30 days in 2005.

Figure 4.1

Percent of Students in Grades 9-12 Who Reported Use of Selected Substances in the Last 30 Days Including Binge Drinking, Statewide (YRBS) [#2001 figures interpolated]



	1999	2001#	2003	2005	2007	2009	2011
Alcohol	49.6%	46.9%	44.2%	43.4%	43.7%	41.4%	38.4%
Binge Drinking	28.8%	27.1%	25.3%	23.9%	24.9%	23.8%	22.0%
Marijuana	23.4%	22.1%	20.7%	18.3%	18.6%	20.9%	20.5%
Cocaine	3.0%	2.7%	2.4%	2.2%			
Cigarettes	31.8%	26.0%	20.2%	16.2%	13.8%	14.8%	12.5%

NSDUH provides New York prevalence estimates for adults and youth from 2002-2003 to 2008-2009 (survey results are reported as two-year averages). These data do not show a definitive long term trend in substance use, with the exception of increases in the non-medical use of prescription painkillers and decreases in cigarette smoking. In general, substance use among young adults (ages 18-25) is substantially higher than among youth (ages 12-17), with older adults (age 26 and older) reporting the lowest use.

NSDUH found that New York was one of only three states that experienced statistically significant increases between 2007-2008 and 2008-2009 in the percent of residents who reported having used a pain reliever non-medically in the past year. Trend analyses reveal that New York was one of four states that experienced a statistically significant increase in the non-medical use of pain relievers among residents 12 and older, from 3.72 in 2002-2003 to 4.37 in the 2008-2009 survey years. Among age groups, New York State's 18-25 year olds have the highest rate of past year non-medical use of pain relievers, which increased from 10.45 in 2007-2008 to 12.05 in 2008-2009. This increase was paralleled by an increase of similar statistical significance occurring among 18-25 year olds residing in the Northeastern region of the U.S. (from 11.07 to 12.00).

The percent of New York State residents, 12 and older, who reported use of a tobacco product in the past month, did not significantly change from 2007-2008 (24.39 percent) to 2008-2009 (24.58 percent) while seven states experienced statistically significant declines, and no state

experienced a statistically significant increase. Similarly, the percent of New York State residents, 12 and older, who reported cigarette use in the past month, remained essentially the same (21.27 in 2007-2008 and 21.32 in 2008-2009), while six states experienced statistically significant declines, and no state experienced a statistically significant increase. Given that New York, along with a few other states including California and Massachusetts, had rates of smoking and tobacco use lower than that of any of the other states in 2007-2008, the absence of any subsequent statistically significant declines in cigarette and tobacco use for New York is not surprising. Furthermore, trend analysis of earlier NSDUH surveys indicates that New York State experienced statistically significant declines in past month tobacco and past month cigarette use between 2005-2006 and 2006-2007. Past month rates of cigarette smoking among all age groups declined during the 2002-03 to 2007-08 time period. Young adults ages 18-25 experienced the most pronounced decline in current smoking rates, from 40 percent (2002-03) to 33 percent (2008-09). Residents of the Upstate Metropolitan and Rural New York regions are more likely to have smoked cigarettes in the past month compared to residents of New York City or the New York Metropolitan Suburban region.

According to NSDUH, the percent of New York State residents 12 and older who reported use of an illicit drug other than marijuana in the past month was stable (3.54 in 2007-2008; 3.65 in 2008-2009), while six states experienced statistically significant declines, and five states, statistically significant increases. Trend analysis of earlier NSDUH surveys indicates that New York State has remained stable on this indicator since 2002-2003 (i.e., any changes that did occur were not statistically significant). In 2008-2009, eight percent of young adults, ages 18-25, used illicit drugs other than marijuana in the past month, compared to three percent of adults older than age 26. No significant difference was found among New York State regions in the rate of adults using illicit drugs other than marijuana in the past month.

Regarding past month marijuana use, the percent of New York State residents 12 and older who currently smoke marijuana has remained relatively stable since 2002-2003. One-in-five (20 percent) of young adults ages 18-25 used marijuana in the past month, compared to one-in-twenty (5 percent) of older adults older than age 26. No significant difference was found among New York State regions in the rate of adults using marijuana in the past month. It must be noted that New York State experienced a statistically significant decline in the percent of residents ages 12 and older, who reported perceiving great risk in smoking marijuana once a month in 2008-2009, and a decline of similar statistical significance occurred for the nation as a whole during this same time period. Since prevention research has demonstrated that attitudes of perceived risk influence behavior, New York State will most likely experience increasing rates of marijuana use among residents of all age groups in future years.

NSDUH found the percent of New York State residents, 12 and older, who reported having engaged in binge drinking[5] in the past month, remained virtually the same (23.25 percent in 2007-2008; 24.08 percent in 2008-2009). No state experienced an increase in binge drinking that was statistically significant, and only two states experienced statistically significant declines. However, given that both of these states had rates of binge drinking that exceeded that of any

[5] Binge Alcohol Use is defined as drinking five or more drinks on the same occasion (i.e., at the same time or within a couple of hours of each other) on at least 1 day in the past 30 days.

other state in 2007-2008; their declines were not totally unexpected. Trend analysis of earlier NSDUH surveys indicates that the rate of binge drinking among New York State residents has remained stable since 2002-03. The most recent New York State data from NSDUH collected in 2008-2009 indicated that almost half of young adults age 18-25 engaged in binge drinking in the past month while less than one-quarter of adults older than 26 did so. Analysis based on New York State's four epidemiological regions indicates that, on average, New York City adults are less likely to engage in binge drinking in the past month than adults in other regions.

The percent of New York State residents 12 and older who reported having had at least one drink of alcohol in the past month stayed the same (55.28 in 2007-2008; 55.71 in 2008-2009) while five states experienced increases that were statistically significant, and only one state experienced a statistically significant decline. Trend analysis of earlier NSDUH surveys indicates that the past month alcohol use among New York State residents has remained stable since 2002-03.

Cocaine use in the past year among New York State residents, 12 and older, was unchanged (2.60 in 2007-2008; 2.66 in 2008-2009) while 11 states experienced statistically significant declines. Significant declines also occurred in the nation as a whole and in every region except the northeast. Only one state experienced a statistically significant increase. Trend analysis of earlier NSDUH surveys indicates that New York State has remained stable on past year use of any type of cocaine since 2002-2003.

Consequences of Substance Abuse

The consequences of substance abuse affect millions of New York State residents annually. The individual, societal, and economic costs include lost earnings and productivity; increased health care spending; alcohol and other drug related automobile crashes and other accidents; and increased need for law enforcement, corrections, and social services.

New York was the only state that experienced a statistically significant increase in the percent of residents, 12 and older, who fulfilled the diagnostic criteria of past year alcohol dependence or abuse (from 7.06 to 7.88) during the years 2007-08 to 2008-09. Analysis of the New York State findings by age indicates that the statistically significant increase was limited to residents 26 and older. New York was also the only state that experienced a statistically significant increase in the percent of residents, 12 and older, who fulfilled the diagnostic criteria of past year substance use disorder (i.e., dependence on or abuse of either alcohol or illicit drugs) (from 8.82 to 9.53).

New York was the only state that experienced a statistically significant increase in the percent of residents, 12 and older, who qualified as needing but not receiving treatment for alcohol use in the past year[6] (from 6.63 to 7.40) during the years 2007-08 to 2008-09. In contrast to the most recent increases described above, trend analyses of earlier NSDUH surveys indicate that the percentage of residents of New York State who fulfilled the diagnostic criteria of past year

[6] Needing But Not Receiving Treatment refers to respondents classified as needing treatment for alcohol, but not receiving treatment for an alcohol problem at a specialty facility (i.e., drug and alcohol rehabilitation facilities [inpatient or outpatient], hospitals [inpatient only], and mental health centers).

alcohol use or substance use disorder or who qualified as needing but not receiving treatment for alcohol use remained virtually unchanged from 2002-2003 through 2007-2008.

The percent of residents, 12 and older, who qualified as needing but not receiving treatment for illicit drug use in the past year[7] remained stable (2.76 in 2007-2008; 2.80 in 2008-2009) while only two states experienced statistically significant declines, and no state experienced a statistically significant increase. Trend analysis of earlier NSDUH surveys indicates that New York State has remained stable on this indicator since 2002-2003.

In 2009, law enforcement officials made 51,016 drinking driver arrests in New York State. Statewide, DWI arrest rates reached a high of 35.4 per 10,000 adult residents in 2006, but declined slightly to 33.8 in 2009. The New York City drinking driver arrest rate more than doubled since 2002, reaching 15.7 in 2007, but then declined slightly to 14.7 in 2009. However, even with this dramatic increase, the New York City arrest rate is less than half the statewide rate. The Rural New York drinking driver arrest rate has declined slightly since 2002, but it is still more than double the statewide rate, at 67.9 DWI arrests per 10,000 adult residents in 2009.

The *2006 OASAS School Survey* indicated that one-in-six high school students 16 and older drove under the influence of alcohol or another drug in the past year. New York City students 16 and older were half as likely as students in the rest of the state to have driven under the influence of alcohol or other drugs in the past year (11 percent vs. 22 percent). The *2006 OASAS Household Survey* found that one-in-eight young adults (18-25) drove a vehicle after drinking or using drugs in the past year.

In 2009, there were 140,599 adult arrests for drug offenses in New York State, a rate of 92.6 arrests per 10,000 adult residents. Although the statewide arrest rate has fluctuated during the 2002-2009 time period, the current drug arrest rate is nearly identical to the 2002 figure of 93.7. The 2009 New York City drug arrest rate of 168.5 is slightly lower than the 2002 figure of 177.9, the highest drug arrest rate during the 2002-2009 time period. Drug arrests in New York City reached their lowest rate of 139.8 arrests per 10,000 residents in 2004. The rest of New York State shows a different trend, with drug arrests increasing from 2002 until 2006, and then decreasing slightly from 2006 to 2009. Drug arrest rates were still higher in 2009 than in 2002 for all of the regions outside New York City. In 2009, the New York Metro Suburban region reported a drug arrest rate of 35.8, per 10,000 residents, while the Upstate Metro Region experienced an arrest rate of 40.0, with Rural New York reporting 24.6 drug arrests per 10,000 residents.

The *2006 OASAS School Survey* indicated that one-in-twenty students in grades 7-12 physically assaulted someone due to the influence of alcohol or drugs in the past year while a similar number got into trouble with the police due to alcohol or drug use. These rates did not vary significantly between New York City and the rest of the state. The *2006 OASAS School Survey*

[7] Needing But Not Receiving Treatment refers to respondents classified as needing treatment for illicit drugs, but not receiving treatment for an illicit drug problem at a specialty facility (i.e., drug and alcohol rehabilitation facilities [inpatient or outpatient], hospitals [inpatient only], and mental health centers). Illicit Drugs include marijuana/hashish, cocaine (including crack), inhalants, hallucinogens, heroin, or non-medical use of prescription-type psychotherapeutics.

also found that one-in-five students in grades 7-12 attended class while intoxicated on alcohol, marijuana, or other drugs in the last six months and 1-in-25 students got into trouble with his or her teachers because of drinking or drug use in the past year. There was no significant difference between New York City and the rest of the state in the percent of students attending class while intoxicated or getting into trouble with teachers due to drinking or drug use.

System Facts: Prevention

PARIS is a web-based information system that supports the annual planning and approval process, service delivery data reporting, and performance measurement of OASAS-funded prevention providers. The annual prevention work plan approval process with review by county and OASAS Field Office program managers produces activity data collection templates for the planned services used by providers to report monthly service delivery. PARIS captures direct service activities reported to OASAS by 184 funded prevention providers.

A distinguishing feature of PARIS is the integration of the planning and activity reporting functions. Each provider is required to conduct an assessment of community needs, describe the populations affected by risk and protective factors for substance abuse, and then select service approaches for targeted groups of individuals or communities. The OASAS state and county review and plan approval process supports the coordination of prevention activities in each county and New York City. When the work plan is approved, a data collection module is automatically formatted for each service contractor and is ready for monthly activity reporting.

In spring 2012, OASAS began testing of a community coalition module in PARIS to incorporate information from providers of indirect and capacity building prevention services such as those delivered by the regional Prevention Resource Centers (PRCs) and by 11 federally funded SPF SIG community coalitions. As this module is enhanced and refined, it will be made available to all 120 substance abuse prevention community coalitions in the state.

Providers Deliver Comprehensive Prevention Services Approaches

1. <u>Evidence-Based Programs/Strategies (EBPS) Classroom Education:</u>

   These are multi-component programs that include classroom and group educational curricula that have been researched and shown to reduce youth substance use and abuse. These programs increase family and youth understanding of the consequences of substance use, improve drug use and other problem behavior attitudes, and teach drug refusal and other social competency skills. Many of them also reduce youth violence and delinquency. Examples are:

   - LifeSkills Training
   - Project SUCCESS
   - Too Good For Drugs
   - Reconnecting Youth.

2. Non-EBPS Classroom Education:

These programs are often similar to EBPS classroom education but have been locally developed or otherwise have not been rigorously evaluated for effectiveness in meeting the OASAS Prevention outcomes.

3. Prevention Counseling:

This service is for youth who are assessed at elevated risk levels and/or have begun using illicit substances and may require an early intervention or referral to more intensive services. Components of prevention counseling include assessment and referral, individual counseling, group counseling, and family counseling. Counseling assessment data in PARIS includes risk factors and alcohol and substance use as well as other service needs.

4. Positive Alternative Activities**:**

These programs consist of drug free pro-social, constructive, and healthy activities that provide opportunities for positive social bonding. These activities can complement EBPS education and decrease the attraction to alcohol, tobacco, and other drugs. Examples are fitness-sports, arts, and cultural-multicultural activities that help to develop a healthy lifestyle.

5. Information Dissemination:

Information dissemination for general and targeted populations can raise awareness about the issues of substance abuse and problem gambling and support for intervening. Information is disseminated through community meetings and events or through media technologies such as newsletters, print media, video, radio, television, or the internet.

6. Community Capacity Building:

These services aim to enhance the ability to more effectively plan, provide, and integrate comprehensive substance abuse and problem gambling prevention services within the community. Examples of these activities include training, technical assistance for schools and social providers, law enforcement, or other groups and community coalition building activities.

7. Environmental Strategies:

Environmental strategies are sets of evidence-based prevention activities that are implemented to: 1**.** improve or develop regulations and policies regarding alcohol/substance use and gambling; 2. increase compliance with regulations and policies to reduce the availability of alcohol, tobacco, other substances, and underage gambling; and 3. change community norms regarding alcohol/substance abuse and problem

gambling. Examples include alcohol outlet/retail lottery sales compliance checks, advertising restrictions, and social norms marketing.

8. Early Intervention Strategies:

Early Intervention services are designed to address substance use initiation behaviors that put a person at high risk for developing a substance addiction. Early Intervention can be effective for Institute of Medicine (IOM) Indicated populations; *i.e.*, those individuals who have demonstrated early involvement with substance use and/or have risk factors that put them at elevated risk for developing addictions. Early Intervention services may include screening and referral to treatment services, but are not a substitute for treatment services. Examples of early interventions include the EBPS Teen Intervene program and the New York State Alcohol Awareness Programs (AAPs).

Prevention Activity Data for 2011

Provider/PRU Count

- OASAS prevention providers deliver addiction prevention services mainly to youths and young adults through designated entities called Program Reporting Units (PRUs). Individual programs may provide multiple services in a county.

- A total of 274 PRUs delivered prevention services in 2011 with the highest number (246) delivering classroom education -EB services and the least (68) delivering Early Intervention services (**Figure 4.2**).

Figure 4.2 PRU Count by Service Approach

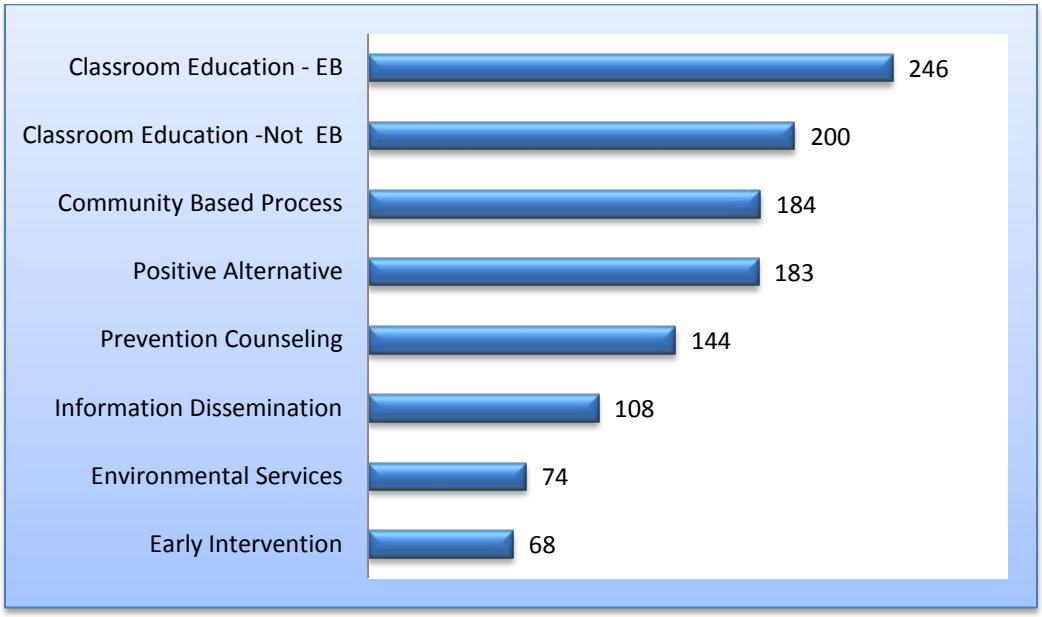


Table 4.3 Service Approach Percentages

Service Approach	PRU Count	
	n	%
Classroom Education - EB	246	90%
Classroom Education -Not EB	200	73%
Community Based Process	184	67%
Positive Alternative	183	67%
Prevention Counseling	144	53%
Information Dissemination	108	39%
Environmental Services	74	27%
Early Intervention	68	25%
Total Number of PRUs	**274**	

EB = Evidence-Based. Percentages do not add up to 100 percent because individual PRUs deliver multiple programs.

