Final Report: The Statewide Advisory Council on the Proposed Creation of a New State Agency for Mental Health and Addictions

New York Association of Alcoholism and Substance Abuse Providers

The Coalition for Behavioral Health

New York State Council for Community Behavioral Healthcare

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Introduction

Governor Cuomo proposed in his 2021-22 NYS budget the establishment of a new single integrated behavioral health (BH) agency to replace the separate Office of Addiction and Support Services (OASAS) and the Office of Mental Health (OMH). Three New York stakeholder organizations--New York Association of Alcoholism and Substance Abuse Providers, The Coalition for Behavioral Health and NYS Council for Community Behavioral Healthcare--were asked by OMH and OASAS to convene an Advisory Council, with OASAS and OMH staff support, to engage diverse stakeholder participation and elicit their perspectives and ideas during March and April 2021. Significant discussions ensued that touched on a wide range of issues and reforms.

Participatory Planning

The overarching goal of this unprecedented stakeholder initiative was to provide an opportunity for service participants, peers, family members, front line staff, community agency leaders and others to have a voice at this pivotal moment of change in the mental health and addiction treatment systems. The conveners wanted to gather the stakeholders' best ideas about improving quality of care, as well as addressing system gaps and inequities. It should be noted that workgroup participants were asked to provide recommendations for a new unified State Office, if the Governor's budget proposal was enacted; workgroup discussions did not include whether or not there should be a new Office, and therefore, the report does not address that issue.

A Steering Committee was formed with 15 participants from the mental health and addiction fields (participants attached). The Committee had geographic, cultural and stakeholder diversity, including consumers, peers and family members.

Ten workgroups were formed to focus on key issues that were vital to a discussion about creating a new state agency. Each workgroup had two facilitators, one primarily associated with mental health and the other with addiction. The workgroups were: Structure of the New State Agency; Regulatory Framework; Access to Integrated Care; Agency Culture; Prevention; Budget; Workforce; Recovery & Stigma; Justice, Equity, Diversity & Inclusion; and Priority Issues. Each workgroup met once weekly during the weeks of March 8, 15 and 22.

There was enthusiastic interest from a very diverse group in attending and participating in all 30 workgroup sessions. With 1,337 people from around the state representing all stakeholder groups participating and providing their feedback, the average attendance for all sessions was more than 100 people. Participants included consumers, peers, family members, mental health and addiction services staff, community agency representatives, local government-run behavioral health program leaders, and other interested people. Most people participated in two or more workgroups and there was continuity of participants, with 80% of those who attended the first meeting also attending the second and third meetings.

All workgroup discussions related to how the system needs to be transformed so that it adequately addresses the

substance use and mental health needs of all people across NYS. Participants were invited to offer suggestions and reflections in response to questions and discussion topics. Over the three meetings, each workgroup reached broad consensus on recommendations to guide planning for a new agency. Many of the recommendations address longstanding systemic challenges, deficits and barriers to equitable quality care. Participants advocated that a number of the recommendations can and should be implemented even before a new agency is created. The recommendations from each workgroup are attached.

The entire process before, during and after the workgroup meetings was guided by the Steering Committee, which convened on multiple occasions. After the workgroup meetings were completed, the Steering Committee and workgroup facilitators met on March 29, April 9 and April 16 to review the recommendations and identify any missed issues and/or recommendations that needed further detail. Every recommendation made by every workgroup and all of the discussion leading up to them was documented by note takers. To maintain the integrity of the recommendations collected by the note takers, the Steering Committee did not omit or add new recommendations to the lists gathered by the note takers. A summary of their additional discussion is attached as a separate document.

New Agency Formation Paused

Even though the Governor's proposal to create a new state agency was not adopted during the recent legislative session, the Advisory Council conveners believe that the recommendations from this unprecedented stakeholder process should be addressed as soon as possible by NYS OASAS and OMH. Below are six overarching critical issues that the convening organizations and participants urge NYS to start tackling right now, with actionable recommendations that can be addressed whether or not a new agency is created. Some recommendations can be implemented relatively quickly through OMH and OASAS policy and/or regulatory changes. Others may require significant advocacy and legislation.

