

## OMH Adult Services – Core Mission Budgeting

Rank	Program/Activity	Description/Population Served	Issues
H/M	Adult Inpatient (State Operated)	16 State Psychiatric Centers operated with app. 3,582 individuals served (8/08).	Undergoing transformation of the system.
H/M	IP Psychiatric Unit/General Hospital	Acute IP psychiatric care, joint license SOMH & SDOH, App. 5,525 adult IP beds; serve app. 220,603 annually.	Poor distribution statewide, high LOS, poor transition to OP – address via clinic restructuring.
H/M	Article 31	9 hospitals statewide, 498 licensed beds.	Considered an IMD (non-MA reimburse-able), poor distribution statewide, high LOS – address via clinic restructuring.
M	OP – Continuing Day Treatment (St. Op.)	CDT programs provide active treatment to maintain or enhance levels of functioning.	Does not allow flexibility to provide a level of support which may be needed; OMH is moving away from CDT to PMHP.
M	OP – CDT	CDT programs provide active treatment and rehab to maintain or enhance levels of functioning.	Incentives to encourage conversion to PROS are under consideration.
H	OP – Clinic Treatment (St. Op.)	Provides treatment to reduce symptoms, improve functioning, and provide ongoing support.	Clinic is developing into a more recovery oriented, person-centered approach.
H	OP – Clinic Treatment (ATL)	App. 441 licensed programs, serve app. 241,146 annually.	Clinic restructuring; pending federal regs. (TCM and UPL).
H/M	OP - Partial Hospitalization (St. Op. & ATL)	Provides treatment to stabilize acute symptoms, alternative to IP, reduce LOS in hospital.	Does not meet OMH mission to provide community based services, has potential to be incorporated into PMHP/examine incentives.
H/M	OP - Intensive Psychiatric Rehab. Treatment (IPRT) (St. Op.)	Time limited with active psychiatric rehab designed to form and achieve mutually agreed-upon goals in living, learning, working and social environments.	Meets OMH mission to assist individuals to lead quality lives in the community, many IPRT services have the potential to be provided in PMHP model.
H/M	OP - IPRT (ATL)	Time limited with active psychiatric rehab designed to form and achieve mutually agreed-upon goals in living, learning, working and social environments.	IPRT targeted for conversion to PROS.
H	OP - Pre-Paid Mental Health Program (PMHP)	Non-comprehensive Medicaid managed care program for adults residing in or discharged from State-Op. PCs and adults who receive SSI/MA only services from State-Op.	Directly related to the OMH mission.
H	OP - Personalized Recovery Oriented Services (PROS)	OP programs. PMHP is a partial capitation program with benefit package consists of primarily OP services and IP coverage after the 60 <sup>th</sup> day. Individuals asked to participate in PMHP must use OMH Medicaid services only.	Represents the most advanced program in NYS for adults in the public mental health system. Funded under the federal MA Rehab Option which is currently subject to moratorium until 4/09.

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H	OP - Assertive Community Treatment (ACT) (St. Op. & ATL)	ACT teams provide mobile intensive treatment and support to people with psychiatric disabilities. Evidence-based care model with CM embedded into it.	ACT financed under MA Rehab Option which is currently subject to moratorium until 4/09. Feds have also stated that monthly case payment models may not be allowed (OMH may be required to redesign the payment model for ACT).
H	Residential – Family Care (St. Op. & ATL)	24-hour care in a supervised setting w/necessary clinical services & CM to link with community support services.	OMH is exploring incentives to expand Family Care.
H	Residential - Congregate & Residential Treatment and Support	4,648 congregate treatment units with statewide average occupancy rate of 94%. Licensed transitional rehab residential programs that teach skills, offer support and help residents achieve highest levels of independence. Residences are single site with private or shared bedrooms for up to 48 individuals.	OMH is examining opportunities to convert Congregate Treatment to more flexible models. For programs with 16 or fewer units, funded under the federal MA Rehab Option which is currently subject to moratorium until 4/09.
H	Residential - Congregate Support	509 units with statewide average occupancy rate of 96%. Single-site residential programs that provide support to maintain an individual's ability to live as independently as possible.	OMH does not anticipate any significant increase in this program category.
H	Residential - Community Residence/Single Room Occupancy (SRO)	1,816 CR-SRO units (with 2,957 in the pipeline and targeted to priority populations including individuals with long LOS in State PCs & NY NY IID). Statewide average occupancy rate of 90%. Provides service-enriched, licensed extended-stay housing with on-site services with private living units.	OMH is encouraging providers to develop mixed-use, integrated housing (rather than housing solely for mental health population), utilizing low-income housing tax credits and other government capital resources.
H	Residential – Apartment Treatment	4,117 Apartment Treatment units with a statewide average occupancy rate of 93% (with 38 units in the pipeline). High level of support and skills training to individuals in apartment settings. Designed to be transitional with average LOS at 18 months.	Apartment treatment gives individuals the most flexibility in receiving services without moving to new locations, better supporting recovery. Apartment treatment is financed under MA Rehab Option which is currently subject to moratorium until 4/09.

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H	Residential – State Operated Community Residences (SOCRs)	531 OMH operated SOCR beds. Designed to provide a therapeutic living environment for residents.	Supported housing model is more in keeping with the direction of the field and with what recipients want.
H	Residential Care Center for Adults (RCCAs)	OMH operates 3 RCCAs at Buffalo, Pilgrim and Rockland PCs with a total of 367 beds. Program of at least 50 beds designed to provide supervised long-term residential services for individuals with chronic mental illness.	No issues.
H	Residential Supported/Single Room Occupancy (SP-SRO)	2,709 SP-SRO units (with 4,732 in the pipeline, most subject to NY NY IID). Provides long-term or permanent housing in settings where residents can access support services successful to living in the community.	
H	Residential - Supported Housing Rental Assistance	12,268 supported housing units with 100% occupancy rate (with an additional 3,323 units in the pipeline). Supported housing allows people to live more independently in the community (rental assistance residents are expected to contribute 30% of their income for rent and utilities). OMH considers supported housing as the most independent option.	OMH is exploring various options for individuals to access supportive services in a flexible manner w/o changing their housing settings. Housing in development is targeted to priority populations including individuals with long LOS in State PCs, homeless individuals, individuals on AOT status, adult home residents.
H	Residential - Supported Housing Community Services	12,268 supported housing units with 100% occupancy rate (with an additional 3,323 units in the pipeline). Supported housing allows people to live more independently in the community. (Community services include all services provided to residents of supported housing programs by the supported housing agency, excluding rental assistance).	Housing in development is targeted to priority populations including individuals with long LOS in State PCs, homeless individuals, individuals on AOT status, adult home residents.
H	Residential – Transitional Residence (TR)	8 TRs with 344 beds operated on the property of the State PCs. Provides short-term (average LOS is 6 months) residential care and treatment for IPs assessed as clinically stable who require additional support and assistance before discharge to more independent CRs. The program is a key component w/i residential care continuum allowing earlier discharge from more costly IP settings.	TRs are an integral component of the State's facilities discharge planning and critical resource to State PCs in meeting the vision of a transformed mental health system.
H	Emergency – Crisis Residence (St. Op.)	24 hour/day stabilization program which provides services for acute symptom reduction and the restoration of an individual's condition pre-crisis level functioning (time limited up to 30 days).	Crisis residence program meets OMH mission to enable individual's with serious mental illness to remain in their community.
H	Emergency – Crisis Residence (ATL)	6 licensed crisis residence programs with 78 units. 24 hour/day stabilization program which provides services for acute symptom reduction (time limited up to 30 days).	Crisis residence beds are a valuable temporary housing option for individuals diagnosed with mental illness as they offer an alternative to hospitalization.