Participant Count:

- Substance Abuse prevention service approaches are broadly classified in two major categories: Direct (Youth/Family targeted) and Indirect (Environmental or system capacity building) services. A total of 463,527 participants received a direct prevention service during the 2011 activity year (**Table 4.4**).

- Classroom Education – EB, which was adopted by 90 percent of PRUs, was correspondingly delivered to the largest number of participants receiving direct services in 2011 (260,125).

Table 4.4

Participant Count by Service Approach for Direct Services, 2011

Service Approach	N	%
Classroom Education-EB	260,125	56%
Classroom Education-Not EB	104,198	22%
Early Intervention	1,633	0.4%
Positive Alternative	54,621	12%
Prevention Counseling	42,950	9%
Total	463,527	

Activity Count:

- There were a total of **499,609** sessions, events, and activities delivered in 2011. Of these, 57 percent (**286,107**) were direct service activities and 43 percent (**213,502**) were indirect services (**Table 4.5**).
- Over one-third (39%) of the direct service activities delivered during the year were EBPS Classroom Education sessions, followed by Prevention Counseling sessions (26%).

- Two prevention service approaches that have outcome research that provides documented evidence of effectiveness in reducing substance abuse (called Evidence-Based Programs and Strategies, or EBPS) are multi-component programs that include Classroom Education and Environmental strategies (**Table 4.5**).
- Since the research was available (1998), providers have been given guidance regarding the benefits of providing EBPS. Since then, OASAS has compiled a "toolkit" of over 60 different EBPS. In 2010, EBPS accounted for 26 percent of the total activity output, up from 14 percent in 2009. In 2011, OASAS policy required providers to allocate a minimum of 35 percent of staff effort Full-Time Equivalent (FTE) to EBPS and this metric was achieved. In 2011, 64 percent (Classroom Education – EB and Environmental) of total output was EBPS.

Table 4.5 Activity Count by Service Approach, 2011

Service Approach	n	%
Classroom Education-EB	110,379	39%
Classroom Education-Not EB	55,637	19%
Early Intervention	829	0.3%
Positive Alternative	45,039	16%
Prevention Counseling	74,223	26%
Total	**286,107**	**57%**
Environmental	207,640	97%
Information Dissemination	5,862	3%
Indirect Total	**213,502**	**43%**
Grand Total	**499,609**	

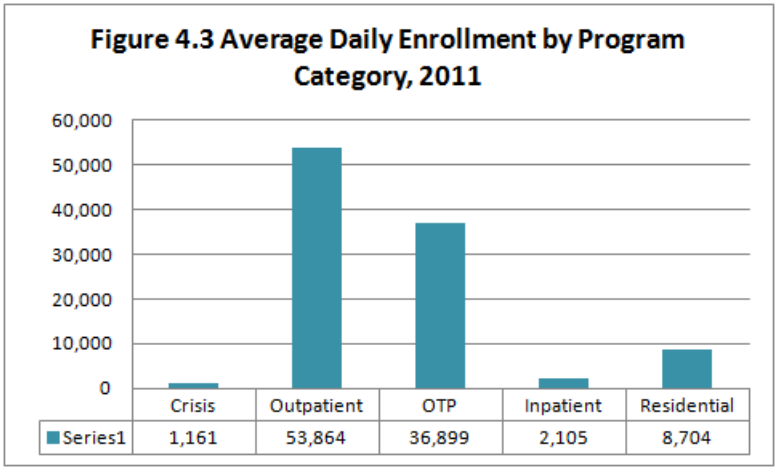
System Facts: Treatment

Nature of the Problem

- OASAS estimates that 12 percent of the New York State (NYS) population age 12 and over or nearly two million people have a substance use disorder.
- Thirty percent of those with a substance use disorder, or 582,000 people, would seek treatment in an OASAS-certified program if it were available.

System Summary

- In 2011, there were 303,245 admissions to OASAS-certified chemical dependence (CD) treatment programs. Almost half of those admissions were to outpatient programs (46%), followed by crisis (30%), inpatient (13%), residential (8%), and opioid treatment programs (OTPs) (4%), which were formerly known as methadone programs.
- Average daily enrollment was 102,737 mostly in outpatient programs (52%) and OTPs (36%) (**Figure 4.3**).



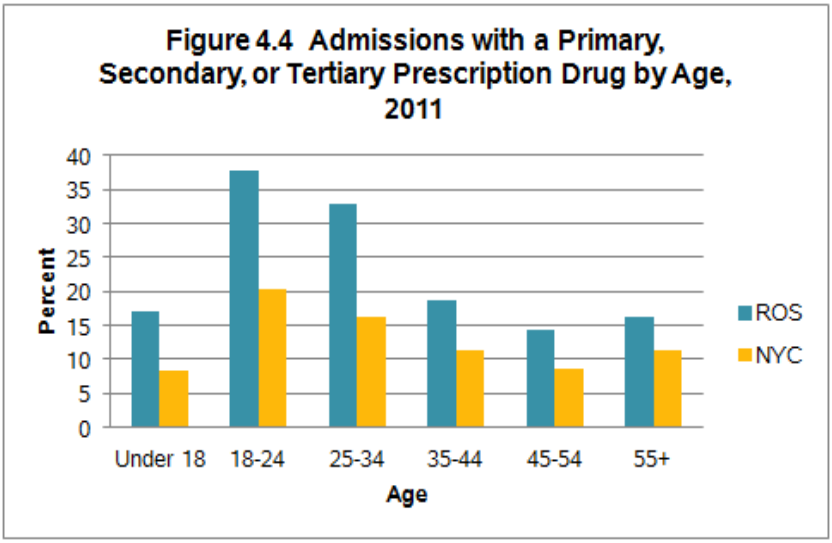
- 253,807 unique individuals received treatment in NYS during 2011.
- As shown in **Table 4.6**, there are just under 1,000 OASAS-certified chemical dependence treatment programs in NYS. Approximately half (51%) of those programs are outpatient programs.

Table 4.6 Program Count by Region and Program Category

Region	Crisis	Inpatient	OTP	Outpatient	Residential	Total
Central	6	7	1	37	30	81
Finger Lakes	6	7	4	42	30	89
Long Island	7	7	8	79	14	115
Mid-Hudson	15	14	10	69	32	140
New York City	34	12	86	186	70	388
Northeastern	4	7	3	50	31	95
Western	5	8	4	48	22	87
Total	77	62	116	511	229	995
Percent of Total	8%	6%	12%	51%	23%	100%

Client Characteristics

- Seventy-five percent were male.
- One-quarter of admissions were ages 45-54, followed by 25-34 (24%), 35-44 (23%), 18-24 (15%), 55 and over (9%), and under 18 (4%).
- Alcohol was the most common primary substance (43%), followed by heroin and other opioids (27%), marijuana (17%), and cocaine/crack (11%).
- Two-thirds (66%) of admissions had two or more problem substances.
- Nineteen percent reported a prescription drug as a primary, secondary, or tertiary substance. 18-24 year olds were most likely to report a prescription drug as a problem substance (**Figure 4.4**).

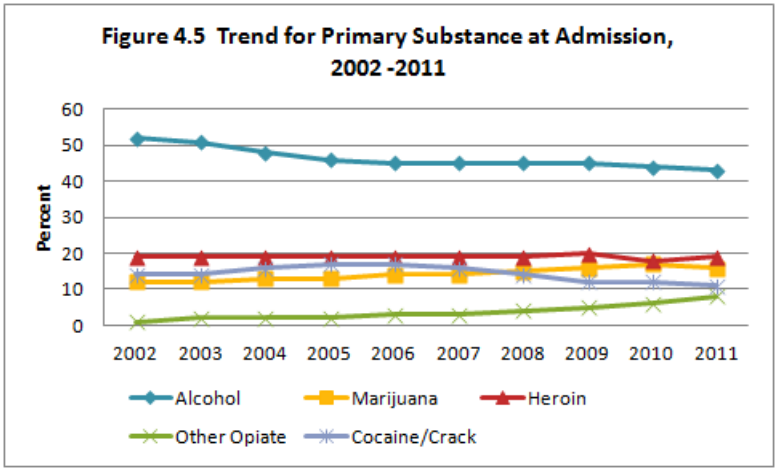


- Just over one-third (35%) of admissions reported a primary, secondary, or tertiary opioid.
- Forty-five percent were White non-Hispanic, 32 percent Black non-Hispanic, 20 percent Hispanic, and 3 percent other non-Hispanic.
- Thirty-nine percent of admissions were high school graduates, 35 percent had less than a high school education, and 27 percent had more than high school.
- Twenty-two percent were employed, 19 percent were unemployed, and 59 percent were not in the labor force.
- Forty-five percent were identified as having a co-existing psychiatric disorder or had ever been treated for a mental illness at admission.
- Eighteen percent were homeless.
- Three percent reported being a veteran.
- The most common referral source was self (35%), followed by criminal justice (21%), other CD programs (15%), health care/social services (12%), CD prevention/intervention (3%).
- Fifty-two percent of non-crisis admissions had criminal justice involvement.
- Seventeen percent reported living with children.[3]
- Seventy-one percent reported using tobacco at admission.
- Over half of discharges paid with Medicaid (57%), followed by none (12%), private insurance (12%), self (8%), DSS Congregate Care (5%), and other (5%).
- Thirty-two percent of outpatient, 68 percent of inpatient, and 36 percent of residential discharges completed treatment.
- Median length of stay for those who completed treatment was 185 days for outpatient, 26 days for inpatient, and 187 days for residential.

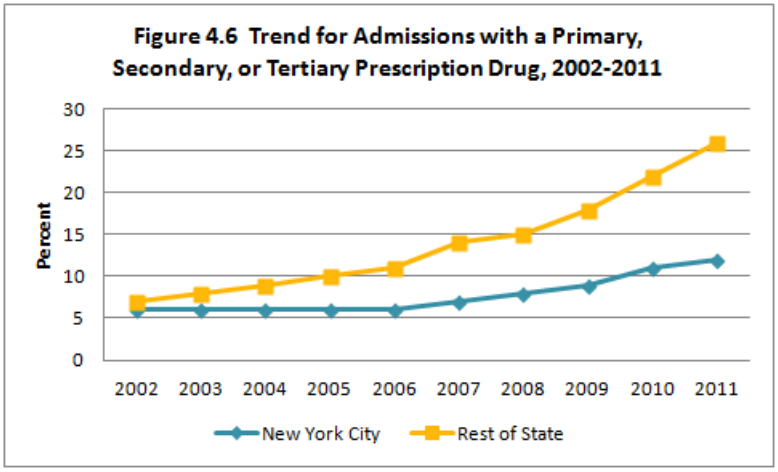
Notable Trends

- The percentage of outpatient admissions has increased from 41 percent to 46 percent, while the percentage of crisis admissions has decreased from 33 percent to 30 percent between 2002 and 2011.

- From 2002 to 2011, the percentage of admissions who reported alcohol as their primary substance decreased from 52 percent to 43 percent, while other opiates increased from 1 percent to 8 percent (**Figure 4.5**).



- As shown in **Figure 4.6**, from 2002 to 2011, the percentage of admissions who had a primary, secondary, or tertiary prescription drug increased from 6 percent to 12 percent for New York City (NYC) residents and 7 percent to 26 percent for rest of state (ROS) residents.



Geographic Comparisons

When comparing those who live in NYC to those who live in the rest of the state, those who live in NYC were:

- More likely to be male (80% vs. 70%).
- Less likely to be age 25 or under (13% vs. 30%).
- More likely to be non-Hispanic Black (45% vs. 20%) or Hispanic (32% vs. 10%).
- More likely to be admitted to a crisis program (41% vs. 21%) and less likely to be admitted to an outpatient program (34% vs. 56%).

- Less likely to have completed high school (57% vs. 72%).
- More likely to be homeless (27% vs. 10%).
- More likely to have a primary substance of heroin (23% vs. 15%) and less likely to have a primary other opiate (3% vs. 12%).
- Less likely to have a primary, secondary, or tertiary prescription drug (12% vs. 26%).
- Less likely to have a co-occurring mental health disorder (39% vs. 49%).
- Less likely to have criminal justice involvement (41% vs. 58%).
- More likely to pay with Medicaid (66% vs. 49%) and less likely to pay with private insurance (19% vs. 5%).
- Less likely to complete treatment in residential (29% vs. 44%), outpatient (28% vs. 34%), and inpatient (64% vs. 70%) programs.

Recovery

Few studies exist that attempt to estimate the number of individuals in recovery from addictive disorders. NSDUH provides estimates of the number of Americans 12 or older in need of treatment for alcohol or illicit drug problems in the past year as well as those who received treatment, but does not provide information about recovery status.

The *2001-02 National Epidemiologic Survey on Alcohol and Related Conditions (NESARC)* sponsored by the National Institute on Alcohol Abuse and Alcoholism (NIAAA) provides a basis for a national estimate of the number of persons in remission from alcohol dependence. The epidemiological literature based on NESARC has defined "persons in remission" from alcohol dependence as persons who have had an alcohol dependence condition in their lifetime based on having met at least three of the seven Diagnostic and Statistical Manual of Mental Disorders Fourth Edition (DSM-IV) criteria in the same year but have not met any of the DSM-IV criteria for alcohol dependence or abuse in the past year. According to this definition, abstinence is not a requirement. In fact, fewer than half of the persons who meet this definition were abstinent in the past year.

The published literature based on NESARC does not directly provide an estimate of the number in remission from alcohol dependence. However, careful analysis of this literature indicates that five to six percent of the adult population is "in remission" from alcohol dependence, which constitutes 11 to 13 million Americans with about two percent of the adult population, five million Americans, abstinent in the past year. These rates applied to New York would mean that 754,000 to 905,000 adult New Yorkers are in remission from alcohol dependence with about 302,000 adult New Yorkers abstinent in the past year.

Please note that the analysis described above is limited to alcohol dependence and does not include persons in remission from the more prevalent condition of alcohol abuse[8] or the conditions of dependence on or abuse of illicit substances or prescribed medications used non-medically. OASAS obtained a copy of the NESARC data set and is conducting a secondary analysis to determine the extent to which estimates can be made for remission from alcohol

[8] Defined in terms of the occurrence of at least one symptom of at least one of four Diagnostic and Statistical Manual of Mental Disorders Fourth Edition (DSM-IV) criteria in any given year.

abuse as well as dependence on or abuse of substances other than alcohol and whether more accurate figures for New York can be developed through synthetic estimation methods. Our preliminary analysis of NESARC data suggests that about seven percent of the U.S. adult population met criteria of remission from dependence on alcohol, and/or illicit drugs, and/or prescription drugs used non-medically while 21 percent met criteria of remission from dependence or abuse on alcohol, and/or illicit drug, and/or prescription drugs used non-medically. A comparison of these estimates to more global recovery estimates based on self-reports is provided below.

Multistate Recovery Survey

OASAS is sponsoring development of a Multistate Recovery Survey through The Partnership for a Drug Free America. The aims of this survey are to: capture the experiences and needs of individuals in recovery; characterize the diversity of recovery paths and experiences; identify barriers to recovery; resources valuable in initiating and maintaining recovery; and service needs as recovery unfolds. Forty-six Single State Agencies (SSAs) have indicated a desire to participate in the Multistate Recovery Survey. If funded, the Multistate Recovery Survey will provide each participating state with information about persons in recovery in its state. This will enable the SSA to develop strategies for transforming to a recovery-oriented system of care (ROSC) based on the needs of its recovering population and the resources available in its communities.