Critical Issues for Immediate Action

1. Significantly improve the service user's experience at OMH and OASAS licensed/certified/funded programs with the goal that every individual and family feel welcome and has access to the behavioral health (BH) services they need and want.

System-wide, individuals of all ages and families who need and use mental health and/or addiction services (BH care) should have a welcoming experience whenever they request assistance. They should be able to receive both mental health and addiction services at any program licensed, certified and/or funded by OASAS and/or OMH (e.g., No Wrong Door). Services should adhere to anti-racist principles, and embrace people and communities in a manner that responds to the needs of underserved communities including people of color, indigenous people, people with vulnerabilities related to hearing, sight and/or mobility, the LGBTQ community, people with intellectual and developmental disabilities and others. Peer services should be widely available in all service settings.

Actionable Recommendations: Actualize a Justice, Equality, Diversity and Inclusion (JEDI) approach in the behavioral health sector by taking the following steps:

- Offer a No Wrong Door approach at OMH and OASAS-licensed/certified service settings by simplifying OMH/OASAS regulations and processes for obtaining an integrated license or certification (e.g., operating certificate);
- Cross train the OMH and OASAS workforce to facilitate access to integrated services and resources (e.g., No Wrong Door);
- Provide reimbursement and fees that support 100% of the cost of delivering services so that a culturally and linguistically diverse workforce can be hired, trained and retained;
- Engage academic partners to prepare the workforce for the delivery of integrated services; and
- More fully integrate peers into the continuum of service delivery by ensuring that services provided by peers are reimbursed at rates at least equal to the cost of rendering their services.

2. Retain and attract a motivated and skilled behavioral health (BH) workforce by providing a living wage and opportunities to improve their position in the workplace over time.

BH clinicians, CASACs, peer specialists, housing case managers, prevention specialists, harm reduction counselors, and others providing BH services are unsung heroes of the pandemic. Treatment, prevention, recovery, case management, harm reduction, residential and other services continued to operate throughout the pandemic, with BH workers providing in-person services as needed (at times without adequate personal protective equipment). Staff pivoted to telehealth and virtual services whenever possible and continued to engage persons needing services and resources. Many BH

workers, in spite of near-poverty or worse wages, put themselves and their families in harm's way risking exposure to COVID. Unacceptably low salaries are the result of NYS-approved Medicaid reimbursement and contract fees that cover program costs in community-based agencies only if staff are paid low salaries and benefits, especially those who are not licensed professionals. Government and hospital-run programs can pay more, so community programs too often lose experienced staff.

Actionable Recommendations: Improve workforce salaries, benefits and career opportunities to reduce staff turnover with the following actions:

- Adjust OMH and OASAS program grant funding, rates and fees to support living wages and improved benefits for the BH workforce;
- Provide annual COLAs that adjust grant funding, rates and fees for inflation and new mandates;
- Offer educational benefits to BH workers so they can advance up the career ladder either through grants to community agencies or by NYS directly funding educational opportunities for the BH workforce; and
- Develop regional and state-wide strategies to recruit and retain BH workers to be collaboratively implemented by OMH, OASAS and service providers.

3. Simplify and align the regulatory and licensing/certification systems to make it quicker and easier for agencies to address unmet community service needs, including through telehealth services and integration of mental health/ addiction treatment services.

OMH and OASAS have different regulatory requirements and processes to obtain an operating certificate. For example, a community provider that wants to establish an integrated program at an OMH or OASAS certified community clinic must first apply for a satellite operating certificate from the other agency. The provider can only apply for an integrated license after the operating certificate is obtained and both co-located clinics are operating as distinct programs conforming to OMH and OASAS' differing operational requirements.