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H	Emergency - Crisis Respite Beds	Non-licensed residential program, or dedicated beds w/i a larger licensed program.	Crisis respite beds are a valuable temporary housing option.
H	Emergency – Crisis Respite Services	9 programs provide a max. of 14 days of services per client/year. Provide relief to the primary care provider, allow situations to stabilize and prevent hospitalizations and/or longer out of home placements.	There continues to be an increasing need for accessible community-based respite options for caregivers who provide ongoing care.
H	Emergency – Crisis Services/Outreach	Includes activities in a non-patient setting to provide support for when a person's acute emotional distress requires immediate attention. Program covers expenses including salaries, wages, professional fees, supplies, travel and purchased or other direct expenses.	Crisis services are essential to the mission of providing treatment w/in the community, assisting people to remain in the community and avoid hospitalizations.
H	Emergency – Crisis Intervention Services	27 programs. Applicable to adults, children and adolescents. Intended to reduce acute symptoms and restore individual to pre-crisis level functioning. Services may be provided in emergency rooms (ER) & residential settings – may be provided by mobile crisis teams at recipients' residence or natural setting.	Mobile crisis teams are able to deliver highly flexible services in natural settings and often divert hospital emergency visits or admissions.
H	Emergency – Comprehensive Psychiatric Emergency Programs (CPEP)	18 hospitals are licensed to operate 19 CPEPS statewide. Four required components of service are: crisis intervention services in the CPEP ER, extended observation beds in hospital, crisis outreach services in the community & crisis residence services in the community. Directly provide the provision of full range of psychiatric emergency services, 7 days/week for a defined geographic area.	Many CPEPs report loss of funds in operating the program, the issue is complex and needs to be examined more closely to assess options that respond to programmatic and fiscal concerns. There may be opportunities to capitalize on disseminating best practices of hospitals that do this well. Nearly all CPEPs report a steady increase in children presenting for services.
H	Support – Care Coordination/Case Management (CM) (St. Op.)	Includes ICM, CM and Mental Health Care Monitoring.	Clinic restructuring. Current programs are funded under TCM Medicaid option.
H	Support - Case Management (CM)	Includes ICM, SCM, CM, BCM, Consumer Service Dollars (Non ICM, SCM, BCM, ACT), ICM/SCM/BCM Emergency & Non-Emergency Service Dollars. App. 25,500 adult slots are funded for ICM, SCM and BCM.	Clinic restructuring. Current programs are funded under TCM Medicaid option.
H/M/L	Support – Community Support Programs (CSP) (St.Op.)	Includes On-Site Rehab, Psychosocial Club, Advocacy/Support Services, Mental Health Screenings, Day Training. CSP includes a wide range of support services for individuals in community settings who have SPMI including those who are homeless.	CSP programs assist OMH meet its core mission. Many of the services have the potential to be provided in the PMHP model. Programs and models that provide advocacy services, peer oriented and family support services and the statewide organizations that support them are of HIGH PRIORITY.

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H/M/L	Support – CSP (ATL)	<p>Includes: On-Site Rehab, Recreation, Transportation, Outreach, Psychosocial Club, Advocacy/Support Services, Drop-in Center, Transition Management Services, Bridger Services, Self-Help Programs, Multicultural Initiatives.</p> <p>Includes sheltered workshop/satellite workshop and client worker program (all 16 PCs participate in employment programs).</p>	<p>Programs are funded by CSP, Reinvestment and LA. All programs are being reviewed w/i the context of ambulatory restructuring initiative.</p> <p>Supported employment is a major focus of OMH mission. All PCs are moving toward supported employment with less or no less reliance on sheltered work.</p>
H/M/L	Support – Employment (St. Op.)	<p>Includes: Sheltered Workshop/Satellite Sheltered Workshop, Transitional Employment Placement, Enclave in Industry, Assisted Competitive Employment, Affirmative Business/Industry, Work Program, Ongoing Integrated Supported Employment Services.</p>	<p>Several issues including conversion to PROS, movement to supported employment and outdated usefulness of the programs.</p>
H/M/L	Support – Employment (ATL)		

## OMH Children & Family Services – Core Mission Budgeting

Rank	Program/Activity	Description/Population Served	Issues
H	Inpatient (State Operated)	6 Children's State-Operated PCs and 8 IP Child and Adolescent units operating in adult PCs, provide a total IP capacity of 535 beds. In NYC and LI, OMH provides intermediate and long term care; Upstate, OMH provide the only access to IP care for children.	In the first quarter of 2008, statewide admissions have increased 8% with statewide discharges increased only 2% with the net effect of raising the average daily census. Workforce recruitment and retention is an issue.
H	IP Psychiatric Unit of General Hospital	460 children's IP psychiatric beds at 24 general hospitals.	Barriers to access are shortage of beds. Lack of child-specialized physician shortages, fiscal constraints and human resource limits hamper the ability to adequately serve children and youth with serious emotional disturbance. OMH plans to work with DOH to develop IP rate restructuring methodology.
H	Article 31 IP	8 private psychiatric hospitals with a 455 bed capacity.	Private hospitals face the same challenges as Article 28 hospitals. OMH plans to work with DOH to develop IP rate restructuring methodology.
H/M	Residential Treatment Facilities	19 State licensed RTFs with 539 beds serving app. 869 children and adolescents annually. Operates at 99.5% occupancy rate.	A challenge for the future is geographic alignment of bed capacity with regional need. NYC and Hudson River regions currently have the highest demand, while per-capita bed totals are higher in Western and Central regions. RTFs face workforce issues, need for capital improvements and use of psychotropic medications. One important approach to examine with transformation is taking an identified portion of current residential capacity and converting it to community resources to maintain children in the home and communities.
H	OP – Clinic Services (St. Op.)	OP clinics for children are operated by the Elmira, Greater Binghamton, Hutchings, Mohawk Valley, St. Lawrence, Capital District and South Beach Adult PCs, as well as WNY, Rockland, Bronx, Brooklyn, Queens, Sagamore Children's PCs.	State operated clinics serve as the safety net for the more indigent, uninsured and underinsured in comparison to their community-operated counterparts.
H	OP – Clinic Services (ATL)	In 2006 clinic treatment was significantly advanced through Achieving the Promise for New York's Children. Each year, more than 120,000 children are seen in mental health clinics.	Clinic restructuring. Pending federal regs (TCM & UPL).
H	OP – Clinic Plus Clinic Treatment, Outreach and Screening	In 2006 clinic treatment was significantly advanced through Achieving the Promise for New York's Children.	Clinics are integral to the core mission of OMH. Pending federal regs (TCM and UPL).
H	OP - Evidence Based Treatment Dissemination Center (EBT-DC) (St. Op.)	EBT-DC is an Achieving the Promise initiative. EBT-DC is a two phase approach which consists of an intensive three day workshop taught by national experts who developed the treatment followed by a full year of biweekly phone consultations. Trainings are offered for two years. A total of 780 clinicians have been trained.	To date, nearly 400 clinicians have been trained in trauma and depression CBT and more than 400 clinicians and supervisors have registered for this year's trainings on disruptive behavior disorder, a waiting list is active.