To facilitate development of this survey, OASAS contracted with the Partnership to implement a series of preparatory studies including focus groups, individual interviews with persons in recovery, and obtaining national estimates of the size of population in recovery (based on self-identification) through the use of a brief household survey (Opinion Research Corporation's CARAVAN® random-digit-dial omnibus survey) of 2,526 adults, 18 years of age and older living in private households in the continental United States conducted in February of 2011. The survey found that ten percent of all American adults, ages 18 and older, consider themselves to be in recovery from drug or alcohol abuse problems.[9] These nationally representative findings indicate that there are 23.5 million American adults who are overcoming an involvement with drugs or alcohol that they once considered to be problematic. This estimate is lower than our estimate of 21 percent in remission based on DSM-IV criteria of dependence or abuse on alcohol, and/or illicit drug, and/or prescription drugs used non-medically but higher than our estimate of 7 percent based on DSM criteria of dependence. However, all three estimates suggested higher rates of recovery/remission among males. All three estimates also suggested higher rates among 35-44 year olds compared with 18-34 year olds or people 55 or older.

The Partnership provided OASAS with reports of findings from this study as well as the other studies conducted as part of its contract with the agency. It developed a revised grant proposal package and will continue to seek federal and private foundation sponsors to support the research.

[9] Defined as an affirmative response to the question, "Did you once have a problem with drugs or alcohol, but no longer do?"

Chapter V: County Planning

New York State Mental Hygiene Law requires all counties and the City of New York to develop and annually submit a local services plan to each state mental hygiene agency. OASAS, OMH, and OPWDD are each required to "guide and facilitate the process of local planning." Historically, each agency conducted its own local planning process and established its own requirements for local compliance.

In 2007, the three state agencies and the CLMHD established the Mental Hygiene Planning Committee and began an effort to streamline and integrate the three separate processes. That year, OASAS and OMH integrated their local planning processes, and in 2008 the OPWDD local planning process was integrated. For the past five years, the three state agencies have worked collaboratively to ensure that local mental hygiene services are planned in a unified and fully integrated manner.

In addition to the annual plan submitted by the LGUs, OASAS actively includes its certified and funded service providers in the local planning process. Each year, OASAS conducts a small number of planning surveys that help to inform a variety of special initiatives or ongoing work of the agency. For example, this year providers were asked to complete surveys on outcomes management practices, domestic violence assessment tools, electronic health records, evidence-based practices, and serving the lesbian, gay, bisexual and transgender (LGBT) population. This chapter contains summary analyses of each of these surveys as well as an analysis of the priority outcomes on which the counties are focusing their planning and system management efforts.

County Priority Outcomes

Since the integration of the mental hygiene local services planning process, county planning efforts have increasingly focused on the needs of individuals with multiple disabilities who may need services from multiple systems. As a result of this shift in focus, the number of county priorities included in the local services plans that address some level of cross-system collaboration, service integration, or care coordination has increased each year. The percentage of priorities that similarly address the needs of individuals served by the separate disability systems, such as housing, advocacy, and other support services has also increased. Overall, 66 percent of the priorities submitted in the current planning cycle were associated with multiple mental hygiene disabilities, while 45 percent were associated with all three disabilities.

In the five years of integrated planning, the percentage of single disability priorities dropped by 68 percent while multiple disability priorities increased by five percent. This year, counties continued to focus their planning efforts more directly on those outcomes that most affect persons with co-occurring disorders who may need services from multiple systems, or persons within each system that may need similar services (e.g., housing, transportation, employment).

To support the greater focus on cross-system planning and the development of priorities and strategies across disability service systems, the *2013 Local Services Plan Guidelines for Mental Hygiene Services* provided counties with a streamlined reporting form and clearer guidance on the development of meaningful priority outcomes and strategies. The expectation was that plans

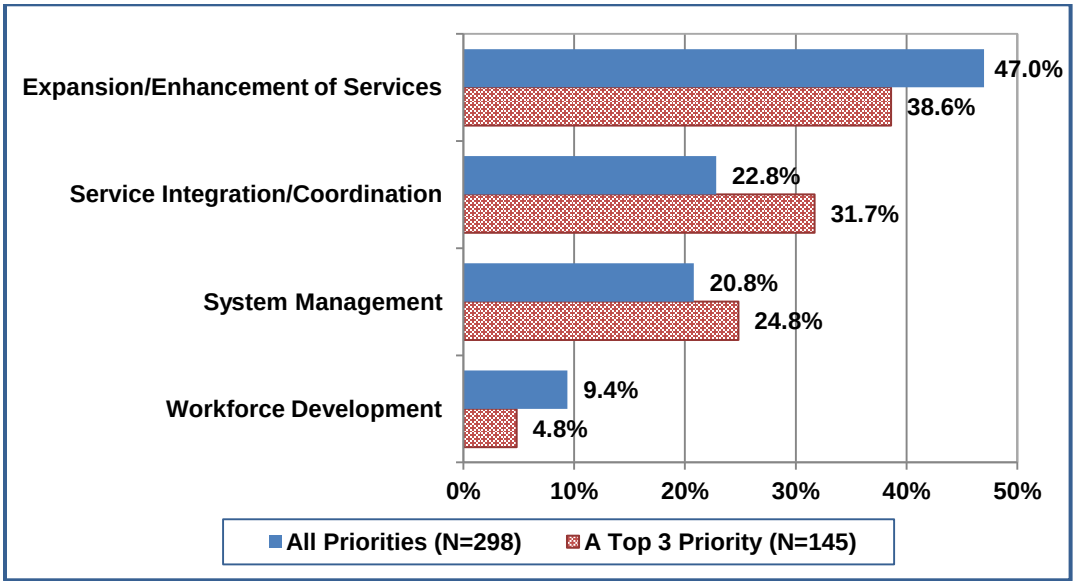
would be more focused and integrated, would result in fewer overall priorities, and would better inform the comprehensive statewide planning efforts of the three state mental hygiene agencies.

This year, county plans included a total of 427 priority outcomes, which was down 33 percent from the previous year and 41 percent from the first year of integrated planning. The reduction in the number of priorities is primarily due to the continued consolidation of priorities that are common to multiple disability areas. With fewer resources available to county mental hygiene agencies and so much attention focused on systemic changes brought about by health care reform and Medicaid redesign, most counties have fewer priorities in their plan that reflect a more realistic set of targeted outcomes. This year, 72 percent of county plans included fewer priorities while only ten percent had more. The average number of priorities dropped from 11.5 to 7.5.

The 2013 local services plans included a total of 305 priorities for which OASAS was indicated as an associated disability agency. A careful review of those priorities brought that number down to 298. The following summary analysis is based on the 298 priorities. Of those, 41 (14%) identified only OASAS as an associated disability agency, while 70 (23%) identified OASAS and OMH together, and 186 (62%) identified all three disability agencies. There was only one priority that identified OASAS and OPWDD together.

As **Figure 5.1** shows, all priorities were sorted into four broad categories. While many priorities covered multiple categories, a primary category was determined for each. This year, counties were also asked to designate their "top three" priorities overall. In previous years, counties were asked to designate their top two priorities in each disability. In another effort to streamline this process and limit the number of priorities, counties no longer needed to designate top priorities in each disability category. In the absence of a rank ordering of all priorities, this designation provides the state agencies with the only means to assign relative weight to the priorities.

Figure 5.1: 2013 County Priority Outcomes by Category (N=298)

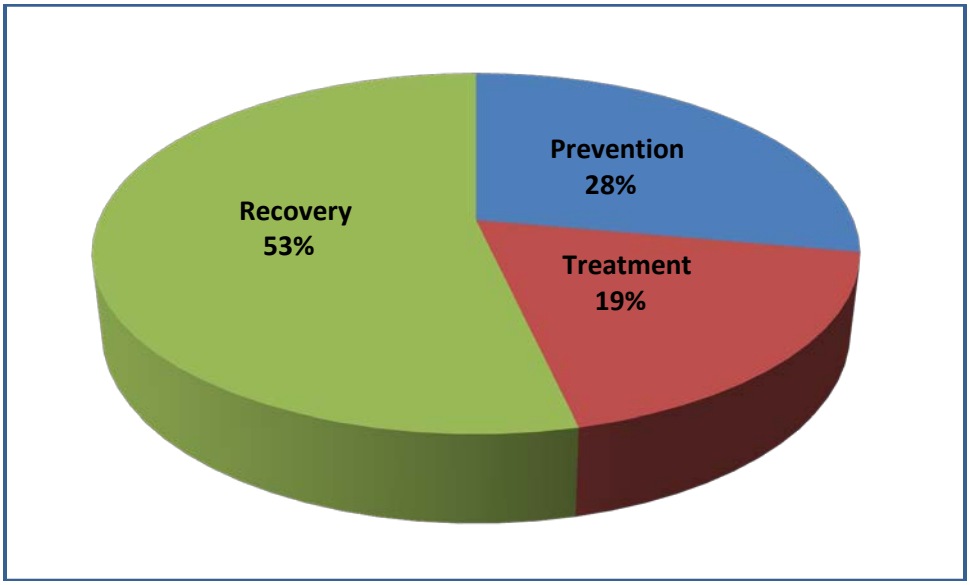


The largest category of priorities included those related to expanding or enhancing prevention, treatment, and recovery services in the community. These priorities represented 47 percent of the total and 39 percent of those designated as a top priority. Priorities related to service integration and coordination represented about 23 percent of all priorities, but 32 percent of the top priorities. Sixty-eight percent of all priorities in this category were designated as a top priority. Priorities related to system management represented only about 21 percent of the total, but 60 percent of those were designated as a top priority. Finally, fewer than one in ten priorities related to the addiction workforce, and only 25 percent of those were designated as a top priority.

Expansion/Enhancement of Services (N=140)

The largest grouping of county priorities was classified as expanding or enhancing existing program services. A number of these priorities cast a wide net and covered multiple service categories. In almost all of those situations, a review of the associated strategies allowed each priority to be categorized as primarily prevention, treatment or recovery. As **Figure 5.2** shows, 53 percent of those priorities related to recovery support services, while 28 percent related to prevention services and 19 percent to treatment services. While there were fewer priorities related to treatment services, that sub-grouping had the highest percentage of designated top priorities (48%), compared with recovery (42%) and prevention (38%).

Figure 5.2: 2013 County Priority Related to Service Enhancement (N=140)



Prevention Services:

There were 39 county priorities focused on prevention services. The area most frequently addressed was suicide prevention, which was identified in over a third of all prevention priorities. A number of counties have been struggling with teen suicides in recent years and it has become a more important local prevention issue in both the mental health and chemical dependence service systems. Most strategies involve a countywide cross-system approach that included education, identifying warning signs and stressors, assessment, and finding evidence-

based practices that can be incorporated into existing prevention programming. One county also linked the need for violence prevention along with suicide prevention.

Another seven priorities specifically addressed underage drinking, with several of them focused on implementing environmental strategies. One county wants to provide Alcohol Basic Training to servers and another county stressed the need to focus more effort on enforcing underage drinking laws. Four counties identified a priority that addresses compulsive gambling, while two others focused on reducing the use of synthetic drugs, and one each addressing opioid overdoses, tobacco use, and prescription drug misuse.

The three primary strategies for addressing prevention priorities included implementing evidence-based practices and environmental strategies, establishing new or strengthening existing community coalitions and task forces dedicated to prevention, and continuing to support school- and community-based prevention and education efforts, including wellness and after school programs.

Treatment Services:

There were 26 county priorities focused on treatment services. Half the priorities included strategies to establish a new program or expand existing service capacity, while the other half included strategies to expand access to treatment services. Specific services included: outpatient (5), crisis (4), residential (2), and inpatient (1). Special populations identified in the priorities included: adolescents (8), seniors (1), veterans (1), and persons with co-occurring disabilities (1). Several counties identified priorities related to implementing evidence-based practices in treatment programs, but they are addressed below under workforce development priorities.

Recovery Services:

There were 75 county priorities focused on recovery services. This category includes all the strategies intended to provide support to persons in recovery, including housing, transportation, vocational and educational services, and peer support.

Housing – As in previous years, the need for safe and affordable housing continues to be the single greatest need identified across the state and across all three disabilities. Here, they represent about a third of all recovery support priorities. Thirty-seven counties identified housing as a priority for the chemical dependence service system, with 24 counties designating it as a top three priority. This was also the top priority shared across the three mental hygiene systems. Most housing priorities identified the need to be safe, affordable, and supportive of recovery. As in previous years, priorities included improving access to both transitional and permanent housing options, including licensed and unlicensed sober apartments and single room occupancy units.

Peer Supports – Twenty-eight priorities focused on the need to provide peer support to persons in recovery. Most of these priorities were focused on getting consumers to play a stronger role in their own recovery by being more actively engaged in their treatment and long-term recovery maintenance. Priorities included providing peer supports to help reduce stigma, increase long

term recovery for consumers, and help individuals establish more healthy lifestyles in the community. Using recovery coaches helps to improve one's chances of securing employment, obtaining permanent housing, and establishing healthy relationships. Other priorities focused on the importance of recovery case management, family supports, and peer-to-peer mentoring in achieving long-term positive outcomes.

Vocational Support – Fourteen priorities focused on providing vocational support services to persons in recovery, most identifying the need to expand vocational rehabilitation opportunities throughout the service system or increase access to a range of competitive employment options in the community. Two counties specifically included a priority to have all their contract agencies that provide vocational services utilize the New York State Employment Services System (NYESS).

Service Integration/Coordination (N=68)

Priorities related to the integration or coordination of services represented about 23 percent of all priorities included in this year's plans. While this category had fewer than half the number of priorities related to the expansion or enhancement of services, 79 percent of these were categorized as a "top three" priority, compared with 50 percent for all other categories. Clearly, with Medicaid reform and the establishment of the regional BHOs, the counties have become increasingly concerned with what the future of the chemical dependence service system will look like and what their role will be.

Fourteen counties identified the integration or coordination of behavioral health and physical health as a priority, while another 13 identified the integration or coordination of mental health and chemical dependence services. Five counties had a priority to improve the coordination of services with the criminal justice system and the courts. One county each identified coordination of services with other human service agencies, the schools, and among addiction service providers.

Special populations identified in these priorities were primarily persons with a co-occurring disability with seven identifying adolescents, and one each identifying veterans and seniors.

System Management (N=62)

System management covers all priorities that relate to planning, outcomes management, contract management, and similar activities that pertain to the county's oversight responsibilities of the mental hygiene service system. They only represent about 21 percent of all priorities, but like priorities related to service integration and coordination, a significant majority of them (68%) were categorized as a "top three" priority. Most system management priorities were in the following three areas:

Collaborating with BHOs/Health Homes:

There were 18 priorities focused on working with BHOs and Health Homes to ensure that the network meets the behavioral health needs of county residents. Some priorities focused on

working with providers to optimize the service system's adaptation to the new health care environment and to support the transition from Medicaid fee-for-service to Health Home managed care. Other priorities focused on the importance of LGU and consumer participation on BHO and Health Home advisory committees and task forces and in the analysis of available data, particularly in the development of Health Homes.

Planning and Needs Assessment:

There were 14 priorities that could be categorized as focused on the LGU's responsibility for engaging stakeholders in a broad-based planning process to identify problems and develop strategies to address them. Several counties identified initiating a strategic planning process focused on specific aspects of the service system (e.g., assessing the needs of at-risk populations, strengthening support and advocacy, responding to tragedies within the community, and strengthening the role of the Community Services Board and subcommittees).

Specific populations identified in needs assessment efforts included seniors and adolescents. Two counties included a priority focus on efforts to expand participation of consumers and families on boards, committees, and task forces. One county is studying the current use patterns of Suboxone, and one county is researching care models to improve outcomes for those with serious behavioral health issues.

Performance Management:

There were nine priorities specifically focused on establishing performance outcomes and monitoring progress. These priorities identified data-driven strategies to monitor utilization patterns and Medicaid spending with a focus on improving retention, achieving cost savings, and making quality system improvements. One county will have each contract agency specify performance outcomes and monitor progress.

Other system management priorities included developing or improving the county emergency response plan for mental hygiene services (3), implementing electronic health records or the New York State Clinical Record Initiative Form (2), and restructuring Single Point of Access (SPOA).

Workforce Development (N=28)

There were 28 priorities focused on workforce development. Eight priorities addressed the need to increase the number of clinical staff trained in integrated treatment for co-occurring disorders, including training on evidence-based practices for treating persons with co–occurring disorders (5), and training on the Focus on Integrated Treatment (FIT) training modules (3). Five priorities focused on implementing strategies to promote staff recruitment and retention, three focused on increasing cultural and linguistic competence of mental hygiene service providers, and three focused on providing training to law enforcement and jail personnel on mental hygiene disabilities. Remaining priorities focused on various trains covering wellness and stress management, SBIRT, opioid overdose prevention, and OASAS/OMH policies and procedures.

Electronic Health Records Survey

Health care reform is creating major changes in the way health care will be delivered in the future. One of these changes is the growing adoption of Electronic Health Records (EHRs), which will improve the quality, efficiency, and care coordination of the nation's health care system. An EHR is a computerized record of health information about individual patients. Such records may include a whole range of data in comprehensive or summary form, including medical history, medication and allergies, immunization status, laboratory test results, radiology images, vital signs, personal stats like age and weight, and billing information. Its purpose is to be a complete record of patient encounters that allows the automation and streamlining of the workflow in health care settings and increases safety through evidence-based decision support, quality management, and outcomes reporting. Under health care reform, the federal government identified a number of core requirements that will be components of an EHR.