Actionable Recommendations: Regardless of whether a new agency is created, OMH and OASAS should take the following steps to improve New Yorkers' access to care, as well as reduce the complexity and time required to establish a new program and comply with ongoing regulatory requirements:

- Align OMH and OASAS licensing/certification regulations and processes for similar program types (e.g., community treatment, residential, etc.);
- Implement regulatory reform that promotes access, equity and inclusion, supports quality care and innovation, and provides opportunities to address social determinants of health as an integral part of prevention, treatment, recovery and harm reduction services;
- Integrate OMH and OASAS housing models to provide increased fluidity and access;
- Prepare to consolidate the expertise and experience of both addiction and mental health housing programs into

one integrated initiative as soon as the new agency is launched;

- Align the program and fiscal audit processes between OMH and OASAS, and standardize it across all program types;
- Provide infrastructure funding for staff training, billing, EHR system updates and other transition costs to support providers' transition to integrated care; and
- Advocate at the federal level for regulatory waivers and support flexible telehealth services post-pandemic, including telephonic services and flexible duration of care requirements.

4. Ensure the financial sustainability of the community behavioral health sector by increasing base funding to cover unfunded mandates and rising operating costs, as well as needed increases in workforce salaries.

During the COVID pandemic, there were alarming rates of suicide, mental health disorders, overdoses and addiction. Mental health and SUD experts expect significant increases in the demand for behavioral health services post-pandemic. The fiscal stress associated with the COVID pandemic and the ongoing workforce crisis experienced by community programs are a dual threat to communities as they try to address escalating need for services. These community programs also had significant unfunded new expenditures for telehealth infrastructure, infection control and staff overtime/incentives. They started 2021 weakened fiscally at a time when the demand for BH care is high and growing.

Actionable Recommendations:

- Modify APG rates to align reimbursement with the actual cost of care;
- Use all newly available funding sources (e.g., COVID relief, block grant increases, opioid settlement funds) to strengthen funding for BH services, address the BH workforce crisis, prioritize improved access to care, address service gaps and underserved people (e.g., older adults, children, crisis services, Black, Indigenous and People of Color (BIPOC)), meet unique needs of urban, suburban and rural communities, close funding gaps for community providers and cover rising agency costs;
- Reinvest any savings resulting from the development of a single agency in community-based services;
- Provide State aid for services to uninsured/underinsured individuals and ensure a fully funded Indigent Care pool;
- Address the limited State aid funding available for addiction prevention services and the general lack of funding for mental health prevention;
- Address the limited State aid funding for harm reduction services and recovery services; and
- Standardize the OMH and OASAS billing, financial reporting and auditing process to reduce complexity and the potential for errors so community agencies can get paid for the service they deliver.

5. Infuse justice, equality, diversity and inclusion (JEDI) in all aspects of behavioral health services and implement strategies to counter stigma.

Communities in NYS often face different challenges and barriers to overcoming stigma in seeking out behavioral health care and facilitating access for all. Health disparities exist in rural, suburban and urban areas of the state. Individually, New Yorkers often face obstacles related to race, immigration status, language, poverty, sexual orientation, age and more.

Actionable Recommendations:

- Require all OMH and OASAS RFP responses to include a description of how JEDI principles will be incorporated in the proposed program or service to address physical and behavioral disabilities, as well as racial, income, language and other barriers;
- Ensure JEDI is a component of staff supervision and require supervisors to receive specialized training;
- Require JEDI training for behavioral health professional licensing and credentialling;
- Promote self-directed care and shared decision making that starts where the person is in terms of their priorities and goals, ensures consumer choice, and focuses on a strengths-based perspective;
- Provide equitable access to technology for New Yorkers who want or need to receive behavioral health care via telehealth;
- Assess the value of behavioral health care using measures that demonstrate increased community tenure and financial stability, connection to community resources and housing, decreased food insecurity, isolation, incarcerations and other contacts with the criminal justice system, and recipient satisfaction with services; and
- Prioritize addressing stigma through public education, workforce training, social media and other strategies now and when the new agency is formed.