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H	OP – Day Treatment (St. Op.)	Provides intensive services to maximize each child's adjustment to academic setting. State operated programs either facilitate transition out of the hospital or prevent hospitalization. Introduction of Intensive Day Treatments is a significant change in State operated programs.	No issues.
H	OP – Day Treatment (ATL)	40 licensed programs serve app. 2,413 children and adolescents. Programs have been operated in collaboration with SED. Program blends mental health and special education services.	Currently being reviewed through the ambulatory restructuring project.
H	Residential – Family Based Treatment (FBT)	Provides care and treatment to children and adolescents with serious emotional disturbance who benefit from treatment in a smaller, more intensive family setting.	With the intro of the Waiver, there have been fewer referrals of younger children. An increasing number of youth have fewer family supports to assist with treatment and discharge planning. Federal Office of Inspector General (OIG) is reviewing FBT in NYS (audit is forthcoming).
H	Residential -Teaching Family Home (TFH)	4 programs in the State with a capacity of 16 beds. The TFH provides an individually tailored residential setting. Program uses trained parents and child care staff for up to 4 youth in the home.	LI has reported success with TFHs. The program in the Hudson River region is in the process of closing the last of three homes in Schenectady, Sullivan and Ulster counties.
H/M	Residential – Community Residence (St. Op.)	16 beds in operation and affiliated with the children's State PCs. Supportive of the clinical treatment plans of 8 children and adolescents with serious emotional disturbance unable to live at home due to treatment needs.	CRs provide a needed alternative to many children and adolescents who would otherwise be accessing hospital or IP units without necessarily needing that LOC.
H/M	Residential – Community Residence (ATL)	304 CR beds operated by private NFPs, 120 beds in various stages of development, 76 beds in RFP process (8 beds to be awarded in NYC via future RFP).	CRs will be increasingly used by older adolescents. Administrative problems include transition between funding streams and SSI funding result in denial of critical SSI funding. Federal OIG is reviewing.
H	Emergency – Crisis Residence (St. Op.)	Program at the Greater Binghamton Health Center provides short term (1-21 day) crisis residential option.	Severe limitations in the current regulatory and funding model prohibit expansion.
H	Emergency – Home Based Crisis Intervention (HCBI)	20 HCBI programs with a statewide capacity of 162 slots.	HCBI is highly cost-effective and options for expansion through inclusion of billable services will be explored within clinic and ambulatory restructuring projects.
H	Emergency - CPEP, CPEP Crisis Intervention; Extended Observation Beds; Crisis Outreach; Crisis Residence	19 programs serve adults and children; 2 programs in NYC serve only children. Four required components of service are: crisis intervention services in the CPEP ER, extended observation beds in hospital, crisis outreach services in the community & crisis residence services in the community. The statewide capacity of short-term observation beds is 83.	The service is largely an adult model. This model is also high cost in comparison to crisis diversion and HCBI.
H	Support – Residential Treatment Facility Transition Coordinator	45 Transition Coords. serve 65-700 children & fams/ year. In 2001, OMH established Transition Coordinators w/i each RTF to ensure family engagem., timely & successful disch. of children and adolescents.	Pending federal regulations re: TCM will need to be monitored for potential impact.

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H	Support – ICM (St. Op.)	Caseloads include 12 children with the expectation that 4 contacts per month are made at a minimum. ICM assists children and their families residing in the community.	Case management has been highly effective in maintaining children with their families in their homes and communities. There are considerable issues with the federal MA regulations regarding TCM and in the underlying assumptions of MA eligibility upon which the ICM and SCM programs have been built. OMH ambulatory restructuring project will be reviewing and recommending changes in CM for children.
H	Support – CM Programs (ATL)	21 ICMs cover 2,608 slots; 78 SCMs cover 1,560 slots. CM and BCM are provided as well.	CM services have been highly effective in maintaining children with their families in their homes and communities. There are considerable issues with the federal MA regulations regarding TCM and in the underlying assumptions of MA eligibility upon which the ICM and SCM programs have been built. OMH ambulatory restructuring project will be reviewing and recommending changes in CM for children.
H	Support – Children’s SPOA	Each county and NYC has developed the SPOA process whereby the needs of particular children are assessed, families are engaged, community responses are explored and service plans developed.	SPOA for children has been highly effective. In 100% of the counties, each child serving system makes referrals to SPOA. OMH and the counties continue to work on improved accountability and performance of SPOA.
H/M/L	Support – School-Based Mental Health Programs (with or w/o clinic treatment)	Include the School Based Mental Health Initiative SBMHI (began in 1995) and the School Support Program (SSP) (began in 2001). 32 school sites and at any given time, serve app. 1,200 children and adolescents through clinic treatment.	OMH is currently OMH is consolidating SBMHI and SSP into one “School Mental Health Program”. Which requires staff to devote 70% of time to treatment services and which stipulates which types of “school collaboration” activities may be supported with OMH State Aid. OMH’s policy direction is to utilize clinic treatment, Clinic Plus and Family Support to collaborate with schools rather than funding a standalone program.
H/M/L	Support – Family Support Services	100 programs serve 17,000 families annually. The goal is to reduce family stress and educate families re: child’s illness and research informed methods to support recovery.	Family Support is a key strategy in the OMH vision for children’s services to enable families to keep children at home while receiving needed mental health services and avoiding expensive out-of-home care. A variety of programs and models are funded as “advocacy” by OMH including peer and Family Support and are HIGH PRIORITY to OMH.
H/M/L	Support – CCSI	CCSI began in the 1990s as a multi agency approach to help counties create local structures to provide cross-system services to children with serious emotional disturbance and behavioral disabilities and who are at risk of residential placement. CCSI ensures delivery of services through a three tier agency structure: Tier I – local community, Tier II – county, Tier III – State.	The continuation of CCSI Tier III has been under review by a workgroup of Commissioners from the child serving agencies in 2008. Configuration of CCSI is expected in 2009.

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H/M/L	Support – Mobile Mental Health Teams (MMHTs) (St. Op.)	MMHTs provide treatment to youth in the custody of OCFs' Division of Juvenile Justice and Opportunities for Youth (DIJOY). Children and adolescents incarcerated in DIJOY facilities with behaviors suggesting psychiatric intervention may be required are treated by the MMHT.	MMHT is an early example of inter agency collaboration to best serve the needs of youth involved in more than one State system. The availability of psychiatric treatment for children in OCFs facilities is beneficial to the child and has added benefit of reducing State costs. .. this service could be expanded or enriched and would be in line with the federal DOJ desire for greater mental health services availability.
H/M/L	Support – South Beach Psychiatric Center Family Court Evaluations (St. Op.)	South Beach PC provides staff to the Staten Island Family Court to conduct psychiatric evaluations of families, children and adolescents who appear in the court primarily in custody cases. The program serves app. 330 families per year.	The OMH program model is highly valued by local family court judges, State, City and local politicians as an example of high quality mental health care and collaboration.
H/M/L	Support - Rural Telepsychiatry (St. Op.)	Active in 12 upstate counties with 2 counties expected to participate soon. Expansion is imminent and will include 21 upstate, rural counties in the initial rollout.	The program is expanding to include primary care providers linked to rural health networks with a goal of reducing crisis and intervening earlier in a child's mental health trajectory.
H	Support – Employment – Innovative Vocational Programs	6 programs serve 220 students annually. Provides vocational/career development services targeting highly individualized, community-based work experience.	The program reports a collective work placement rate of 39%. While successful in its outcomes, the program is still in need of an ongoing source of funding.
H	Support – HCBS Waiver	Includes: Family Support, Crisis Response, Skill Building, Intensive In-Home Care, Respite Care, Individualized Care Coordination.	Potential federal regulations for TCM are expected to have significant impact on Waiver. This issue is under review by the ambulatory care restructuring committee.
H	Support – Kids Oneida	125 slots serve 180 children per year. Program provides CM via its service coordinators for a provider network that offers more than 50 traditional and non-traditional services in Oneida County.	Kids Oneida has shown significant, positive outcomes for Oneida County and has become the county's version of the HCBS Waiver program. Kids Oneida has not proven a strategy that can be widely implemented statewide. A strategy for the localized success of this program will need to be identified.

## OMH Forensics – Core Mission Budgeting

Rank	Program/Activity	Description/Population Served	Issues
H	Inpatient (State Operated)	2 free-standing maximum security forensic facilities for non-sentenced individuals at Mid Hudson Forensic PC and Kirby FPC; 2 maximum security regional units at the Rochester Regional Forensic Unit and Northeast Regional Forensic Unit – funding supports a total of 506 IP beds.	Physical plant issues with aging facilities and issues related to Civil Service classifications and overtime.
H/M	Inpatient – DOCS (St. Op.)	209-bed IP Joint Commission accredited hospital at Marcy (operated by the CNYPC), serves app. 65,000 inmates with average LOS of 60 days.	CNYPC lacks a swing ward in which to place inmates in the event of an emergency necessitating movement of individuals or affected wards to other locations.
H/M	Support – On site Services to DOCS (St. Ops.)	OP services provided in 55 DOCS facilities. There are 23 OP clinics with 14 full satellite units, providing a total of 196 crisis beds, 591 Intermediate Care program beds, 199 Transitional Intermediate Care beds, 108 Special Treatment Program beds and 102 Behavioral Health Unit beds and clinic services. Serves app. 8,500 inmate/patients of the DOCS inmate population.	Two-thirds of the caseload is not for inmates with serious mental illness and would not be a priority population outside the confines of the DOCS system. The opportunity exists for OMH to assume safety net function by serving inmates diagnosed with a serious mental illness. In addition, there is opportunity to gain greater service efficiency, effectiveness and quality by consolidating resources across the forensics system at DOCS.
H	Support – Community Support Program	The forensic CSP facilitates collaboration and coordination between mental health services and law enforcement/ criminal justice programs in the community, provides training to criminal justice practitioners to improve services for persons with mental illness w/in the system, identifies gaps in programming for persons with mental illness in the system, and works with partners to develop effective responses. There are app. 20 programs funded.	There is no separate funding stream for CSP (except Wellness Self-Management). Forensic CSP relates to the core mission of OMH.  The Conference is identified as a partner with OMH and the CSP.