In the spring of 2012, OASAS conducted a survey of all certified and funded treatment providers to assess their current status on the adoption of an EHR, including whether existing systems included the core federal requirements. The survey also asked providers about the barriers that may have hindered their organization's ability to adopt an EHR and what their understanding was of the potential federal funding opportunity for EHR adoption. The information obtained through this survey will help OASAS to identify how best to assist providers in achieving their participation with this health reform initiative. The survey was conducted as a part of the annual local services planning process. A total of 411 providers were surveyed, with 388 (94.4%) responding.

Adoption of an EHR is a critical component of health care reform and required for meaningful integration of substance use disorder (SUD) treatment with primary care. To assess the current status of the adoption of EHRs within the OASAS-certified treatment system, providers were asked to indicate if they currently utilized an EHR. If they did not currently utilize an EHR, they were asked to indicate the extent to which they were pursuing adoption. As **Table 5.1** shows, 37 percent of all providers responding to the survey indicated that they currently utilized an EHR, while another 28 percent indicated that they were actively pursuing the adoption of an EHR within the next 12 months. About 28 percent indicated that they were interested in adopting an EHR but had yet to actively pursue it. Only about seven percent of respondents indicated that their organization had no plans to adopt an EHR.

Table 5.1: Status of EHR Adoption by Provider Ownership Type

Ownership Type	N	Currently Utilizes An EHR	Actively Pursuing An EHR	Interested But not Pursuing	No Plans To Adopt An EHR
All Ownership Types	385	36.9%	28.3%	28.1%	6.8%
Voluntary	301	35.5%	30.9%	26.6%	7.0%
Proprietary	41	26.8%	24.4%	36.6%	12.2%
Local Government	31	41.9%	19.4%	38.7%	0.0%
State Operated	12	91.7%	0.0%	8.3%	0.0%

Local government and state operated providers were the most likely to have already adopted an EHR, while proprietary for-profit providers were least likely to be utilizing an EHR or actively pursuing one. In fact, proprietary providers were twice as likely as the rest of the treatment system to indicate that their organization had no plans to adopt an EHR.

Providers indicating that their agency currently utilized an EHR or actively pursuing the adoption of an EHR within the next year were asked to identify the product they used or were planning to adopt. Respondents identified a variety of products with Avatar by Netsmart reported by 25 providers, followed by Celerity (21), AWARDS by Foothold Technologies (19), Anasazi (18), and TenEleven Group (17). Others representing at least five percent of the total included Information Management Associates (IMA) (14) and Meditech and Accumedic at 12 each. Other products listed included Netsmart (unspecified), TIER by Netsmart, EPIC, eClinical Works, and Allscripts. Celerity, Accumedic and EPIC were the only products reported more often by providers that were pursuing but had not yet adopted an EHR.

The survey identified 17 separate EHR functions that represent the core federal requirements for adoptability and asked those respondents with an existing EHR whether those functions were incorporated into their system. **Table 5.2** shows the responses ranked by the percentage reporting that the function was incorporated into their EHR.

Table 5.2: Functionality Incorporated into Existing EHR

EHR Functionality	N	Yes	No	Partially	Not Sure
Records patient demographics	139	97.8%	0.0%	2.2%	0.0%
Maintains an up-to-date list of current diagnoses	141	92.2%	3.6%	2.8%	1.4%
Maintains active medication list	140	81.4%	10.7%	5.7%	2.1%
Bills for services	141	80.9%	9.9%	5.7%	3.6%
Records patient smoking	141	80.9%	7.1%	4.3%	7.8%
Implements at least one clinical decision support tool	141	78.0%	9.2%	2.8%	9.9%
Incorporates lab test results into clinical record	140	65.7%	22.1%	7.9%	4.3%
Provides summary care record for transitions in care or referrals	140	62.9%	20.7%	5.0%	11.4%
Generates patient lists by condition for quality improvement, disparity reduction, research, outreach	141	56.0%	19.2%	7.1%	17.7%
Provides patients with an electronic copy of their health information upon request	140	50.0%	29.3%	5.7%	15.0%
Records and charts changes in vital signs	140	48.6%	38.6%	5.0%	7.9%
Implements drug-drug, drug-allergy interactions	140	45.7%	28.6%	5.0%	20.7%
Generates/transmits prescriptions electronically	140	43.6%	47.1%	3.6%	5.7%
Reports quality measures to the state	140	35.0%	41.4%	6.4%	17.1%
Exchanges key clinical information electronically to other health providers	141	27.0%	50.4%	13.5%	9.2%
Sends reminders to patients per patient preference for preventive/follow-up care	139	15.8%	60.4%	5.8%	18.0%
Provides patients with electronic access to their health information	140	14.3%	70.0%	2.9%	12.9%

Nearly all providers (98%) indicated that patient demographics were included and their EHR maintained an up-to-date list of current diagnoses (92%). At least 75 percent of respondents also indicated that their EHR maintained an active medication list (81%), billed for services (81%), recorded patient smoking status (81%), and incorporated at least one clinical decision support tool (78%).

At the other end of the spectrum, more than half of the respondents indicated that a specific function was either not incorporated into their EHR, or they were not sure if it was, including generating and transmitting prescriptions automatically (53%), reporting quality measures to the state (59%), exchanging key clinical information electronically to other health care providers (60%), sending reminders to patients for preventive or follow-up care (78%), and providing patients with electronic access to their health information (83%).

While more than a third of all providers reported using an electronic health record, there remains a significant challenge to implement system functionality that meets the federal definition of "meaningful use." As **Table 5.3** shows, the average number of functions incorporated into the existing EHRs is 9.7 out of the 17 listed. Further, of the 142 providers that reported using EHRs, only 6 indicated that their systems met all of these federal standards.

Table 5.3: Number of Functions Incorporated into Existing EHR by Ownership Type

Ownership Type	N	0 to 5 Functions	6 to 9 Functions	10 to 13 Functions	14 to 17 Functions
All Ownership Types	142	13.4%	37.3%	35.9%	13.4%
Voluntary	107	14.0%	38.3%	32.7%	15.0%
Proprietary	11	18.2%	27.3%	36.4%	18.2%
Local Government	13	0.0%	38.5%	53.9%	7.7%
State Operated	11	18.2%	36.4%	45.5%	0.0%

Note: Six providers indicated that their EHR incorporated all 17 indicated functions.

There are a number of potential barriers that could hinder a provider's ability to adopt an EHR. As **Table 5.4** shows, financial barriers are the most significant. The cost of buying the product or web service poses the greatest barrier as 80 percent of providers indicated that it was at least a minor barrier and 61 percent indicated it was a significant barrier. The cost of adapting the organization's facilities to use EHRs was reported as at least a minor by 77 percent of respondents and was the only other significant barrier identified by a majority of providers.

When comparing responses by ownership type, at least 92 percent of voluntary providers indicated that every financial barrier was at least a minor barrier. A greater number of voluntary providers than proprietary providers reported financial barriers. Fewer than ten percent of proprietary providers indicated that any of the financial considerations was a barrier to adopting an EHR. While the cost of purchasing the EHR software or web service was identified as a significant barrier by 67 percent of proprietary providers, over 87 percent of voluntary providers indicated that it was a significant barrier. A similar difference was reported for other costs associated with the adoption of an EHR.

Table 5.4: Barriers that have Hindered the Agency's Ability to Adopt an EHR

Barrier to Adoption of an EHR	N	Significant Barrier	Minor Barrier	Not a Barrier
FINANCIAL BARRIERS:				
Cost of adapting facility (network, PCs, etc.) to use EHRs	345	51.6%	25.8%	22.6%
Cost of buying EHR software or web service	243	60.9%	19.0%	20.1%
Cost of staff training	342	38.0%	36.0%	26.0%
Cost of maintaining EHR service	341	48.7%	29.3%	22.0%
EHR FUNCTIONALITY BARRIERS:				
Choosing the right solution	347	33.7%	39.8%	26.5%
Adapting the system to meet substance use disorder requirements	345	31.0%	38.8%	30.1%
Less detailed and complete patient notes	343	12.0%	36.4%	51.6%
Conversion efforts from existing computer systems	344	33.4%	30.8%	35.8%
Risk to patient confidentiality	345	11.3%	27.5%	61.2%
Inability to use dictation to create notes	341	12.9%	25.5%	61.6%
USABILITY BARRIERS:				
Staff learning curve due to lack of technical skills	346	25.7%	48.8%	25.4%
Staff resistance to change	346	15.0%	51.5%	33.5%
Increase in staff time devoted to administration/record keeping at the expense of time with patients	344	30.5%	42.2%	27.3%

In another effort to assess the readiness to adopt an EHR within their organization, the survey asked providers to indicate their agency's level of understanding about the federal American Recovery and Reinvestment Act's Electronic Health Records Initiative. As **Table 5.5** shows, only one of five providers indicated that they were very knowledgeable about the federal EHR initiative while nearly that many indicated that they had no knowledge at all. Voluntary providers appear to be most knowledgeable while proprietary providers seem to be least knowledgeable.

Table 5.5: Agency Understanding of the Federal EHR Initiative

		Level of Understanding		
Ownership Type	N	Very Knowledgeable	Somewhat Knowledgeable	Not at all Knowledgeable
All Ownership Types	354	20.1%	61.9%	18.1%
Voluntary	278	23.4%	60.1%	16.6%
Proprietary	34	5.9%	61.8%	32.4%
Local Government	30	13.3%	73.3%	13.3%
State Operated	12	0.0%	75.0%	25.0%

To expand awareness of the Electronic Health Records Initiative, the federal government has funded the State Department of Health (DOH) to promote EHR adoption, established Health Information Technology (HIT) extension centers, and funded demonstration programs in New York State. The survey included a number of statements about DOH efforts and other means to educate providers about the initiative and asked providers if each of those statements reflected their experience. As **Table 5.6** shows, few providers indicated that those statements pertained to their organization, although a significant percentage was just not sure. In particular, only 16 percent reported being contacted by DOH about the federal program, and only 10 percent reported finding the Health Information Technology extension centers to be useful. Again the high number of providers indicating "Not sure" suggests that there may not be a lot of familiarity with these centers. It is apparent that most of the knowledge providers have about the federal EHR initiative has come from the trade literature or sources other than federal or state agencies, including briefings that staff has attended.

Table 5.6: Agency's Involvement in NYS DOH EHR Efforts

Do the following this statements reflect your agency's experience?	N	Yes	No	Not Sure
As a Medicaid provider, the Department of Health has made outreach efforts to this agency and/or its medical staff about the federal program.	329	16.1%	44.1%	39.8%
This agency has found the HIT extension center(s) to be useful.	347	10.1%	36.9%	37.7%
This agency is aware of the federal Beacon and other federal demonstration projects.	347	21.0%	45.0%	31.3%
Staff from this agency have attended briefings on the EHR initiative.	350	32.3%	47.4%	13.3%
This agency learned about the federal EHR Initiative from the trade literature or other sources.	347	47.0%	28.5%	25.0%

Providers seeking to purchase an EHR system frequently asked about products used by other providers. Information collected through this survey, including provider contact information and the EHR systems currently being utilized, has been provided to the field offices and can now be shared with all interested providers.

Domestic Violence Assessment Survey

OASAS is a member of the State Office for the Prevention of Domestic Violence's (OPDV's) Domestic Violence Advisory Council. As part of its participation on this Council, OASAS added questions to its client discharge form on whether or not a client was ever a victim or perpetrator of domestic violence. In 2010, 11.3 percent of patients discharged from non-crisis chemical dependence treatment programs reported being a victim of domestic violence and 5.2 percent reported being a perpetrator. In 2011, non-crisis programs reported that 11.7 percent of their clients identified themselves as a victim of domestic violence (DV) or intimate partner violence (IPV). Another 16.5 percent could not be determined. Programs also reported that 5.7 percent of their clients identified themselves as a perpetrator, with another 17.7 percent that could not be determined. About 17 percent of their clients reported that they were both a victim and a perpetrator.

In 2011, OASAS conducted a survey of treatment programs as part of the annual local services planning process to determine the extent to which programs were assessing and referring individuals to the domestic violence service system. The results provided OASAS and OPDV with information to better understand the needs of individuals affected by both substance use disorders and domestic violence. A total of 1,022 programs were surveyed, with 990 (96.9%) responding. Ninety-four percent reported that they screened their incoming clients to determine if they were domestic violence victims. Since most OASAS programs do not provide treatment for domestic violence, referrals must be made to a domestic violence program. Ninety-one percent of those programs that screen also reported referring people to appropriate services, mostly to domestic violence programs, coalitions, or mental health programs.

Eighty percent of programs responding to the survey also reported screening clients for domestic violence perpetration. Seventy-seven percent of those programs reported making referrals to appropriate services. Most programs referred clients to a spousal abuse group, anger management therapy, or mental health services. It should be noted, however, that research conducted in 2012 suggests that anger management is not an effective therapeutic tool for domestic violence perpetrators.

The relationship between substance use disorders and domestic violence complicates treating individuals affected by both. If both problems are not addressed, the effectiveness of interventions for each could be seriously compromised. Research shows that a history of traumatic events, including domestic violence, is significantly associated with substance use and the development of substance abuse disorders among individuals. Thus, a history of trauma among persons with a substance use disorder is much higher than in the general population.

However, as noted above, less than 12 percent of clients discharged from OASAS-certified non-crisis treatment programs in the past two years reported being a victim of domestic violence, and another 17 percent either refused to answer the question or their status could not be determined. This could indicate the importance of the primary counselor addressing the status of the client as a victim or perpetrator of domestic violence in the discharge summary and ensuring that it is reported to OASAS.

A history of domestic violence appears to be under-reported in the discharge data, even as most programs reported that they screen clients for domestic violence victimization. To understand this apparent discrepancy, more information is needed regarding the types of screens used and the efficacy with which they are implemented. This information could help to determine if there is a need for different protocols regarding the use of screening tools such as when, where, and how the screening occurs during the course of treatment.

Screening for DV/IPV Victimization

As a follow-up to the 2011 provider survey, OASAS conducted a second survey in 2012 seeking additional information to better understand and address the needs of individuals affected by substance use and domestic violence/intimate partner violence. Providers were asked when they screen for domestic violence victimization and perpetration, what tools they use, and what

services they provide. Statewide, 95 percent of OASAS treatment programs (954) responded to the survey.

About 90 percent of programs responding to the survey reported screening for DV/IPV victimization at some point during the client's treatment episode. As **Figure 5.3** shows, 76.8 percent screen at admission, 10.8 percent at discharge, and 52.1 percent at any time during treatment. Nearly all of those programs that reported screening at discharge also reported screening at admission.

Figure 5.3: When DV/IPV Victimization Screening is Conducted (N=951)

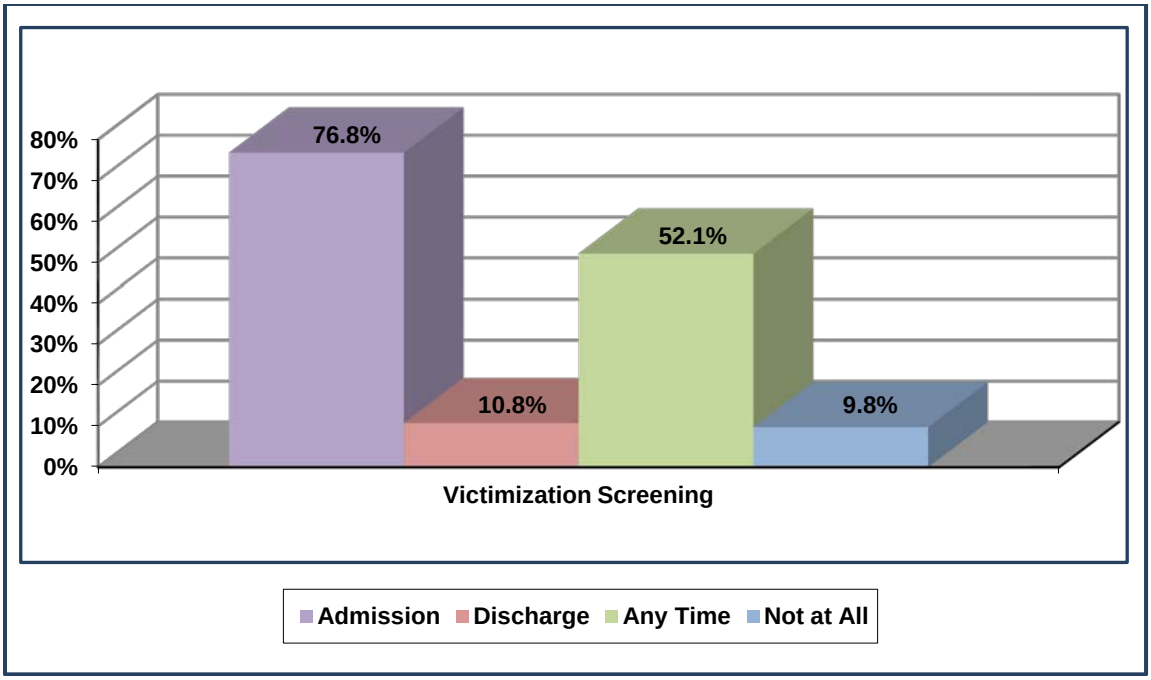


Table 5.7 shows when screening is conducted for domestic violence victimization by service type. While all service types primarily screen at intake, it is most likely to occur in inpatient rehabilitation and outpatient programs, with over 80 percent of each reporting so, while fewer than 70 percent of crisis and methadone programs reported screening at intake. Outpatient and residential programs are twice as likely as other services to screen at discharge. It should be noted that the discharge form used by crisis services does not ask about domestic violence.