6. Promote transparency and collaboration between OMH, OASAS and community stakeholders.

Stakeholders participating in the workshops expressed frustration at the often inconsistent, inadequate and even at times lack of communication between OMH/OASAS, community agencies and other stakeholders about important changes in the mental health and addiction treatment systems. Confusion, lost revenue and unfunded mandates, as well as problematic policy, regulatory and/or guidance activities have resulted from the lack of timely input by stakeholders.

Actionable Recommendations:

- Create a state-level platform for the meaningful input of service users, peers, family members and line staff into the planning, implementation and oversight of OMH and OASAS' current and new service initiatives, including a new state agency.

- Improve communication between the Central Offices and Field Offices so that there is a consistent approach among the Field Offices with respect to the certification process and on other issues;
- Standardize the interpretation of OMH and OASAS regulations by auditors;
- Streamline the process for issuing and updating guidance to the field; and
- Notify and seek input from community providers about regulatory and standard of care changes prior to adoption.

Advisory Council Workgroup Recommendations

(The list of workgroups is in no particular order)

Structure of the New State Agency

Guiding principles for structure

The Structure Workgroup proposed the following fifteen guiding principles to strategically advance the successful implementation of a new Office of Addiction and Mental Health Services:

1. Embrace justice, equity, diversity and inclusion (JEDI) principles
2. Advance access to addiction and mental health services, including for individuals with co-occurring disorders
3. Integrate addiction, mental health and primary care services
4. Reinvest savings from improved efficiencies of operation to increase services
5. Strengthen workforce capacity
6. Re-envision regulatory effectiveness including incentivizing innovation
7. Preserve established specialized addiction and mental health expertise
8. Reduce stigma facing individuals and families experiencing addiction and mental health challenges
9. Support fiscal stability for provider agencies
10. Maximize revenues from state, federal and insurance streams
11. Consolidate organizational functions within the new agency
12. Advance the effective use of technology such as tele-practice
13. Encourage greater use of peers in service delivery and consumer input in developing policies and practice guidelines
14. Identify and remedy more quickly areas of policy and practice that impede effective service delivery
15. Address geographic inequities such as unique rural service delivery challenges

Additionally, the Structure Workgroup offered the following recommendations:

- The structure of the new agency should include a high-level position focused on Justice, Equity, Diversity, and Inclusion (JEDI). This position/department should include as part of its mission addressing barriers to accessing person-centered services for persons with disabilities, including intellectual and developmental disabilities, and hearing, mobility and visual impairments, developmental disabilities; elevate peer voice in the structure; and increasing consumer/family input in agency policy and procedures.
- The structure of the new agency should support and focus on addressing the unique issues of rural and urban access. It should support local and regional planning processes throughout the State. The new agency should also support stigma reduction, spirituality, and collaboration with faith-based organizations.
- The new agency should support and promote co-occurring disorder and integrated care models of treatment (e.g., biopsychosocial), while retaining expertise on addiction-specific and mental health-specific areas of policy, practice, and prevention. An emphasis should be to create and sustain a unified agency culture.
- The new agency should support an opportunity for regulatory reform that supports innovation, provider viability, and opportunities to address social determinants of health as an integral part of prevention, treatment, recovery,

and harm reduction. Consideration should be given to establishing a unified Department of Housing incorporating the expertise and experience of both addiction and mental health housing initiatives.

- The new agency should support the consolidation of functions such as licensing/ certification, training, legal affairs, workforce development, and fiscal management. A priority of fiscal management should be (at the least) "maintenance of effort" in the expenditure of State funds, while maximizing the federal sources and insurance reimbursement to strengthen the system of care. Attention should also be given to reforming Medicaid and Managed-Care rate setting to better support the needs of providers and consumers for timely access, comprehensive care, and innovation. Any savings from administrative efficiencies should be re-invested in prevention, treatment, and recovery. The regional offices of the new agency should be structured to provide consistent and timely support across all regions of the state.
- The new agency should support the recognition that provider agencies operate in both the current mental health and addiction systems and that a goal would be "no wrong door" for access to services. The new agency should promote the use of technology such as tele-health, and unify data reporting mechanisms, such as electronic medical reporting, and other requirements to ease burdens on provider agencies.
- The new agency should be phased in to allow for thoughtful attention to a wide range of important issues by all stakeholders, including children and families whose needs must be adequately addressed in the new agency. The phase-in should be timely enough to allow for addressing these important issues quickly, so as to make a significant positive difference in the lives of individuals and families suffering from addiction and mental health conditions.