## OMH Sex Offender Management and Treatment Act (SOMTA) – Core Mission Budgeting

Rank	Program/Activity	Description/Population Served	Issues
H	Classification (St. Ops.)	SOMTA requires a process for evaluating the mental condition of certain sex offenders scheduled to be released from the custody of “agencies with jurisdiction: to determine whether the individual is a “sex offender requiring civil management”. The statute assigns a number of duties and responsibilities to OMH relative to identification, assessment, treatment of individuals found by the court to be in need of civil management. The process for review by OMH is rigorous and labor intensive.	Given the sensitive nature of the work, OMH’s commitment to the high priority the Classification System requires, a quality assurance program is vital to ensure that work products, documents used in court proceedings and statutorily required civil management determinations are accurate and adherent to best practices and national standards. Recruitment and retention of staff is necessary. Additionally, as a recent Court of Appeals decision, DOCS has released a number of inmates subject to a period of post-release supervision and pertains also to individuals subject to Article 10 review with a one to two day turnaround – urgent referrals remain a struggle for OMH. Additional issues include: psychiatric evaluations must be performed w/1 5 days; examiners and clinicians are subject to court subpoenas, judges and courts are unable to use videoconferencing technology.
M/L	IP Services – Secure Treatment Facility	Under SOMTA, OMH is required to accept custody for the purposes of providing care, treatment and control of individuals following a finding of probable cause. Secure treatment facilities include: MPC (20 bed Ward), CNYPC (5 Wards with capacity to serve 125 individuals), St. Lawrence PC (2 Wards operating with a capacity of 44). Each facility houses and treats its patients separate from the IP populations at the PCs.	As of July, 101 of 149 patients w/in the sex offender treatment program were being held on probable cause orders waiting trial. This is significant because these individuals do not participate in treatment in a meaningful way and are disruptive to the treatment milieu. OMH is exploring with DOCS less costly approaches to care. OMH is also reviewing staffing level restructuring and dealing with workforce issues (staffing shortages, transportation requirements).
H	OP – Strict and Intensive Supervision and Treatment (SIST) (St.Op.)	Under SOMTA, sex offenders who are adjudicated to be in need of civil management may be placed by the court in secure treatment or in OP civil management under a regimen of SIST. Sex offenders who are deemed no longer dangerous may be placed on SIST upon transition to the community. The primary goal of SIST is to enhance community safety through effective treatment and management of designated sex offenders in the community. OMH works with DOP and OAG, with treatment providers in State DOCS facilities to develop SIST plans.	SIST individuals require a team of professionals. As the numbers of individuals are released into SIST increases, there will be a need to hire staff – DCS has authorized AOT Compliance Specialists to serve this purpose. Dedicated funding is unavailable to assist offenders to secure/maintain housing and employment. Service provision would be enhanced through a network of treatment providers organized to support SIST.

# OMH Research, Administration & Finance, Capital Program & Miscellaneous – Core Mission Budgeting RESEARCH

<b>Rank</b>	<b>Program/Activity</b>	<b>Description/Population Served</b>	<b>Issues</b>
H	Research – State-Operated IP Program	3 IP units at the NYS Psychiatric Institute (NYPPI): (4 Center Unit is a 12 bed unit focused on studies of suicidal behavior: mood disorders and eating disorders), (5 South Unit is a 24 bed unit focused on psychotic disorders, substance abuse and depression), (4 South Unit is a 22 bed unit and provides psychiatric services to patients who reside in the surrounding Washington Heights community – also includes 2 off-site ambulatory clinics at Inwood and Audobon).	Staff is the principle issue facing both Institutes.
H	Research – State-Operated OP Program	2 IP units at Nathan Kline Institute (NKI): the units are in the Clinical and Research Evaluation Facility (CREF) where researchers study treatment-refractory schizophrenia and novel therapeutic approaches as well as aggression and violence in persons who suffer from mental illness. Each CREF unit has 12 beds.	The principle issue facing both programs include funding.
H	Research – State Operated Research	Both NYSPI and NKI provide OP services.  NYSPI and NKI are statutorily charged with conducting research to improve the mental health of the State's citizens.	Erosion of funds, especially federal; federal requirements related to funds.

## ADMINISTRATION & FINANCE

<b>Rank</b>	<b>Program/Activity</b>	<b>Description/Population Served</b>	<b>Issues</b>
H/M/L	State Administration and Finance	OMH Mission is to promote the mental health of all New Yorkers with a particular focus on facilitating hope and recovery for adults with serious mental illness and children and SED. The OMH Central Office is organized around the populations served in the system and includes 3 Divisions, 5 Field Offices, 8 Offices, 4 Centers.	OMH has undergone an extensive review of its operations and reduced state spending consonant with the Governor's recent order. A significant challenge of OMH will be to preserve core mission functions in the wake of a fiscal crisis, declining staff levels and a hard hiring freeze.
H/M/L	Administration – LGUs	Administration and TA is provided for all mental health agency programs as well as in areas such as clinical oversight, QA and planning. Funding for TA is made available within the individual program resources or by use of personnel funded under the State purposes portion of the budget. LGUs and eligible providers of mental health services contract under OMH FO to arrange for TA.	

# OMH Research, Administration & Finance, Capital Program & Miscellaneous – Core Mission Budgeting

H/M/L	Administration – LGUs		
		<p>Includes Reinvestment and Medicaid Grant Program: the program includes all local government costs related to administering mental hygiene services that are provided by a local government or by voluntary agency pursuant to contract with an LGU. Counties also administer and oversee AOT.</p>	
		<p>Monitoring, Evaluation, CSS: CSS funding provides for monitoring and evaluation activities associated with the program and fiscal management of CSS provided by a Core Service Agency and costs incurred by the LGU for administration. CSS funds have been used to develop social clubs, transportation and various community support and employment support programs.</p>	<p>Many of the CSS programs were converted to MA add-on funding; others are being reviewed w/in context of ambulatory restructuring project.</p>
		<p>Subcontract Services: expenses incurred which are payments to subcontract provider agencies for program delivery; does not include agency administration.</p>	
		<p>Conference of Mental Hygiene Directors: In 1997, the Conference implemented its TAP to help county directors collectively meet the challenges of changed and changing systems. The Project regularly issues publications, reports and tools for use by the counties. The program category represents funds used by the Conference to provide TA to counties</p>	<p>Reliance on MA funding is an ongoing concern for the counties, as they have lost the flexibility using State Aid to support local initiatives. Fiscal management of county-operated programs and the need for TA has been a priority for TA projects directed by the Conference. Lastly, because many individuals come into contact with a variety of different government agencies, and receive care from a system that is fragmented, the Conference plays a central role in coordinating and facilitating cross-systems collaboration and system performance as they relate to the provision of integrated services for NY's clients.</p>
		<p>SPOA:OMH charged counties with developing local strategies to prioritize their high-risk populations for the purpose of creating easy access to CM, ACT and housing systems. SPOA connects eligible applicants with appropriate vacancies in these three systems through a process that identifies individuals most in need of services, manages service access and tracks vacancies and utilizations. SPOA helps counties achieve community-based mental health systems that are cohesive and well coordinated.</p>	<p>There may be conflicts among priority populations for equal access to limited resources.</p> <p>Implementation of federal TCM regulations could have significant impact on the range of services that SPOA process would manage.</p>

## OMH Research, Administration & Finance, Capital Program & Miscellaneous – Core Mission Budgeting

M/L	Legislative Member Items (St. Ops)	OMH's budget includes funding for legislative Member Items to support 2 initiatives: 10 new research scientists at NKL and new laboratory equipment at NKL.	
M/L	Legislative Member Items (ATL)	OMH's budget includes funding to support a variety of initiatives: MHA of Rockland County, MHA of Orange County, Relief resources, Hospital Audiences, Farm Net, Occupations, Inc., Ohel Children and Family Services, NASW training for mental health services to vets, Health Care Coverage for Direct Care Workers, Children's Day Treatment, North Country Children's Mental Health Programs.	