Table 5.7: DV/IPV Victimization Screening by Service Type (N=951)

DV Services Offered	All Services	Service Type				
		Crisis	Inpatient	Methadone	Outpatient	Residential
At Intake	76.8%	67.1%	83.6%	63.8%	80.8%	75.6%
At Discharge	10.8%	6.6%	6.6%	4.8%	12.2%	13.3%
At Any Time	52.1%	47.4%	57.4%	66.7%	53.5%	42.2%
Not at All	9.8%	18.4%	3.3%	10.5%	7.6%	12.9%

Screening for DV/IPV Perpetration

As **Figure 5.4** shows, about 77 percent of all programs responding to the survey reported screening for DV/IPV perpetration at some point during the client's treatment episode.

Figure 5.4: When DV/IPV Perpetration Screening is Conducted (N=949)

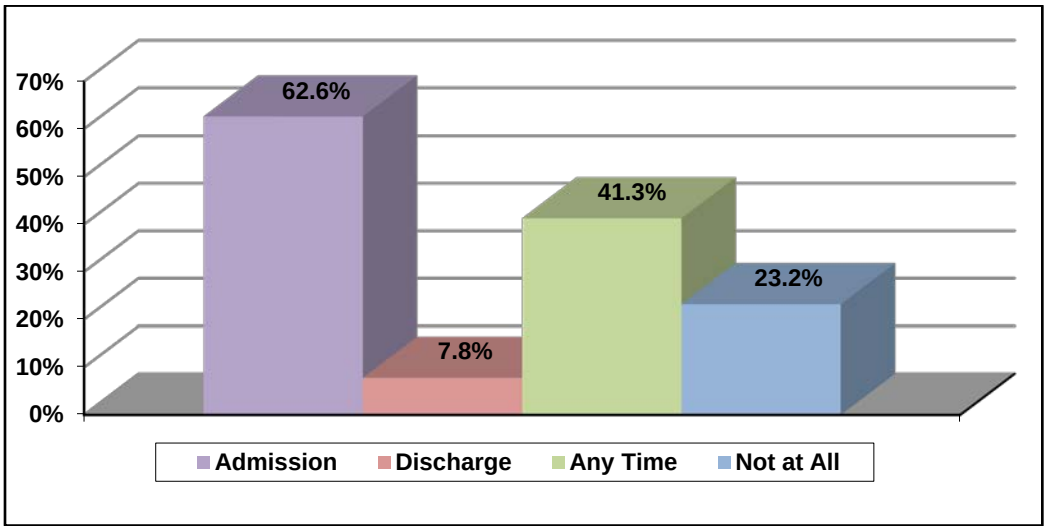


Table 5.8 shows when screening is conducted for domestic violence perpetration by service type. Not surprisingly, the pattern is similar to what is shown in **Table 5.7** for domestic violence victimization. Screening is most likely to occur in outpatient, inpatient and residential programs and least likely to occur in methadone programs.

Table 5.8: DV/IPV Perpetration Screening by Service Type (N=949)

DV Services Offered	All Services	Service Type				
		Crisis	Inpatient	Methadone	Outpatient	Residential
At Intake	62.6%	47.4%	70.5%	45.7%	65.9%	66.2%
At Discharge	7.8%	2.6%	4.9%	1.0%	9.5%	7.8%
At Any Time	41.3%	42.1%	41.0%	41.0%	44.6%	41.3%
Not at All	23.2%	30.3%	23.0%	43.8%	18.0%	23.2%

Screening Tools

Over the last decade, the recognition of the importance of a coordinated response to domestic violence has promoted a range of initiatives within the addiction services field, such as the development of policies, protocols (e.g., Southeastern Sydney and Illawara Area Health Services [SESAHS] 1997) and training programs.

Routine screening is one initiative that has been recommended to increase the identification of individuals, particularly women, who are experiencing violence in their relationships. Early

identification of abuse is essential to eliminating violence and subsequent health problems. Universal screening procedures may be the most effective way to identify battered intimate partners. The signs of abuse are not always visible, and if clinicians rely on the presence of suspicious injuries to ask individuals about violence, they may miss the chance to provide valuable assistance. Worse yet, they may misdiagnose the underlying cause of the substance abuse problems or provide treatment options that could further jeopardize the person's physical and psychological well-being (e.g., prescribing tranquilizers).

The importance of addressing domestic violence in substance abuse treatment becomes evident when one reviews the research. Individuals who abuse substances are more likely to experience domestic violence in relationships (Miller, Downs, & Gondoli, 1989). Women who experience domestic violence are more likely to misuse prescription drugs as well as alcohol (Stark & Flitcraft, 1988). To produce successful outcomes, both issues must be treated together. Otherwise, a vicious cycle of victimization, substance abuse, impairment of emotional development, and limited stress coping skills results. Because of the incidence and prevalence of domestic abuse in the population of substance abusing individuals, it is recommended that all people served in the substance abuse treatment setting be screened for domestic abuse.

Programs were asked if they utilized a standardized screening tool for DV/IPV victimization or perpetration at any time during a client's treatment episode. Based on the survey responses, it is apparent that not all programs were responding to the term standardized screening tool to indicate a tool that has been validated and standardized. Available standardized tools that fit these criteria may be found on the Centers for Disease Control and Prevention (CDC) website at: http://www.cdc.gov/NCIPC/pub-res/images/IPVandSVscreening.pdf.

Of those programs that reported screening for DV/IPV victimization, 16.4 percent reported using a standardized tool. Methadone programs (22%) and outpatient programs (20%) utilize a screening tool most frequently, while inpatient programs (10%) and residential programs (8%) utilize a screening tool the least frequently. Eighty-four percent of programs that reported using a standardized screening tool specified using questions in the psycho-social assessment, which would not fit the criteria as a standardized screening tool as cited above. No other specific tool was reported by more than four percent of respondents.

Of those programs that reported screening for DV/IPV perpetration, 8.8 percent reported using a standardized screening or assessment tool. Outpatient programs (12%) are most likely to utilize a screening tool for DV/IPV perpetration. The Abusive Behavior Inventory (13%) was the only tool reported by more than five percent of respondents. However, 77 percent reported a screening tool not listed on the survey, most identifying using the psycho-social assessment, which again would not be considered a standardized screening tool.

DV/IPV Services Provided

Programs were asked to indicate from a list of DV/IPV services the ones they offer to their clients. As **Table 5.9** shows, most programs reported making referrals to either a local DV/IPV service provider (80%) or mental health service provider (65%). In both cases, methadone programs are the most likely to refer out for these services. Individual DV/IPV counseling

within the program was also reported by a majority of all services except residential services, where about 43 percent reported offering it. Responses were similar for safety planning, as about 46 percent of all programs reported offering it, with inpatient and methadone programs most likely to offer it and residential programs least likely to offer it. Providing an educational group within the program had the greatest variation between service types, as that ranged from a low of 13 percent among methadone services to a high of 59 percent among inpatient programs. While about nine percent of **all** programs reported providing no DV/IPV services to their clients, about 18 percent of crisis programs reported not offer any services.

Table 5.9: DV/IPV Services Offered to Clients by Service Type (N=949)

DV Services Offered	All Services	Service Type				
		Crisis	Inpatient	Methadone	Outpatient	Residential
Refer to DV Services	79.8%	75.0%	80.3%	88.6%	81.7%	73.0%
Refer to MH Services	64.8%	61.8%	72.1%	77.1%	63.6%	60.6%
Individual Counseling	51.3%	52.6%	57.4%	63.8%	51.4%	42.9%
Safety Planning	46.2%	52.6%	57.4%	58.1%	45.5%	37.2%
Educational Group	29.6%	29.0%	59.0%	13.3%	29.8%	28.8%
Group Counseling	20.4%	14.5%	23.0%	11.4%	21.2%	24.3%
Other Service	3.9%	4.0%	8.2%	3.8%	2.7%	5.3%
No Services Offered	8.9%	17.5%	6.6%	3.8%	8.4%	10.2%

Outcomes Management Survey

OASAS conducted the Outcomes Management Survey as part of the annual local services planning process in 2012 for the third consecutive year. It gathered information from service providers and LGUs regarding the extent to which outcomes management practices are being utilized. In this context, outcomes management is defined as the systematic use of client and program level data to set targets and assess and improve performance. These surveys have coincided with a concerted effort by OASAS to improve and expand the availability of quantitative information regarding program performance. In July, OASAS released the 2012 Treatment Program Scorecards. This is the second year that OASAS has issued treatment scorecards for use by the general public, LGUs, and the provider community. The scorecards are posted on the OASAS website and accessible to the public via the Provider Directory Search function at: http://www.oasas.ny.gov/providerDirectory/index.cfm

In addition to the development of the treatment program scorecards, OASAS has made outcomes management one of its ongoing priorities. The following metric is included on the 2012 OASAS Dashboard:

Metric 7: Utilize outcome management concepts that focus on performance measures and hold both OASAS and its providers accountable.

Submetric 7.1: **Increase the use of outcomes management across the addictions system by increasing the percentage (68% to 75%) of providers and local governmental units (48% to 50%) that report reviewing and acting on outcome focused data on a quarterly basis.**

Over the three years this survey was conducted, minor changes were made to some of the questions, so there are some limitations in making comparisons. In most cases, comparisons are limited to the last two years. The response rates over the three years ranged from 94.5 percent to 95.9 percent for providers and 98.2 percent to 100 percent for LGUs. With near universal response to the survey, the results that follow are very representative of the overall addiction service system in New York State.

Table 5.10 shows the percentage of providers and LGUs reporting that they had an active outcomes management program in place. Both providers and LGUs showed a substantial increase in the use of outcomes management, with the number of providers increasing by 74 (up 20%) and LGUs increasing by nine (up 28%).

Table 5.10: LGUs and Providers Reporting an Active Outcomes Management Program

	2011			2012			Change	
	N	Yes	Pct.	N	Yes	Pct.	Yes	Pct.
Providers	548	373	68.1%	526	447	85.0%	+74	+19.8%
LGUs	57	32	56.1%	57	41	71.9%	+9	+28.1%

These results indicate that the ongoing efforts of OASAS to support the integration of outcomes management practices are having the desired effect on both providers and counties.

When asked how long their agency had been using outcomes management, a majority of LGUs and providers indicated that they had been using outcomes management for at least the past five years. As **Table 5.11** shows, 59 percent of providers reported having used outcomes management for at least five years, up from 46 percent reported last year. About 71 percent have been using outcomes management for at least three years, up from 57 percent reported last year.

Table 5.11: Length of Time Providers Have Been Using Outcomes Management

	2011		2012	
Length of Time	N	Pct	N	Pct.
Providers:	**548**		**526**	
At least ten years	N/A	---	158	30.0%
At least five but less than ten years*	252	46.0%	150	28.5%
At least three but less than five years	60	10.9%	64	12.2%
At least one, but less than three years	43	7.8%	57	10.8%
Less than one year	14	2.6%	17	3.2%
Have not used outcomes management	175	31.9%	79	15.0%

**In the 2011 survey, this option read "At least five years."*

As **Table 5.12** shows, 40 percent of LGUs reported having used outcomes management for at least five years, down from 46 percent reported last year. About 12 percent have been using outcomes management for at least three years, up from 11 percent reported last year.

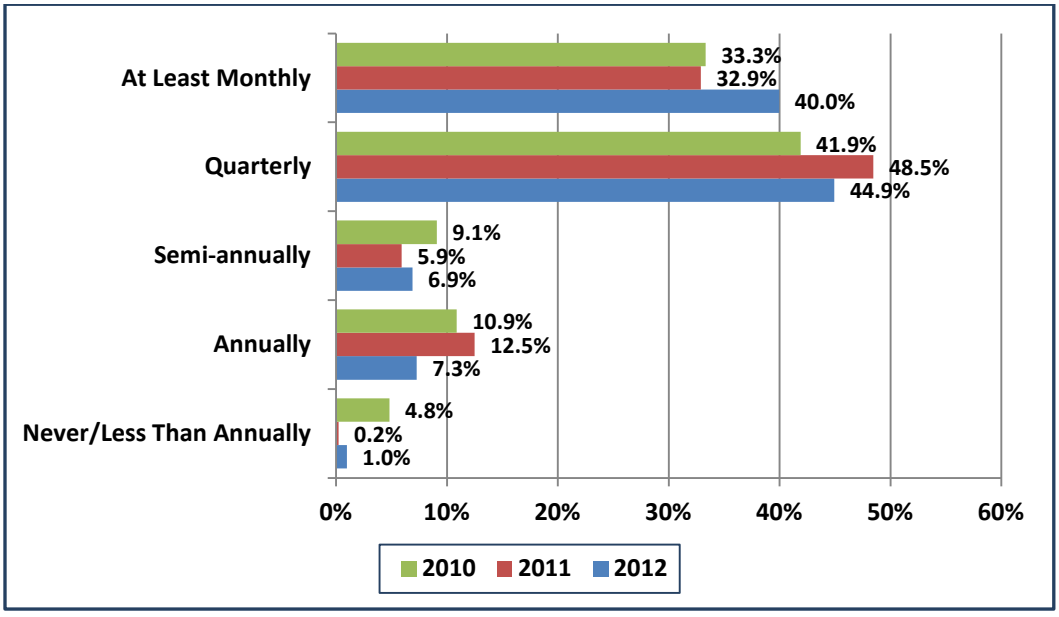
Table 5.12: Length of Time LGUs Have Been Using Outcomes Management

	2011		2012	
Length of Time	N	Pct.	N	Pct.
LGUs:	**57**		**57**	
At least ten years	N/A	---	9	15.8%
At least five but less than ten years*	26	46.0%	14	24.6%
At least three but less than five years	9	10.9%	7	12.3%
At least one, but less than three years	9	7.8%	10	17.5%
Less than one year	5	2.6%	1	1.8%
Have not used outcomes management	8	31.9%	16	28.1%

**In the 2011 survey, this option read "At least five years."*

LGUs and providers also reviewed progress toward performance targets on a quarterly basis to a greater extent in 2012. As **Figure 5.5** shows, the percentage of providers that reported reviewing progress toward established program outcomes on at least a monthly basis has remained relatively constant over the past three years. However, the percentage that reported reviews on at least a quarterly basis has increased from about 75 percent in 2010 to about 85 percent in 2012.

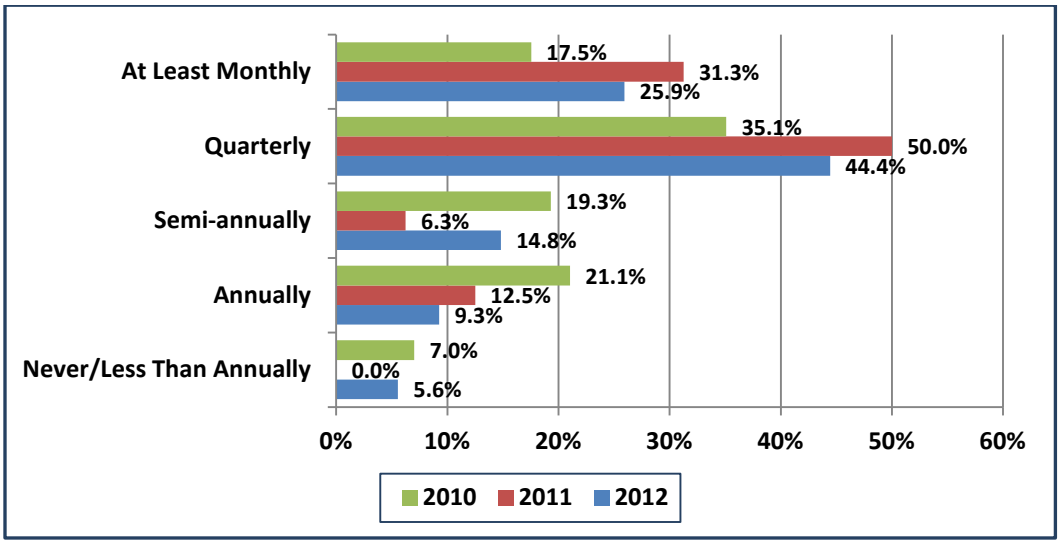
Figure 5.5: Frequency of Provider Reviews of Progress on Program Outcomes



As **Figure 5.6** shows, the change among LGUs is even more dramatic. The percentage of LGUs that reported at least monthly reviews of progress on program outcomes increased from about 18

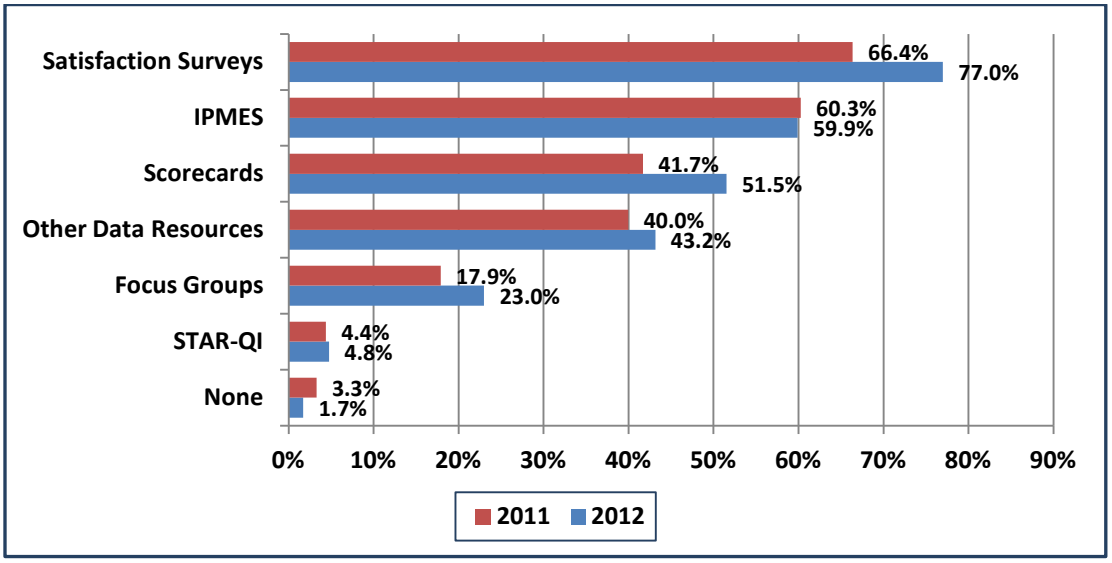
percent in 2010 to about 26 percent in 2012. The percentage of counties doing reviews on at least a quarterly basis increased from about 53 percent in 2010 to about 70 percent in 2012.