Regulatory Framework

1. In order to emphasize the "no wrong door" approach, develop an integrated license which allows for specialized services.
    a. All providers will have the ability to assess and connect individuals to the appropriate type and level of care
2. The regulatory framework should be developed after completing an examination of what other States have done and with an effort to establish uniformity between federal, state, and payer requirements.
3. In order to assist the community in transitioning to integrated care, in which all providers are able to assess individuals and connect them to the appropriate care, a clear pathway should be provided, and change should occur gradually.
    a. To reduce the likelihood of destabilizing the behavioral health system
    b. To reduce the potential of program closures – which would reduce access
4. A Regulatory Framework should be developed to promote access, equity and inclusion, and quality care.
    a. regulations should raise the bar
    b. emphasis should be placed on the voice of the recipient and protection of each individual's rights
    c. layers of regulation should not be created to address deficiencies by individual providers
    d. regulations should be developed with billing, MCO requirements in mind – but should NOT be plan-driven
5. A Regulatory Workgroup should be created (to mirror OASAS system) – to obtain stakeholder input on regulatory development/revision. This furthers the goal of regulations which promote person-centered care.

6. Streamline the process to obtain an integrated license (operating certificate) and remove current regulatory barriers to doing so.
    a. Eliminate the requirement of having a current license from OMH and OASAS to obtain an integrated license
    b. Look at the waiver process
    c. Consider a method similar to OMH's "optional services" when applying for a license
7. Standardize the process for licensure and audit across all program types.
    a. Standardize regulations across programs pertaining to items such as incident management, patients' rights, etc., while maintaining separate regulations for specific levels of care and program types.
        i. Start with programmatic oversight
        ii. Move towards level of care regulations
        iii. Address fully integrated service
    b. Improve communication between Central Office and Field Offices (and promote a consistent approach between regional certification staff)
        i. Standardize the interpretation of regulation by auditors
    c. Streamline the guidance process (issued and updated guidance)
        i. Notification of regulatory or standards of care changes should be done in advance and communicated clearly and widely. Eliminate Local Services Bulletins.
    d. Audit Certification focus and tools should be on anchors of care and quality rather than forms, dates, etc.
8. While remaining mindful of safety issues, reduce redundancies and burdensome regulations.
    a. Develop a comprehensive assessment with room for additional focus on mental health or substance use.
    b. Eliminate periodic treatment/service plan review requirements. Move to progress notes as the review process or at least standardize required time frames across program types.
    c. Eliminate requirement of psychiatrist sign off.
9. Continue the creative opportunities developed during the COVID-19 pandemic -while recognizing that some waivers require continued waivers on the federal level.
    a. Telehealth
    b. Use of telephonic intervention
    c. Reduction of minimum service duration requirements
10. The development of regulations pertaining to the workforce should standardize title definitions, incorporate training expectations and opportunity, and respect the role of individuals with lived experience.
    a. Standardize the title of Qualified Mental Health Professional and other titles used across both agencies
    b. Don't allow new regulations to limit the scope of practice for the CASAC workforce
    c. Reduce regulations that restrict the ability of the workforce to do their job
    d. Continue the progress being made in valuing individuals with lived experience
    e. Recognize that individual practitioners may maintain specialty focus
    f. Expectation of workforce ability to provide integrated care should be accompanied by training opportunities