### CAPITAL PROGRAM

Rank	Program/Activity	Description/Population Served	Issues
H/M/L	Administration Accreditation	Personal & non-personal services.	Campus planning, development & design, project mgt.
H	Energy Conservation	OMH facilities are inspected by two entities.	OMH must ensure compliance.
H	Health and Safety	Reduction of energy consumption.	Must have payback analysis to ensure investment.
H	Minor Rehabilitation	Ensure compliance with safety codes, OSHA, etc.	State inpatient infrastructure must be maintained.
H/M/L	New Facilities	Minor alterations and improvements.	State inpatient infrastructure must be maintained.
H/M/L	Plan Preparation	Prepare & review of plans, surveys, appraisals, etc.	State inpatient infrastructure must be maintained.
H/M/L	Preservation of Facilities	Construction, reconstruction, improvements, etc...	State inpatient infrastructure must be maintained.
H/M/L	Program Improvement	Construction, reconstruction, improvements, etc...	State inpatient infrastructure must be maintained.

### MISCELLANEAOUS FUNDS

Rank	Program/Activity	Description/Population Served	Issues
H	Mental Hygiene Gifts & Donations (St. Op.)	Special revenue fund to account for various gifts & donations to mental hygiene facilities for purpose designated by donor.	
H	Mental Health Grants & Bequests (St. Op.)	Special revenue fund to account for various gifts & donations.	
H	Cook Chill Account (St. Op.)	Created as a cost reduction and QI programs, stabilized food cost to OMH and allows higher quality of food than otherwise available to patients.	This program is the cornerstone of emergency management and disaster needs. Cook Chill just lost the account for HHS. Cook Chill also serves OCFS, OMRDD, OASAS.

# OMH Research, Administration & Finance, Capital Program & Miscellaneous – Core Mission Budgeting

H	Research Recovery Account (St. Op.)	Research Foundation for Mental Hygiene is a private- NFP incorporated on behalf of the State Department of Mental Hygiene in the furtherance of research, teaching & training in all areas of mental disability.	Funding is largely through federal government, foundation and industry grants and contracts. Indirect cost reimbursement from grants and contracts is a means through which the State can recoup some of its research investment costs. A percentage of indirect funds from grants resides in the Research Recovery Account and can be used to offset agency's operating costs. Funds are available to support central administration, research associates, equipment provided through external grants, travel, conference expenses, contractual services, grant writers to increase income from non-state resources and other research initiatives.
H	Internal Services Fund (St. Op.)	The Internal Services Fund (Ulrica Sprint Shop) was established in 1844 to serve the printing needs of the Mental Hygiene Department. The print shop was combined with the Central Office Design center in the 1980's and the organization is now called the Printing & Design Service. Today, it provides all publication and reproduction services to OMH, Field Offices, PCs, other state agencies and many county/local NFP organizations.	
H	Community Stores Account (St. Op.)	An enterprise fund to account for community store operations in Mental Hygiene Facilities. Revenue sources include sales of merchandise in various community stores and canteens located in mental health facilities. Funds are expended for the operating expenses of the stores.	
H	Sheltered Workshop Account (St. Op.)	An enterprise fund to account for sheltered workshop operations in Mental Hygiene Facilities. Revenue sources include contract work performed for private business and the sale of manufactured articles. Funds are to be expended for the operating expenses of sheltered workshop programs.	
H	Medication Grant Program (ATL)	In addition to the AOT, the statute established a grant program administered by OMH that provides funds to counties for medication and certain other services to treat mental illness during the period that an individual's eligibility for MA is being determined. MCP provides coverage for the costs of certain psychotropic meds and other services. 43 counties participate.	

## **OMH Research, Administration & Finance, Capital Program & Miscellaneous – Core Mission Budgeting**

H	Special Revenue Federal Funding (St. Op.)	Community Mental Health Services Block Grant	Up to 5% of the grant may be used for administrative purposes.
H	Special Revenue Federal Funding (ATL)	Community Mental Health (CMHS) Services Block Grant Shelter Plus Care Permanent Housing for the Handicapped Homeless Program Projects for Assistance in Transition to Homelessness Grant	CMHS Block Grant has statutory MOE.

## OMRDD Core Mission Budgeting

Rank	Program/Activity	Description/Population Served	Issues
H	Residential – Family Care (FC)	Serves: 2,243 state-operated and 473 voluntary operated. FC is a licensed residential program that provides a structural and stable home environment within a family unit to a person with a developmental disability. The program provides residential and rehabilitative services.	The number of people participating in FC has declined over the years as it has become more difficult to recruit FC providers as current providers retire or age out of the program. OMRDD sees FC as a program model upon which to build a growing stable community-based structure.
M/L	Residential - Community Residences (CRs)	Serves 415 individuals, voluntary operated. CRs are licensed type of residential program that provides housing, supplies and services to individuals with developmental disabilities. 24-hour on site supervision is known as Supervised CR and the model that does not require 24-hour staffing is Supportive CR.	While expanding the residential service delivery system, the CR model is rarely used. As long as individuals remain in CRs, adequate funding is needed to sustain high quality care. OMRDD uses Individualized Residential Alternatives which are a HCBS Waiver service.
H	Residential - Individualized Residential Alternative (IRAs)	Serves: 7,154 in state-operated and 19,781 by voluntary operated; 248 providers statewide. IRAs provide room, board and individualized protective oversight of individuals with DD. The residence is available with 24-hour on-site supervision (Supervised IRA) or a model that does not require 24-hour staffing (Supportive IRAs)	When expanding the residential service delivery system, the IRA is the predominant option chosen. A majority of funding for residential development (NYSCARES and Community Placement Process) is ultimately allocated to IRAs.
M	Residential - Intermediate Care Facility (ICF)	Serves: 597 in state-operated and 5,554 by voluntary operated. Provides housing and 24-hour support and services to individuals with DD. Services are comprehensive and include professionally developed and supervised activities and therapies planned for each resident by an interdisciplinary team.	When expanding the residential service delivery system, this model is not often used except when developing children's residential placement opportunities.
H/M	Institution – Small Residential Units (SRUs)	1 SRU exists on the grounds of Sunmount DDSO; serves 20 individuals. An SRU is an ICF with limited capacity designed for the purpose of providing small residential group settings on the grounds of DCs. Individuals may have significant behavioral issues. The intent is to transition individuals into community-based settings.	OMRDD has formed a board within the agency leadership to plan and implement transition for individuals in the SRU.
H/M	Institution - Developmental Center (DC)	The following DCs/census is: B. Fineson/130; Brooklyn/96; Broome/133; Taconic/62; WNY/56. DCs are large state-operated ICF/DD authorized under MHL to provide housing, services, supports for people with DD. DCs are located on campuses and are considered institutional settings. Since Willowbrook, OMRDD has continued downsizing DC population.	OMRDD continues to run down census at DCs; next announced closure of West Seneca DC will allow 56 individuals to move into the community, Taconic DS has been approved for closure and will allow 62 individuals to move into the community. Formal closure plans will be developed for B. Fineson, Brooklyn and Broome. The pace of rundown plans will depend on the future fiscal environment.
H	Institution – Specialized Autism Programs	Serves 71 individuals in state-operated facilities (B. Fineson/26 and Capital District/45. Specialized units for individuals with autism are certified as intermediate care residential facilities. Many have behavior problems.	The ultimate goal is to successfully transition individuals residing in these institutional units into community settings. There is continual need for training all staff due to rapidly changing information.