Figure 5.6: Frequency of LGU Reviews of Progress on Program Outcomes



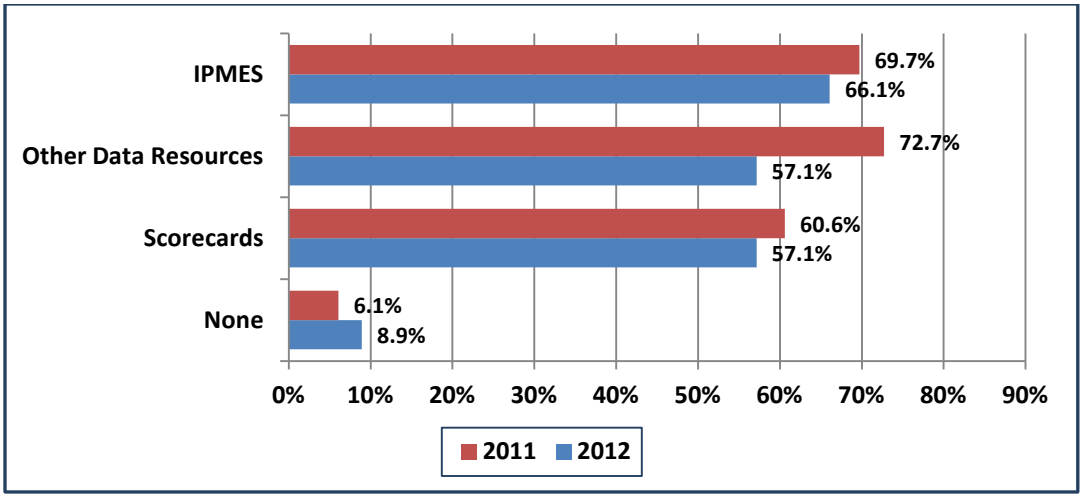
The results demonstrate tangible progress on one of the key OASAS 2012 dashboard metrics regarding increasing the use of outcomes management across the addictions field by increasing the percentage of providers and LGUs that report reviewing and acting on outcome focused data on a quarterly basis. The survey also showed a general increase in the use of treatment program scorecards to track progress toward performance targets. As **Figure 5.7** shows, most of the listed data sources showed an increase in use between 2011 and 2012. In 2012, the use of client satisfaction surveys was reported by 77 percent of providers, up from about 66 percent in the previous year. The use of IPMES data remained unchanged at 60 percent, while the use of scorecards increased from 42 percent to 52 percent.

Figure 5.7: Data Used by Providers to Track Progress on Performance Targets



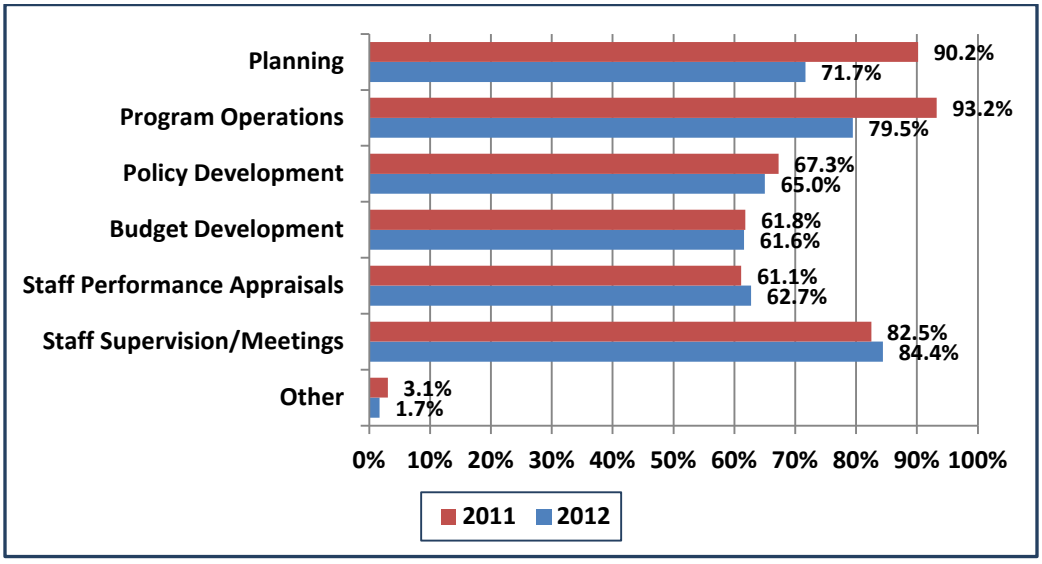
As **Figure 5.8** shows, the use of selected data sources to track progress on performance targets decreased slightly between 2011 and 2012. IPMES data was reported most often, used by 66 percent of LGUs in 2012, down from 70 percent in the previous year, while the use of treatment program scorecards decreased from 61 percent to 57 percent. Since the 2012 scorecards were only recently released and OASAS staff is continuing to provide training on the scorecards, it is expected that the percentage of LGUs that use the scorecards to track progress on performance targets will continue to increase over time.

Figure 5.8: Data Used by LGUs to Track Progress on Performance Targets



In 2012, providers and LGUs also reported high utilization of performance data to support program management decision making. As **Figure 5.9** shows, at least 60 percent of all providers reported using performance data for each listed decision making opportunity. Program performance data is most often used in individual staff supervision or staff meetings (84%).

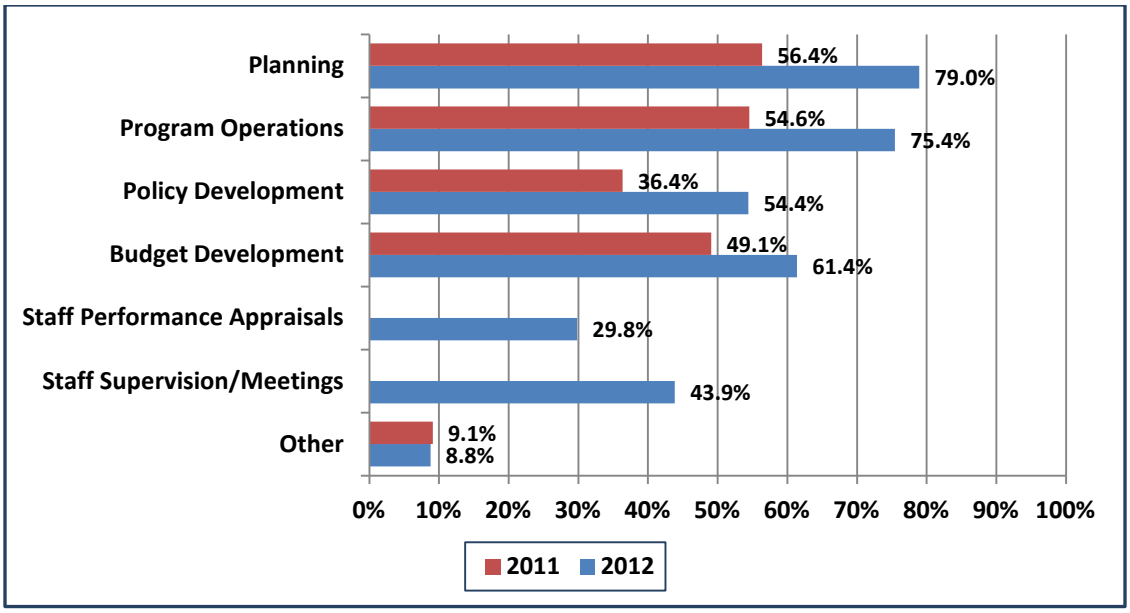
Figure 5.9: Provider Use of Performance Information to Support Decision Making



Last year, most providers reported using this information for planning and program service operations; however, this year there was notable decline in utilization, going from 90 percent to 72 percent for planning and from 93 percent to 80 percent for program service operations.

LGUs reported significant increases in the use of performance information to support decision making between 2011 and 2012. As **Figure 5.10** shows, planning and program service operations were the two functions for which performance data supports decision making in 2012, as reported by 79 percent and 75 percent, respectively. A majority of LGUs also reported using performance data to make policy and budget development decisions. While last year's percentages were much lower in all categories, the results from the 2010 survey were fairly consistent with this year's results for the categories that were included in all three surveys. One possible explanation for the dip last year may be the result of an unusually high turnover among LGU management staff between 2010 and 2012.

Figure 5.10: LGU Use of Performance Information to Support Decision Making



Most responses to the outcomes management survey suggest that activities associated with outcomes management have increased over time, particularly in the last year. More providers and LGUs reported having an active outcomes management program in place, with a higher percentage of them being in place for at least three years. The frequency with which progress on outcomes is reviewed has steadily increased over the past three years. Finally, a significant percentage of providers and LGUs continue to report using data to track progress on performance targets and to support decision making on a variety of functions. These changes are the result of a number of factors that could include the following:

- The increased availability of performance information by OASAS and in particular the public posting of treatment program scorecards as well as the conversion of IPMES to electronic form.

- The significant environmental changes in the treatment field toward performance and outcomes management, including the increased focus on the part of the federal government.
- The current implementation by New York State of BHOs and Health Homes and the federal implementation of the Affordable Care Act.

Based on the results of these surveys as well as discussions with providers across the state through a series of regional forums conducted during June 2012, there are a number of justifications for continuing to implement outcomes management practices among providers and LGUs. In general, the field appears to be going in the right direction in the key areas associated with increased outcome management implementation. Given the amount of change being experienced by the field and turnover that is expected among key staff due to impending retirements, continued attention will be needed by OASAS staff to ensure that this momentum is maintained.

While not reflected in the survey data, feedback from the field has reinforced the need for OASAS to focus attention on data quality and integrity to ensure that the measures reflected in publically available reports are as accurate as possible. It is incumbent on OASAS to continue to work to ensure that data submitted by providers is made available to the field for ease of access and analysis. Finally, a strategy should be implemented to help support cross agency learning and technical assistance as a way to ensure ongoing discussions with the field on this important topic.

LGBT Special Population Survey

According to SAMHSA, the lesbian, gay, bisexual, and transgender (LGBT) population has experienced disparities in access, quality, and outcomes of care and has been underserved or inappropriately served by the behavioral health care system. Unfortunately, OASAS does not collect information specific to the LGBT population through any of its existing client or program reporting systems. With limited available data, it is difficult to assess the treatment experiences of this population or to quantify barriers that may exist in New York State.

As part of the annual local services planning process, OASAS conducted a survey of all treatment programs in the spring of 2012 seeking to establish baseline data regarding the LGBT population within the OASAS treatment system and to give programs an opportunity to share related knowledge and experiences with OASAS. The results of the survey will be used to assess the extent to which programs report serving LGBT individuals and the efforts they report taking to ensure that their needs are being appropriately and adequately addressed.

A total of 998 treatment programs were surveyed, with 953 (95.5%) responding. Regional response rates range from 92.6 percent in New York City to 99.2 percent on Long Island, and service type response rates ranged from 90.5 percent opiate treatment programs to 98.7 percent in crisis and residential programs.

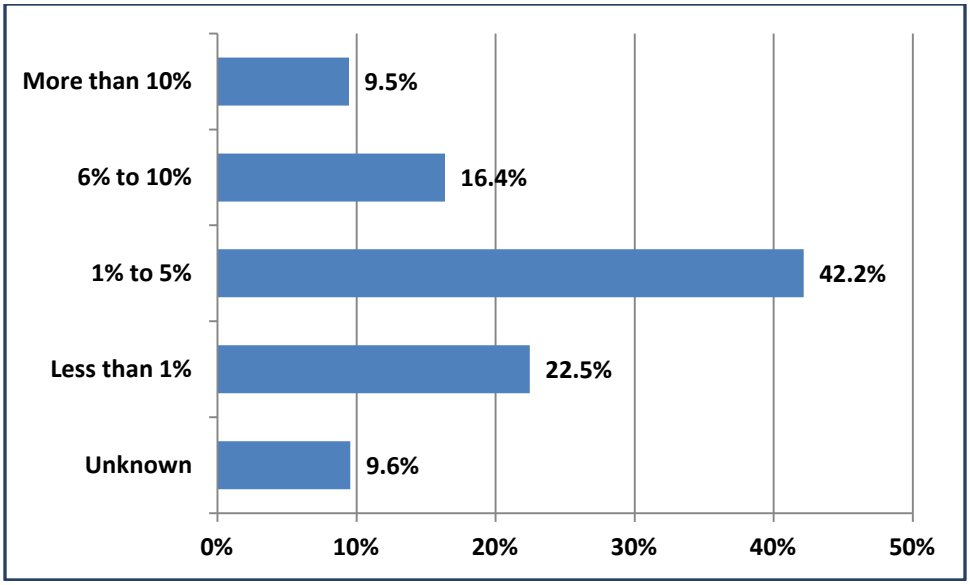
Overall, 82.8 percent of survey respondents reported that their program provided treatment services to LGBT individuals during the previous 12 months, with another 8.3 percent indicating

that they were not sure. Only 8.9 percent reported that their program did not serve LGBT individuals over the past year. On a regional basis, the lowest treatment rates were in the Northeastern Region (77.2%) and New York City (79.1%), while the highest rate was in the Finger Lakes Region (92.9%). By service type, the rates ranged from 79.6 percent for residential programs to 91.8 percent for inpatient programs.

Programs were asked to identify how it is determined that a patient is LGBT. The three most common responses were through questions asked during the intake assessment, self disclosure, and identification during the psychosocial or comprehensive evaluation. An intake assessment frequently will specifically ask about an individual's sexual orientation or ask about their relationships, sexual history, or sexual practices. Self-disclosure could occur at any time during the treatment episode, but is often made during the intake assessment or during an individual or group counseling session.

Since the sexual orientation of a patient may not be apparent, and because programs are not required to collect that information, they were asked to estimate the percentage of their total admissions over the past 12 months that were LGBT. As **Figure 5.11** shows, about a quarter of all programs reported that more than five percent of their patient population were LGBT, while the greatest number of programs (42%) reported that the LGBT population was between one and five percent of the total. About 23 percent of all programs reported that the LGBT population was not served at all or represented less than one percent their patient population, while one in ten reported that it was unknown if they served any LGBT individuals.

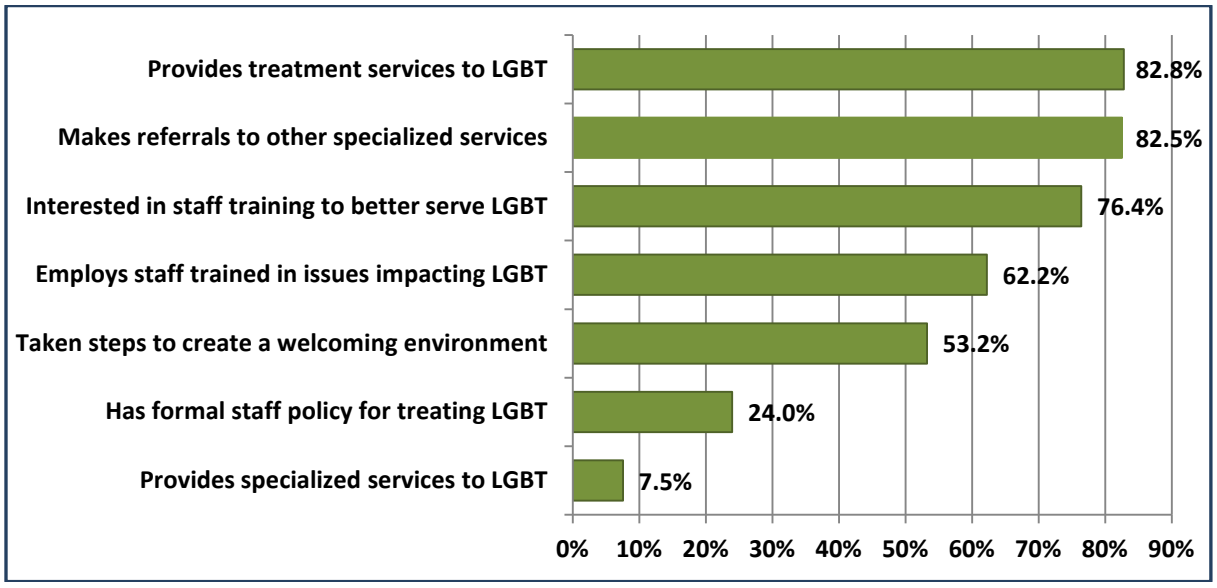
Figure 5.11: Estimated Percentage of Program Admissions that is LGBT



OASAS is interested in the efforts taken by treatment programs that allow them to better serve the LGBT population and create a more open and welcoming environment for them. As Figure **5.12** shows, only 24 percent of all respondents reported that their program had a formal staff policy for treating LGBT individuals. However, many respondents noted that, while they do not have a formal policy in place, they do not discriminate and are accepting and welcoming of all

populations, including LGBT. The Finger Lakes Region (13%) and the Northeastern Region (17%) had the lowest percentage of programs with a formal policy, while New York City (29%) and the Western Region (29%) had the highest percentages. A significant difference was reported by opiate treatment programs, with 47 percent of programs reporting a policy, and all other service categories ranging from 15 percent to 23 percent.

Figure 5.12: Statewide Summary of Questions about Serving LGBT Population



A majority of programs (53.2%) reported that they had taken steps to create a more open and welcoming environment at the program to better serve LGBT individuals. There was not a lot of variation in responses from one region of the state to another, with the exception of programs in the Northeastern Region (37%) and the Central Region (29%) reported taking such steps. There was much more consistency across service categories as the percentage ranged from 51 percent of outpatient programs to 60 percent of opiate treatment programs.

When asked to describe the steps programs take to create a more open and welcoming environment, most survey respondents noted that they make it a point to identify patient needs and choices and try to accommodate them to the extent possible and to create a safe and supportive environment. Many programs also reported either encouraging or mandating cultural sensitivity or diversity training for staff, and some extended that training to their patients as well. A few respondents noted that they make sure that brochures and other literature features both heterosexual and LGBT individuals and couples, and a few respondents reported establishing a LGBT support group.

Employing staff trained on issues impacting LGBT individuals is the most common step programs have taken to better serve the LGBT population. Whether a program recruits staff with relevant training or provides the training to current staff was not determined, but 62 percent of all respondents reported that their program employed staff with such training. Most regions of the state had between 63 percent and 68 percent of the programs that reported employing staff trained on issues impacting LGBT individuals. Fewer than half the programs in the Central Region (48%) and the Northeastern Region (46%) reported having trained staff. Again, opiate

treatment programs had the highest percentage of programs that reported having trained staff (77%), while all other service categories reported between 55 percent and 64 percent.

Only about eight percent of all programs reported that they provided specialized services to LGBT individuals. Of those, about 58 percent reported offering group counseling sessions and about 24 percent reported offering individualized counseling. Two programs from the same agency reported providing counseling to LGBT couples. Offering specialized services was most frequently reported by programs in New York City (12%) and opiate treatment programs (13%).

While few programs reported providing specialized services to LGBT individuals, 83 percent reported that they made referrals to other specialized service providers. Making referrals was reported most frequently by programs in New York City (92%) and least frequently by programs in the Central region (63%). The variation between services was smaller, ranging from a low of 77 percent at residential programs and a high of 94 percent at opiate treatment programs.

As mentioned earlier, 62 percent of respondents reported employing staff that were trained on issues impacting LGBT individuals, and many respondents noted that they encouraged or mandated staff training on cultural sensitivity or diversity. When asked if their program would be interested in staff training and supports that would enable them to better serve LGBT individuals, 76 percent indicated that they would. The interest in staff training is highest in the Western Region (96%) and in the Central Region (84%) and is lowest in the Finger Lakes Region (61%) and the Northeastern Region (65%). When asked to describe the training and supports they would be most interested in receiving, most respondents reported that general information to better understand this population and their needs would be helpful. Where they were specific, respondents identified cultural competency or sensitivity training, particularly in rural areas where acceptance may not be as great. Other staff training and supports included training on specialized treatment practices, addressing the trauma and domestic violence associated with LGBT individuals, and more information about other referral services in the community.

Appendix:Fast Facts

Medicaid Fast Facts

Veterans Fast Facts

Fast Facts for Criminal Justice

Medicaid Fast Facts

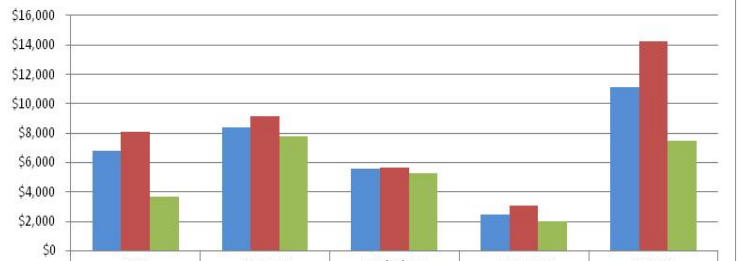
Overview:

- During SFY[1] 2011, $838,697,619 was spent to provide chemical dependence (CD) services to 162,701 Medicaid recipients[2] who made 5,693,220 CD claims.
- The greatest number of recipients were served in outpatient programs (118,065), followed by methadone (35,501), crisis (26,301) and inpatient rehabilitation (17,706).
- Statewide, most Medicaid CD spending during SFY 2011 was for outpatient services ($288,041,040). However, New York City spent the most Medicaid dollars for opioid treatment program services ($170,808,855), followed by outpatient services ($155,651,884).
- The most Medicaid dollars per recipient were spent on inpatient services (Figure-1) with $8,391 statewide, $9,138 for NYC and $7,823 for the rest of the state (ROS). However, the most dollars were spent per claim on crisis services ($747 statewide, $775 NYC, $626 ROS).
- Over 1.7 billion Medicaid dollars ($1,744,293,622) were spent to provide non-CD services to recipients of CD services in SFY 2011.
- Of the approximately 2.5 million people in NYS aged 18 and over and eligible for Medicaid, 5.5% received CD services in SFY 2008[3]. OASAS estimates that 11% of this age group has a CD problem. One percent of the almost 500,000 people ages 12 through 17 who are Medicaid eligible received CD services in SFY 2008[3]. OASAS estimates that 10% of this age group has a CD problem.
- Looking at eligibility categories, penetration rates (number of recipients receiving CD services divided by total number of recipients) are highest in the 18 and over age group for Safety Net Assistance (33%) and lowest for Medicaid only (3.5%). In the 12 through 17 age category, rates are highest in Temporary Assistance to Needy Families (1.8%) and lowest in the Safety Net Assistance (0.7%).

Trends:

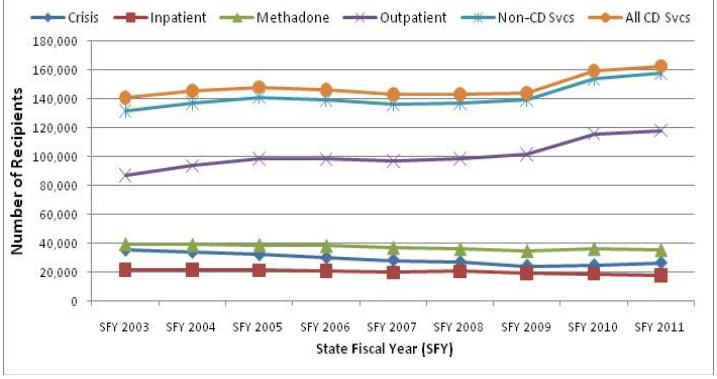
- The number of recipients statewide for crisis, inpatient and methadone has steadily decreased (Figure-2).
- Dollars spent on all CD services tend to arc between 2003 and 2007 and then begin to decrease (Figure-3). Particularly, dollars spent on methadone and outpatient services have remained fairly steady, but crisis services have decreased and outpatient services increased in the last few years. The largest increase in dollars spent has occurred with non-CD services.

Figure 1. Medicaid Dollars Spent per Recipient by Service for SFY 2011



	Crisis	Inpatient	Methadone	Outpatient	Non-CD
NYS	$6,802	$8,392	$5,615	$2,439	$11,124
NYC	$8,109	$9,138	$5,674	$3,041	$14,227
ROS	$3,663	$7,823	$5,288	$1,979	$7,474

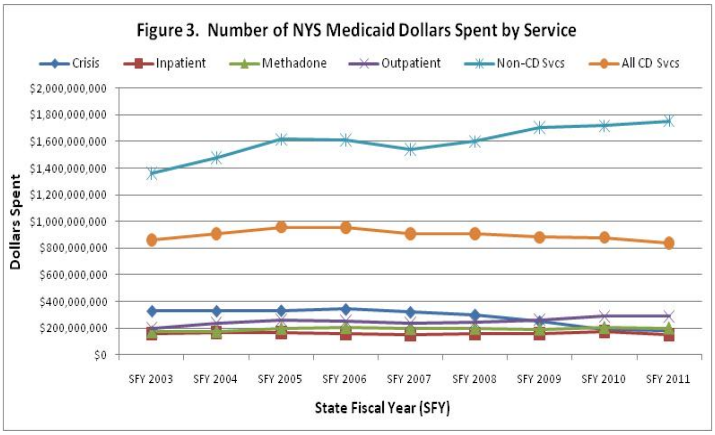
Figure 2. Number of NYS Medicaid Recipients by Service



- Medicaid claims have followed a similar pattern as dollars spent, except that claims for crisis services have remained steady, even though dollars spent have shown a continuous decline over the years.
- Penetration rates in both the 18 and over and 12 to 17 age groups have decreased slightly since SFY 2003.

1. The 2011 State Fiscal Year (SFY) runs from April 1, 2010 through March 31, 2011.
2. Data does not include payment made to chemical dependence providers by Medicaid Managed Care (MCO) organizations. As of SFY 2011, the following services were not eligible for Medicaid reimbursement, and therefore, are not reflected in Medicaid data: medically monitored withdrawal, non-medically supervised outpatient and residential programs.
3. "SFY 2008 is used to estimate CD services to Medicaid eligibles as this reflects the most recent information available at this time from the New York State Health Department."
4. Non-crisis admissions

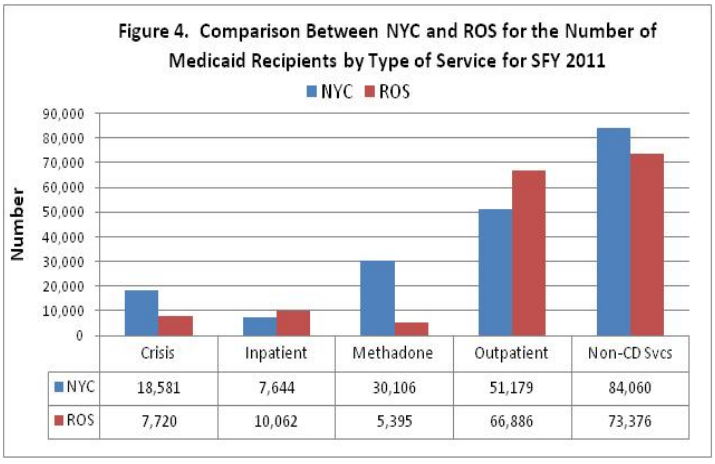
Sources: NYS OASAS Data Warehouse (Client Characteristics and Comparison sections) and NYSDOH eMedNY Data Warehouse (Overview, Trends and Geographic Differences sections). Document last updated January, 2012.



Client Characteristics:

Over half (52.6%) of SFY 2011 discharges were paid by Medicaid. Of those paid by Medicaid:

- Most were discharged from outpatient programs (50.5%), followed by crisis (27.8%), inpatient (15.1%) and methadone (5.8%)
- The most common primary substance used at admission was alcohol (40.5%), followed by opiates (26.4%), marijuana (18.3%) and cocaine/crack (12.1%)
- 68.3% had a secondary substance and 31.0% had a tertiary substance
- 72.3% were male
- Ages 45-54 was the most common age group (26.6%), followed by 35-44 (25.9%), 25-34 (23.1%), 18-24 (13.1%), age 55 and older (7.6%) and under 18 (3.8%)
- Black/Non-Hispanic was the most common race-ethnicity group (37.6%), followed by White/Non-Hispanic (35.5%), Hispanic (24.1%) and Other/Non-Hispanic (2.9%)
- The most common principal referral source was self (39.9%), followed by criminal justice (23.4%), health care/social services (17.2%), other CD (15.6%) and CD prevention/intervention (4.0%)
- 16.4% were homeless
- 56.3% lived in New York City
- 38.7% had criminal justice involvement
- 58.9% had at least a high school level of education
- 2.7% reported being a veteran
- 47.7% had a co-occurring mental health disorder[4]
- 70.0% used tobacco in the last week prior to admission[4]
- 57.4% have children[4]
- 45.7% completed treatment



Comparisons:

When compared to those who did not pay with Medicaid, those who did pay with Medicaid were:

- More likely to be female (27.7% vs. 22.5%)
- More likely to reside in New York City (56.3% vs. 41.2%)
  - Less likely to have criminal justice involvement (38.7% vs. 44.8%)
  - More likely to have a co-occurring mental health disorder (47.7% vs. 35.0%)
  - More likely to be Black/Non-Hispanic (37.6% vs. 26.3%) and Hispanic (24.1% vs. 16.7%)
  - Less likely to be employed (13.7% vs. 32.4%)
  - More likely to have less than a high school education (69.6% vs. 58.9%)
  - More likely to have children (57.4% vs. 50.5%)

Geographic Differences:

1. The 2011 State Fiscal Year (SFY) runs from April 1, 2010 through March 31, 2011.
2. Data does not include payment made to chemical dependence providers by Medicaid Managed Care (MCO) organizations. As of SFY 2011, the following services were not eligible for Medicaid reimbursement, and therefore, are not reflected in Medicaid data: medically monitored withdrawal, non-medically supervised outpatient and residential programs.
3. "SFY 2008 is used to estimate CD services to Medicaid eligibles as this reflects the most recent information available at this time from the New York State Health Department."
4. Non-crisis admissions

Sources: NYS OASAS Data Warehouse (Client Characteristics and Comparison sections) and NYSDOH eMedNY Data Warehouse (Overview, Trends and Geographic Differences sections). Document last updated January, 2012.

- Comparing New York City to the rest of the state, a larger percentage of NYC recipients was served in crisis and methadone programs compared to the rest of the state (crisis: 70.6% vs. 29.4% and methadone: 84.8% vs. 15.2%). However, a smaller proportion of NYC recipients were served in inpatient and outpatient programs compared to the rest of the state (inpatient: 43.2% vs. 56.8% and outpatient: 43.3% vs. 56.7%). More NYC recipients were provided non-CD services than the rest of the state (53.4% vs. 46.6%). These comparisons are shown in Figure-4.
- A review of all CD services shows that the cost per NYC recipient was $6,426 and $3,692 per recipient in the rest of the state. Geographic cost differences between service types are shown in Figure-1.
- Overall penetration rates are slightly lower in New York City (5.0% for those age 18 and older, 0.6% for ages 12-17) compared to the rest of the state (6.4% for those age 18 and older, 2.0% for ages 12-17). Rates have decreased slightly since SFY 2003 in both NYC and the rest of the state for those age 18 and older and have decreased for ages 12-17 in the rest of the state while remaining steady for this age group in New York City.