## OMRDD Core Mission Budgeting

H	Institution - Multiple Disabilities Unit (MDU)	Serves 239 individuals in state-operated facilities (B. Fineson/80; Broome/17; Brooklyn/40; Staten Is./36; Taconic/66. An MDU is an ICF that provides residential and intensive behavioral and psychiatric treatment services to people dually diagnosed with mental illness and DD. The ultimate goal is to transition individuals into the community, although some institutional capacity must remain so that individuals referred by OMH can be admitted.		Competing priorities include: OMH demand for beds, limited opportunities to meet DDSO priorities, access to adequate psychiatric services both while the individual resides in the MDU and later upon movement to the community. OMRDD will undertake a multi-year effort to restructure/refine all existing special units to: consolidate/downsize, refine scope/purpose, determine the impact on need for capacity in voluntary sector and how to reassign state employees.
H	Institution – Regional Behavioral Treatment Unit (RBTU)	Serves 73 individuals on the Brooklyn DDSO campus. An RBTU is an ICF that provides treatment to people with DD who have significant behavioral challenges and require enhanced treatment and intervention.		The goal is to develop the ability to transition individuals into community settings supported by an adequate plan to manage their significant behavioral issues.
H	Institution – Special Behavioral Unit (SBU)	Serves 47 individuals in state-operated facilities (B. Fineson/8, Broome/11, Capital District/6, Finger Lakes/22). An SBU is an ICF that provides treatment services to individuals who have substantial behavioral needs and require enhanced treatment/intervention for these behaviors.		The SBU serves as an environment to determine effective treatment strategy that will diminish problematic behaviors. The goal is to successfully transition individuals to community settings.
H	Institution - Center for Intensive Treatment (CIT)	Serves 139 individuals at Sunmount (81) and Valley Ridge (58). CITs are ICFs for individuals with a clinical diagnosis of MR. CITs are considered “Designated Secure Facilities” under NY CPL and provide intensive treatment w/i the most structured and secure environments w/i OMRDD.		CITs must maintain adequate capacity in order to accept court referrals of individuals who cannot be safely served in another environment but who do not belong in prison because of the developmental disability. Balancing security issues while maintaining compliance with ICF certification standards is an ongoing challenge.
H	Institution – Regional Intensive Treatment (RIT)	Serves 151 individuals at Brooklyn (51), Finger Lakes (39), Sunmount (61). RITs are ICFs for individuals with DD. RITs are “Designated Secure Facilities” under NY CPL and provide intensive treatment w/i a moderately secure, highly structured IP setting.		Maintaining the balance between security and active treatment is an ongoing challenge.
H	Institution - Local Intensive Treatment Unit (LIT)	Serves 335 individuals at Brooklyn (38), Broome (111), Finger Lakes (64), Sunmount (62), Taconic (60). LITs are ICF for individuals with DD. They are structured intensive treatment programs that provide IP services to assist individuals who have progressed from more secure programs (CITs or RITs) or who require intensive treatment in a somewhat secure environment due to issues in other less structured settings.		The major issue for LITs is having community step down options available for individuals who complete the LIT program and deemed appropriate for community living.
H	At-Home Supports – At-Home Residential Habilitation	Serves 4 in state-operated setting and 8,503 by 257 voluntary providers. Funding provided through HCBS Waiver is available to support 8,000 individuals with DD who live independently or with their family.		This service is in high demand and supports the core mission of OMRDD. The major expansion of this program (2/1/09) is the linchpin of OMRDD’s planned transition to individualized care.

## OMRDD Core Mission Budgeting

H	At-Home Supports – Individualized Supports and Services (ISS)	Serves 2,034 individuals by voluntary agencies. ISS offers supports, including goods, services and rent subsidies, to enable individuals with DD to live independently in their own homes.	This type of service exemplifies the direction that OMRDD’s transformational agenda is heading. The program currently serves a small proportion of individuals in need of residential services. As part of an effort to expand use of this service, OMRDD is developing a proposed shelter subsidy that will streamline access to this and other residential services and provide greater portability of funding.
H	Day Programs – Supported Employment	127 state enrolled and 8,295 voluntary enrolled through 147 providers. This employment option allows people to be employed in a regular job in the community. Supported employment is paid competitive work performed by individuals with DD who require support to obtain and sustain employment. Supports and services may include: job coaching, job development/finding, situational assessment and reassessment, skill training etc...	The current unemployment rate among individuals with DD may be 85%, although many individuals want to and are capable of work. OMRDD believes in the employability of people who have DD. OMRDD is committed to an “Employment First” policy.
H	Day Programs – Day Habilitation	4,106 state enrolled and 36,620 voluntary enrolled through 259 providers. Day Hab services are aimed primarily at developing those activities and skills outside of a person’s home that assist in developing a full life in the community.	OMRDD is seeking to undertake a comprehensive restructuring of day hab to address: conversion of these programs to more employment preparation and supported employment ops; and develop programming that more adequately addresses the needs of the increasing number of senior citizens with DD.
M/L	Day Programs – Pre-Vocational Services	168 state enrolled and 9,025 voluntary enrolled through 88 providers. Prevoc services are aimed at preparing an individual for paid employment. Services teach concepts such as: following directions, attending to a task, problem solving and safety. Basic understanding of job performance requirements is also an important aspect.	The low employment rate of individuals with DD suggests that these services need to be more specifically linked to employment outcomes.
H	Day Programs – Blended Day Services	867 voluntary enrolled. Initiated in 2004 as an OPTS program, the goal is to provide more individualized services and expanding opportunities. Blended day services provide a combo of Day Hab, Prevoc and supported employment.	The potential for this approach will continue to be explored, even in light of current fiscal constraints.
M/L	Day Programs – Day Training	121 state enrolled and 1,311 voluntary enrolled. Day training programs were developed years ago to bridge the gap between day treatment and workshop. A second round of day training programs were developed as senior citizen programs for people who want to retire from other day services.	While this service model is not fully consistent with current agency priorities and approaches, OMRDD recognizes the need and challenge of developing an effective transition plan that addresses the needs of the current program participants. OMRDD is exploring various options for integration into other programs.
M/L	Day Programs – Sheltered Workshops	141 state enrolled and 9,978 voluntary enrolled. Sheltered workshops provide paid work to people with disabilities in a controlled and protective work environment. Workshops usually subcontract with businesses to provide meaningful work for individuals with DD.	Workshops have a long history in the community. They do not offer community integration and independence of competitive employment self advocates are demanding. OMRDD continues the shift from sheltered workshops toward supp. empl.

## OMRDD Core Mission Budgeting

M/L	Day Programs – Subchapter A – Day Treatment	26 state enrolled and 2,575 voluntary enrolled. Day treatment is a planned combination of diagnostic, treatment and rehabilitation services provided to persons with DD in need of a broad range of clinically supported and structured habilitation services.	Today, this model is rarely used. Efforts are being made to convert remaining day treatment programs to day habilitation (HCBS Waiver service).
H	Waiver Respite	9,657 voluntary enrolled through 199 providers. Services that provide temporary relief to families and caregivers. Offered in and outside of the home and available day, evening and overnight.	This service is in high demand and supports OMRDD's core mission. It is increasingly difficult to meet the demand due to workforce recruitment issues.
M	Article 16 Clinics	12,688 state enrolled and 29,754 voluntary enrolled. Article 16 clinics provide clinical services of principally a habilitative nature (long term therapies) to individuals w/DD.	DOH and other state agencies including OMRDD are reforming certification logic for clinic. A number of Article 16 clinics are impacted by this reform in that they may become dual certified clinics by OMRDD and DOH. Some Article 28's may also become dual certified by DOH and OMRDD, some Article 28's may switch to an Article 16.
M	Medicaid Service Coordination (MSC)	10,951 state enrolled and 64, 118 voluntary enrolled. MSC provides assistance to persons in accessing services and supports, provided by qualified coordinators using person-centered planning. For individuals eligible for MA, service coordination is provided by OMRDD MSC, for individuals non-MA eligible, service coordination may be available as a mirrored state funded or FS funded service.	A team is looking at overall approach to promoting informed choice and continued relevance of MSC to this goal.
H	Care-At-Home Waiver (CAH)	575 voluntary operated. CAH model waiver program is designed to assist families with a child with complex health care needs and developmental disability to maintain children at home. Up to 600 children can be enrolled in CAH.	The CAH waiver enables families to keep their developmentally disabled child at home, thereby keeping the family unit together and avoiding costly out-of-home placements.
H	Self-Determination – Consolidated Support Services – Residential & Nonresidential	226 voluntary operated. CSS is a HCBS Waiver service which offers the opportunity to self-direct supports and services by controlling the use of an individualized budget managed through a fiscal agent.	OMRDD's evaluation of this pilot reveals that consistently, when the individual has greater control to purchase what s/he needs rather than what is offered to them by a provider, annual costs are typically 12% lower than when a person with the same characteristics is served through traditional mechanisms.
H	Family Support Services (FSS)	Respite, information & referral, family & individual counseling, recreations, other (transportation, CM, home care). 41,445 voluntary enrolled.	This service category must continue to be grown. Any decrease in services would greatly impact a family's ability to continue to provide care for their loved one at home. OMRDD will be moving forward with regulations to mandate applications for MA services for all those receiving or applying for services to expedite MA funding conversion.

## OMRDD Core Mission Budgeting

H	Central Coordination & Support  OMRDD Administration	Executive Leadership, Office of the Counsel, QA, Workforce & Talent Development, Information Management Solutions, Service Delivery & Development, Fiscal & Administrative Solutions, Policy & Enterprise Solutions.	
L	Hepatitis B Program	Provides reimbursement for the costs of shots and laboratory fees for employees whose occupational duties include OMRDD operated/certified programs or other work setting might expose them to blood or other potentially infectious materials. OSHA regs required each DDSO to establish bloodborne pathogen exposure control plans.	This program should be considered for incorporation into existing funding stream to minimize the administrative workload.
H	Medicaid Transportation	Transports individuals with DD to state-operated day activities.	This program is an ineffective way to support transportation needs and OMRDD is exploring ways to fund this service through other mechanisms.
M	Special Olympics	NYS provides state funding to support expenses associated with the statewide Special Olympics Games. Training costs for athletes, organizing games/events, assist local and state programs in PR, education, fund-raising and outreach.	
L	Epilepsy Coalition	The Coalition was formed to promote awareness of epilepsy and its consequences to public and private sectors in NYS to provide more funding opportunities to the epilepsy system to improve the quality of life for those who live with epilepsy.	Although the objectives of the program are laudable, it is not clear that the program is necessary to the implementation of OMRDD's core mission.
M	Voluntary Fingerprinting	Chapter 575 of the Laws of 2004 requires OMRDD to conduct criminal background checks for new employees of every provider of service who contracts with OMRDD. Over 50,000 individuals are fingerprinted yearly.	
L	Statewide Epilepsy	Epilepsy chapters across the state receive funding to support a variety of services to people with epilepsy including counseling, outreach, CM, information and referral. The chapters also provide education.	
L	Legislative Grants	Grants added to OMRDD's budget each year for various NFP agencies.	
H	Capital Programs		

## OASAS - Core Mission Budgeting

### HIGH PRIORITY PROGRAMS

Program	Description/Issues	Population Served	Number of Programs (2008-09)
Addiction Treatment Centers (ATCs)	13 ATCs -- 652 inpatient beds including 10 swing bed detox and 2 CR programs with 30 beds	Unique People: 10,069	16 programs
Chemical Dependence Prevention Services	Prevention Services		240 programs funded through 223 providers
Intensive Residential	24 hour/day, 7 day/week residential services for individuals not in need of psychiatric, IP chemical dependence or acute hospital services	16,002 unique clients/ 2,140,872 patient days	89 programs funded through 41 providers
Residential Chemical Dependency Program for Youth	Voluntary residential recovery home for youth provides therapeutic care	70 unique clients/ 9,017 patient days	4 programs funded through 4 providers
Residential Rehabilitation Services for Youth	Inpatient treatment program for youth through a multi-disciplinary team	923 unique clients/ 91,257 patient days	9 programs funded through 9 providers
Community Residential	Structural therapeutic services coupled with outpatient treatment	5,044 unique clients/ 505,454 patient days	80 programs funded through 54 providers
Supportive Living	CR program providing congregate living to chronic alcoholic; fellowship & peer support	428 unique clients/ 64,177 patient days	6 programs funded through 5 providers
Primary Care Alcoholism Program (Alcohol Crisis Center)	Inpatient care in a medically supported environment	896 unique clients/ 8,495 patient days	1 program funded through 1 provider
Prevention Resource Centers	Training and TA centers	At-risk youth	2 Centers through 2 Providers
Gambling Treatment	Outpatient treatment to compulsive gamblers	726 individuals/ 10,468 OP visits (2007)	24 programs funded through 22 providers
Gambling Prevention	Prevention activities targeted to decrease risk factors	2,000 individuals	20 programs funded through 20 providers
Medically Supervised Withdrawal Services/Inpatient Residential	Inpatient service provided under the care of a physician; medical supervision for individuals undergoing moderate withdrawal	2,709 unique clients/ 15,198 patient days	4 programs funded through 3 providers
Medically Supervised Withdrawal Services – Outpatient	Outpatient services provided under the care of a physician; medical supervision for individuals undergoing moderate to mild withdrawal	240 unique clients/ 5,831 total outpatient visits	1 program funded through 1 provider
Medically Monitored Withdrawal	Can be provided by any provider certified by OASAS; for individuals suffering from mild withdrawal with situational crisis	12,001 unique clients/ 121,593 patient days	19 programs funded through 18 providers
Medically Supervised Outpatient	Individual and group counseling; medical staff are part of multi-disciplinary team; rate structure under review for APGs	79,228 unique clients/ 2,143,073 OP visits	249 programs funded through 174 providers
Outpatient Rehab Services	Serves the more chronic individuals with inadequate support systems; inadequate functional skills; health care needs; under review for APGs.	4,713 unique clients/ 218,362 total visits	37 programs funded through 25 providers