[1] Mental illness does not include crisis admissions, as this item is not collected on the crisis admission/discharge form.
Source: NYS OASAS Client Data System – Data Extract June 17, 2012

OASAS New York State Office of Alcoholism & Substance Abuse Services
Improving Lives. *Addiction Services for Prevention, Treatment, Recovery*

Veterans Fast Facts

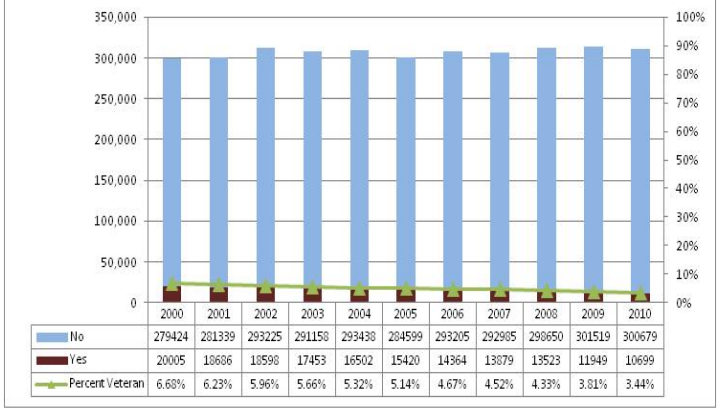
System Capacity for Calendar Year (CY) 2010:

- There were 10,699 admissions (3.4%) to New York State (NYS) OASAS certified chemical dependence treatment programs who reported being a veteran of the United States Armed Forces. Veterans were most commonly admitted to crisis programs (37.1%), followed by outpatient (36.9%), inpatient (15.2%), residential (6.6%) and methadone (4.2%).
- 11,121 veterans were in treatment and the average daily enrollment for veterans was 3,910, mostly in methadone programs (45.9%), followed by outpatient programs (41.5%)
- There were 45 veteran admissions to problem gambling programs, representing 8% of all gambling admissions

Trends for CY 2000-2010:

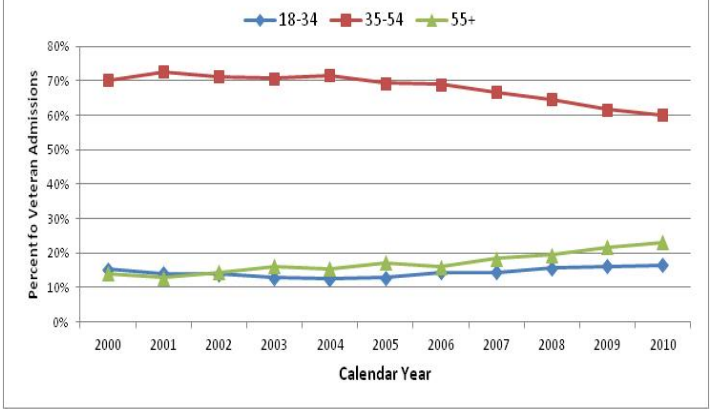
- The number of veteran admissions, as well as the percentage of veterans decreased from 2000 to 2010 (Figure-1).
- Trends in age show that veteran admissions for ages 35-54 have decreased steadily since 2000, while the number of admissions age 55 and over have increased. Admissions for age 18-34 have remained relatively constant (Figure-2).

Figure 1. Number and Percent of Veteran Treatment Admissions CY 2000-2010



	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
No	279424	281339	293225	291158	293438	284599	293205	292985	298650	301519	300679
Yes	20005	18686	18598	17453	16502	15420	14364	13879	13523	11949	10699
Percent Veteran	6.68%	6.23%	5.96%	5.66%	5.32%	5.14%	4.67%	4.52%	4.33%	3.81%	3.44%

Figure 2. Percent of Veteran Admissions by Age Group for CY 2000-2010



Client Characteristics for CY 2010:

- 93.8% were male and the most common age group was 45-54 (41.2%), followed by 55 and older (23.1%), 35-44 (19.0%), 25-34 (12.7%), 18-24 (3.9%) and under 18 (0.2%)
- 47.7% were white non-Hispanic, 36.3% black non-Hispanic, 13.4% Hispanic and 2.6% were other non-Hispanic
- Primary substances of abuse were alcohol (60.6%), followed by heroin/other opiates (19.1%), cocaine/crack (13.0%), marijuana (5.7%) and other (1.4%). 59.8% reported a secondary substance, while 25.8% reported a tertiary substance.
- 13.3% had less than a high school education and 79.6% were unemployed (i.e. did not indicate any of the following: being full or part-time employed, being employed in a sheltered workshop or being a student)
- Principal referral sources were primarily self (35.9%), followed by other chemical dependence (CD) programs (18.6%), criminal justice (16.2%), other/unknown (12.5%), health care/social services (12.0%) and CD prevention/intervention (4.8%)
- 32.4% had criminal justice involvement and 21.9% were homeless
- 32.5% were identified as having a co-occurring psychiatric disorder or ever treated for mental illness[1]
- 79.0% indicated ever using tobacco and 70.7% used tobacco in the week prior to admission
- Primary payment sources at discharges were Medicaid/Medicare (45.0%), followed by none/unknown (17.9%), private insurance (12.4%), self-pay (9.4%), other (8.8%) and VA (6.5%)
- The median length of stay for crisis services was 5 days, 21 days for inpatient, 100 days for residential and 102 days for outpatient services
- 56.0% completed all or most treatment goals at discharge

Comparisons for CY 2010:

When compared to those who are not veterans, veterans were:

- More likely to be male (93.8% vs. 74.1%)
- More likely to be age 55 and older (23.1% vs. 7.2%)
- More likely to use alcohol as their primary substance of abuse (60.6% vs. 43.3%)
- More likely to have education beyond high school (39.9% vs. 24.7%)
- More likely to have longer lengths of stay for all levels of care
- More likely to complete treatment (56.0% vs. 47.7%)

[1] Mental illness does not include crisis admissions, as this item is not collected on the crisis admission/discharge form.
Source: NYS OASAS Client Data System – Data Extract June 17, 2012

FAST FACTS FOR CRIMINAL JUSTICE INVOLVEMENT

Definition: Criminal Justice (CJ) Involvement is determined if CJ status at admission is indicated, alternative to incarceration is selected or one of the following principal referral sources is selected upon admission: Drinking Driver Referral, Police, Family Court, Other court, Alternative to Incarceration, City/County Jails, DOCS, Division of Parole, Drug Court, OCFS, Probation, DLR District Attorney, DLR Court, DLR Probation, DLR Parole General, DLR Parole Release Shock, DLR Parole Release Willard or DLR Parole Release Resentence.

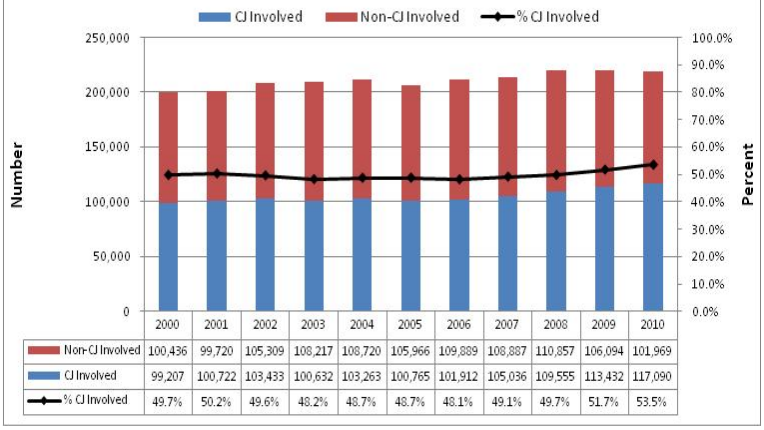
System Capacity for CY 2010:

- There were 117,090 non-crisis admissions with CJ involvement in New York State during the 2010 calendar year (CY), mostly to outpatient programs (74%), followed by inpatient (13%), residential (11%) and methadone (2%).
- Those with CJ involvement represented 53% of non-crisis admissions.
- Average Daily Enrollment for those with CJ involvement was 44,952. Most of these were in outpatient programs (75%), followed by residential (12%), methadone (11%) and inpatient (2%).
- 123,210 individuals with CJ involvement were in treatment in New York State during CY 2010.
- 226 New York State programs treated a majority (70% or more) of those with CJ involvement.

Admission Trends for CY 2000 through CY 2010:

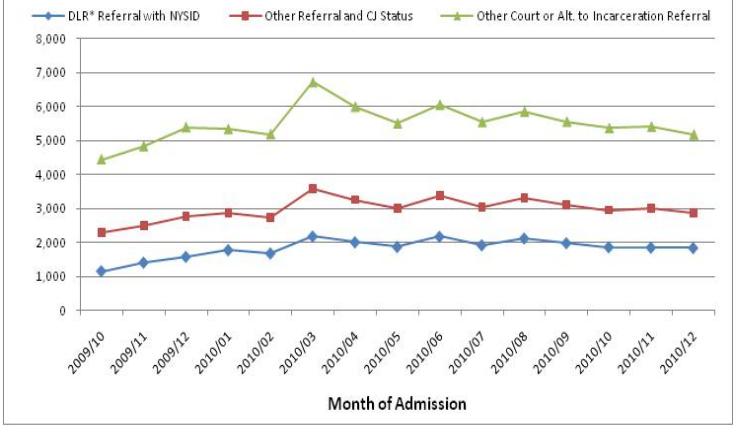
- The number and percent of non-crisis admissions with CJ involvement remained fairly steady until 2007, when a continual increase began (Figure-1).
- October 7, 2009 marks the beginning of NYS Drug Law Reform (DLR). Figure-2 estimates the impact on the number of non-crisis treatment admissions as a result of DLR by CJ referral category and CJ status if the referral was indicated as Other. There appears to be an increase in admissions through March, 2010, indicated by a peak, and then the trend levels off through the next 5 months. Beginning in August, 2010 through the end of the year, a slight decline in admissions is shown.

Figure-1: Number and Percent of Non-Crisis Admissions with CJ Involvement Compared to Total Admissions for CY 2000 through CY 2010



	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Non-CJ Involved	100,436	99,720	105,309	108,217	108,720	105,966	109,889	108,887	110,857	106,094	101,969
CJ Involved	99,207	100,722	103,433	100,632	103,263	100,765	101,912	105,036	109,555	113,432	117,090
% CJ Involved	49.7%	50.2%	49.6%	48.2%	48.7%	48.7%	48.1%	49.1%	49.7%	51.7%	53.5%

Figure-2: Number of Non-Crisis Admisisons Since the Implementation of DLR* by CJ Referral Type (October 7, 2009 through December 31, 2010)



Client Characteristics for those in Treatment during CY 2010:

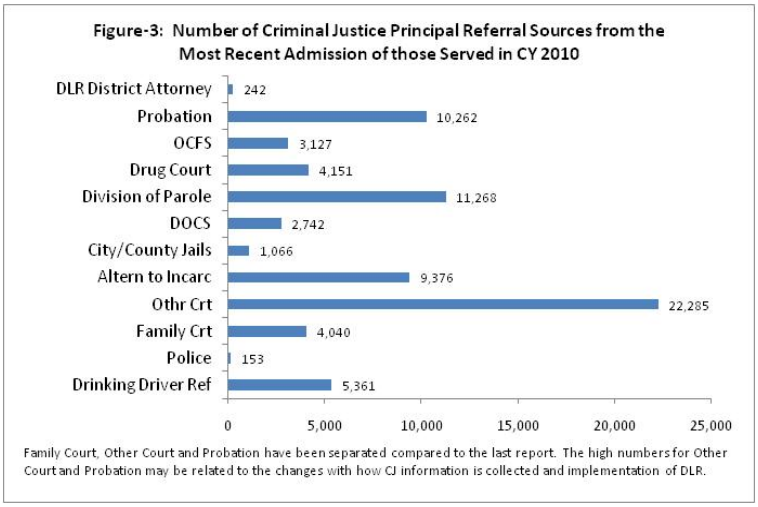
- 77% were male and 28% were between the ages of 25 and 34, followed by 18-24 (23%), 35-44 (21%), 45-54 (17%), under age 18 (6%) and older than 55 (4%).

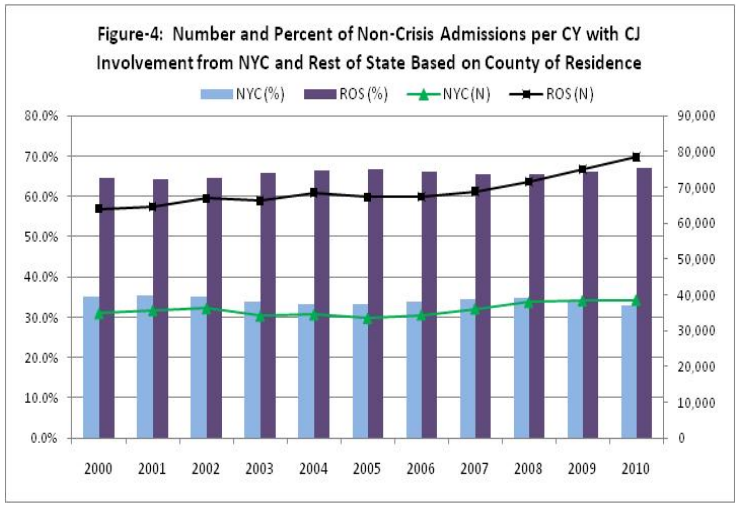
Statistics do not include crisis admissions, as criminal justice items were only recently collected on the crisis admission/discharge form as of 6/1/2005.

*DLR admissions are defined if the admission date is on or after October 7, 2009 AND the principal referral source is equal to one of the following: Other Court, Alternative to Incarceration, NYSID number received (i.e. referral indicated with DLR categories of: court, probation, parole general, parole release Shock, parole release Willard, or parole release resentence), or a referral of Other AND at least one CJ status is indicated.

Source: NYS OASAS Client Data System (admission-discharge data) for the period January 1, 2000 to December 31, 2010 (Extract: October 30, 2011)

- Primary substances of abuse indicated at admission were alcohol (39%), marijuana (31%), crack/cocaine (11%), heroin/other opiates (17%) and other (2%). Compared to the previous CJ Fast Facts for 2007, the decline in cocaine/crack use, down from 17% previously, and increase in other opiates, up from 13% previously, is representative of national trends and OASAS data in recent years.
- 46% were white non-Hispanic, 30% black non-Hispanic, 21% Hispanic and 4% other non-Hispanic.
- 37% had less than a high school education and 64% were unemployed.
- The majority of principal referrals sources indicated were related to criminal justice (61%), followed by other/unknown (14%), self-referral (9%), other chemical dependence (CD) program (9%), health care social services (5%) and CD prevention/intervention (2%). A detailed description of principal referral source groups for criminal justice is provided in Figure-3 on the next page.
- 5% were homeless at admission and 3% reported a positive veteran status.
- 9% indicated some form of physical impairment while 37% were identified as having a co-existing mental health disorder or had ever been treated for mental illness at either admission or discharge.
- 61% used smokeless tobacco or smoked tobacco in the week prior to admission.
- The primary payment source indicated at discharge was mostly Medicaid Fee for Service (FFS) (38%), followed by self-pay (16%) and Medicaid Managed Care (8%). Private insurance (managed care) and private insurance (FFS) were both indicated by 6%.
- 45% completed treatment.





Comparisons for those in Treatment during CY 2010:

Compared to those in treatment who do not have CJ involvement, those ***with*** CJ involvement are:

- More likely to be admitted to residential (16% vs. 9%) and outpatient programs (69% vs. 54%)
- More likely to be male (79% vs. 66%)
- More likely to be between the ages of 18 and 34 (49% vs. 30%)
- More likely to indicate marijuana as the primary substance used at admission (27% vs. 11%)
- More likely to be employed (36% vs. 26%)
- More likely to self-pay (20% vs. 10%) and less likely to use Medicaid (41% vs. 53%) in order to pay for their care
- Less likely to be homeless (6% vs. 14%)
- Less likely to be identified as having a co-occurring mental illness (29% vs. 43%) and less likely to indicate having any physical impairments (8% vs. 10%)
- More likely to complete treatment (40% vs. 31%)

Geographical Differences in Admissions for CY 2010:

The number and percentage of admissions with CJ involvement is lower among New York City residents compared to residents in the rest of New York State (Figure-4). While the number of admissions with CJ involvement in New York City appears to have remained steady the last few years, the percentage compared to the rest of the state has declined slightly. In addition, both the

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Statistics do not include crisis admissions, as criminal justice items were only recently collected on the crisis admission/discharge form as of 6/1/2005.

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Source: NYS OASAS Client Data System (admission-discharge data) for the period January 1, 2000 to December 31, 2010 (Extract: October 30, 2011)

number and percent of admissions with CJ involvement for the rest of New York State has shown a continual increase since 2007. Compared to those with CJ involvement who reside in the rest of the state, those ***residing in New York City*** are:

- More likely to be admitted to residential treatment (18% vs. 8%)
- More likely to be Hispanic (36% vs. 10%) and black non-Hispanic (47% vs. 22%)
- More likely to be unemployed (77% vs. 64%) and less likely to have graduated high school (35% vs. 41%)
- More likely to report marijuana (42% vs. 26%), heroin (16% vs. 11%) and crack/cocaine (15% vs. 11%) as the primary substance used at admission
- Less likely to be identified as having a co-occurring mental illness (29% vs. 45%)
- Less likely to complete treatment (33% vs. 42%)

Statistics do not include crisis admissions, as criminal justice items were only recently collected on the crisis admission/discharge form as of 6/1/2005.

*DLR admissions are defined if the admission date is on or after October 7, 2009 AND the principal referral source is equal to one of the following: Other Court, Alternative to Incarceration, NYSID number received (i.e. referral indicated with DLR categories of: court, probation, parole general, parole release Shock, parole release Willard, or parole release resentence), or a referral of Other AND at least one CJ status is indicated.

Source: NYS OASAS Client Data System (admission-discharge data) for the period January 1, 2000 to December 31, 2010 (Extract: October 30, 2011)