## OASAS - Core Mission Budgeting

<p>Methodone Maintenance – Outpatient</p>	<p>Methodone treatment provided on an ambulatory basis (daily)</p>	<p>26,782 unique clients/4,703,821 units of services</p>	<p>67 programs funded through 32 providers</p>
<p>Methodone Maintenance - Residential</p>	<p>MTPs administer methadone by prescription with rehab assistance in residential setting</p>	<p>129 unique clients/16,335 patient days</p>	<p>3 programs funded through 3 providers</p>
<p>Methodone-to-Abstinence – Outpatient</p>	<p>Methodone treatment provided on an ambulatory basis with gradual decreased doses</p>	<p>206 unique clients/31,297 patient days</p>	<p>1 program funded through 1 provider</p>
<p>Methodone-to-Abstinence – Residential</p>	<p>Methodone treatment provided in residential setting with gradual decreased doses</p>	<p>727 unique clients/96,678 patient days</p>	<p>2 programs funded through 2 providers</p>
<p>Recovery Community Centers</p>	<p>Centers utilize peer to peer recovery support services</p>	<p>Individuals and families in the prevention &amp; treatment system</p>	<p>4 programs funded through 4 providers</p>
<p>NY NY III – Post Treatment Housing</p>	<p>Homeless housing initiative in NYC</p>	<p>250 unit operational; 75 operational in 1/09 – homeless single adults completing substance abuse treatment</p>	<p>10 programs funded through 10 providers</p>
<p>NY NY III – Housing for Persons at Risk of Homelessness</p>	<p>Homeless housing initiative in NYC</p>	<p>287 scattered-site rental subsidies</p>	<p>1 program funded through 1 provider</p>
<p>Shelter Care Plus</p>	<p>Part of HUD's Homeless Assistance Program</p>	<p>Homeless single adults and families (must have begun substance abuse treatment when they were homeless)</p>	<p>50 programs funded through 28 providers</p>
<p>Permanent Supportive Housing</p>	<p>Rent subsidies, CM, employment counseling</p>	<p>Single adults and families who are homeless or at risk of homelessness</p>	
<p>Case Management</p>	<p>Activities which link client to the service system</p>		<p>58 programs funded through 50 providers</p>
<p>Specialized Services Substance Abuse Programs</p>	<p>Alternative to incarceration program (parole violators) provided at the Edgecombe facility</p>	<p>Currently has provided services to more than 390 detainees</p>	<p>1 program funded through 1 provider</p>
<p>Local Governmental Unit Administration</p>	<p>Local government costs related to administration of mental hygiene services</p>		<p>61 "programs" funded through 57 "providers"</p>
<p>Managed Addiction Treatment Services</p>	<p>Provides case management services to high cost utilizers of services – Medicaid eligible recipients of chemical dependency services</p>	<p>1,400 individuals actively enrolled</p>	<p>23 programs funded through 23 providers</p>
<p>Dual Diagnosis Coordinator</p>	<p>Specialized support services to provide coordinated care for individuals with co-occurring disorders</p>	<p>Individuals with co-occurring disorders</p>	<p>6 programs funded through 6 providers</p>
<p>Road To Recovery</p>	<p>Alternative to incarceration program</p>	<p>Non violent repeat felony offenders with chemical dependency issues – currently serving 350 clients</p>	<p>16 programs funded through 16 providers</p>
<p>Support Services – Educational</p>	<p>Specialized chemical dependency related services to provide education support</p>	<p>Various</p>	<p>6 programs provide education services on meth use; 1 provides intervention, referral &amp; eval. to Native American population in NYC. 1 programs provide education to addiction professionals</p>

## OASAS - Core Mission Budgeting

Community Services – Underage Drinking	“Underage Drinking – Not A Minor Problem” campaign	Youth under the age of 18	28 programs funded through 25 providers
Resource	Specialized support services to provide resource support such as training	3 contracts for training providers on prevention, co-occurring disorders, methadone and legal issues affecting clients with criminal justice involvement	3 programs funded through 3 providers
Program Administration	Specialized support to provide program administration	None	1 program funded through 1 provider
Program Development – Treatment Services	OASAS Scope of Responsibilities		
Program Development – Prevention Services	OASAS Scope of Responsibilities		
Program development – Recovery Services	OASAS Scope of Responsibilities		
Executive Office, Statewide Field Operations, Counsel, Fiscal Administration, Information Technology, Management Services & Emergency Management, Human Resources Management, Capital Management			
Long Range and Local Services Planning; Program Performance Monitoring and Data Reporting; Data Management; Project Evaluation	OASAS Scope of Responsibilities		
Grants Management	OASAS Scope of Responsibilities		
Credentialing	OASAS Scope of Responsibilities		
Certification, Facility Evaluation & Inspection, Fiscal Audit & Review, Standards Compliance, Enforcement	OASAS Scope of Responsibilities		
Practice Improvement, Epidemiology, Ethnography & Needs Methodology	OASAS Scope of Responsibilities		
Training	OASAS Scope of Responsibilities		

## OASAS - Core Mission Budgeting

### MEDIUM PRIORITY PROGRAMS

**Federal Policy:** Supports the efforts to influence the policies, laws, regulations which affect OASAS' ability to plan for and provide quality treatment, prevention and recovery services

**Program Improvement:** Provides assistance to providers to improve program services including: Best Practices Focused Implementation Study, NIATx 200 and START-SI

**Research and Development:** Promote and conduct research projects that address policy issues and development needs in the addiction field through the OASAS Research and Development Agenda; collaboration with sponsors, researchers, policy makers and services providers; and direction of and/or participation in collaborative research and development projects

**Needs Assessment and Outcome Management:** Development and maintenance of the treatment need methodology which is used for local needs assessment and planning efforts; also used for the Certification Bureau's review of applications for new and expanded capacity; guides the development of treatment resources to ensure equitable distribution of services statewide.

**Job Placement Initiative:** Vocational rehabilitation focusing on job referrals and placement.

**Vocational Rehabilitation:** Prepares people for employment by helping them choose a vocational role and function consistent with their abilities and interests. All chemical dependence services patients in treatment are eligible for vocational rehabilitation.

**AIDS Resource Center:** These hospital based programs provide AIDS/HIV resource services to substance abuse programs and their clients; in 2008-09 there are a total of 7 hospital based programs funded through 7 providers.

**AIDS Resource (Non Hospital Based):** These programs provide AIDS/HIV resource services to substance abuse programs and their clients; in 2008-09 there are a total of 15 non-hospital based programs funded through 15 providers.

**COSA (Children of Substance Abusers):** Prevention and intervention strategies for COSAs; in 2008-09 there are 4 programs funded through 4 providers.

**Intake, Outreach & Referral Units:** Specialized support services including short term screening and intervention services to link clients to treatment; serves residents of certain homeless shelter served by the NYC DHS; in 2008-09 there are 3 programs funded through 3 providers.

**Chemical Dependence Inpatient Rehabilitation Services:** Intensive program for clients requiring evaluation and treatment services in a highly structured setting; model provides short term program severely compromised by their addiction; there are 996 unique clients served, 23,194 total patient days. In 2008-09 there are 2 programs funded through 2 providers.

**Enhanced Methadone Maintenance – Outpatient:** In addition to methadone maintenance programs, these enhanced programs provides various specialized services to meet unique needs of clients. In 2008-09 there are 2 programs funded through 2 providers.

**Enhanced Medically Supervised – Outpatient:** In addition to medically supervised, these enhanced programs provide various specialized services which are non-Medicaid reimburse able (anger management, child care, job readiness). In 2008-09 there are 27 programs funded through 25 providers.

**Community Mobilization:** Supports formal training to develop local strategic action plans which include science based prevention strategies.

## **OASAS - Core Mission Budgeting**

### **LOW PRIORITY PROGRAMS**

**Sub allocation to DOH/AIDS Institute:** The SAPT block grant stipulates that 5% of funding must be set aside for early HIV intervention services on site of treatment for substance abuse disorders (given the concerns in the 1990s that HIV infection was spread through sharing of needles).

**Sub allocation to DOCS:** SAPT block grant funds are used to support treatment by DOCS staff for inmates in maximum security facilities.

**MOU with DOCS:** SAPT block grant funds to support access to community-based outpatient chemical dependence treatment services for persons on work release.

**Outpatient Chemical Dependence for Youth:** Serve youth between the ages of 12 and 18 by providing a drug-free setting with active treatment. Outpatient services for youth can be sufficiently provided through 822 clinics. In 2008-09 there is 1 program funded through 1 provider.

**Residential Chemical Dependence for Youth:** A voluntary intensive IP rehab program for youth. This program is no longer viable since providers have converted to RRSY. There are no funded programs.

**Criminal Justice Intervention/DWI:** Serves individuals in county/local jails with alcohol/drug abuse problems; this program consists of organized activities designed to ensure that persons charged with an alcohol related driving offense are screened and evaluated for treatment. Some of the activities are coordinated by the county.

**Street Ethnography (Street Studies):** As part of OASAS Epidemiological efforts, OASAS performs research studies and investigations.

**Legislative Member Items:** Currently there are 45 programs funded through 29 providers.

**Support Services – Medical/Legal/Psychological:** This program primarily provides research on methadone treatment. In 2008-09 there is 1 program funded by 1 provider.

**KEEP Units – Outpatient:** Methadone treatment delivered on an ambulatory basis. In 2008-09 there are no funded programs.

**KEEP Units – Prison:** Methadone treatment delivered in a prison setting (Riker’s Island). In 2008-09, there is 1 program funded through 1 provider.