Access to Integrated Care

1. Ensure that Key Elements of an Integrated System are included in the new agency plan:
    a. No wrong door philosophy
    b. Commitment to improved access
        i. Accommodations are available for individuals with disabilities
        ii. Streamline and simplify recipient enrollment
    c. Focus on person-centered care and treatment of the whole person
        i. Including environmental factors and social determinants of health
    d. Emphasis on shared value, language, and decision making
    e. Recognition of the continued need for specialty treatment
    f. Availability of resources and training
    g. Interdisciplinary approach
    h. Multidisciplinary collaboration and communication
2. Engage recipients in the development and evaluation of the new agency
    a. Emphasis on recipient choice
    b. Include youth and family involvement in key decision making
    c. Promote access, trauma-informed care, and harm reduction through peer involvement
3. Focus on the vision of an integrated system before the development of regulations and reimbursement.
    a. Engage the field for input in the development of a detailed vision for a new State agency, implementation of the activities of the new agency, and for continued feedback from the field as the new agency progresses.
    b. Family, youth and peers need to continue to be involved, and not just for a rubber stamp.
    c. Provide regulatory flexibility
4. Outline and share a clear path/roadmap toward integration and obtain stakeholder feedback before implementation.
    a. Define mileposts and the transformational changes needed for agencies who may be starting at different stages of integrated care.
    b. Consider engaging agencies who are already providing integrated care in the development of best practices and/or lessons learned.
    c. Consult models of person-center, integrated care – such as ACT
5. Identify funding to support the cost of providing integrated care in the community.
    a. NYS funding resources need to be identified. For example, training resources that are in place already, such as CTAC can be used.
    b. Needs to be a strategic look at the system to ensure funding, rather than trying to continue maintaining the current system. We need to stabilize the system of funding, while enabling continued access. Smaller organizations would not be able to keep up in a rapidly changing environment without transition funding, but there is a need for financial support broadly in the behavioral health sector. We can't continue to rely on people to do more with less. There needs to be available funding across the board.
    c. CCBHC is the current model that covers the cost of comprehensive care. If we are to ask people to provide

comprehensive care, the rates need to cover comprehensive care.

   d. Ensure training resources are available
   e. Ensure that providers who are treating communities of color receive adequate support and funding.

6. Include primary care in the plan for integrated care – encourage partnerships using telehealth or mobile medical units (FQHC)
   a. NYS Department of Health should be included in the discussion on integration.
7. To further emphasize the focus on treating the whole person, expand the disciplines included in an integrated care team - develop a framework which could be utilized by agencies and encourage community partnerships.
   a. Vocational Specialists
   b. Occupational Therapists (to assist individuals in engaging in meaningful activities in addition to addressing treatment needs and collaborating on technology access)
   c. Targeted case managers, transition specialist, independent living centers
   d. Encourage collaboration with the faith-based community
   e. Consider resources available in the recipient's natural environment
8. Address the lack of resources in some smaller communities, by encouraging regional partnerships to provide integrated care.
9. In promoting the development of a workforce able to provide effective integrated care, focus on best practices, staff training, and supervision to achieve the following:
   a. Core competency – to include cultural competence
   b. Increased skills of relationship building and engagement
   c. Effective functioning of a multidisciplinary team
      i. Striving to meet recipient needs concurrently as opposed to sequentially
10. Engage academic partners to prepare future workforce for the delivery of integrated care.
11. Invest in technology to include assistive technologies and a focus on the use of platforms to connect recipients with services.
   a. New agency should draft guidelines for effective use within the mental health population

Agency Culture

1. The new agency should be developed with an emphasis on:
   a. the whole person (in their environment)
   b. Social determinants
   c. Empathy - emphasized in all aspects of development
   d. Recipient need
   e. Person-centered, strengths-based approach
   f. Trauma-informed approach
   g. Reducing stigma
   h. Attention to language
   i. Integration as an expectation for integrated care

j. Continual process of evaluation and change

2. State agencies should increase transparency and the new agency culture should be reflected in the mission statement:
    a. Mission statement should be based on input from stakeholders
    b. Culture involves the vision and principles of the agency as well as the strategic intent of what drives the mission, regulations, guidance documents, departments
    c. With a strong focus on justice, equity, diversity, and inclusion
    d. Focus on collaborative relationship with the community (remove the top-down nature of the relationship between community agencies and the State agency)
3. A new agency should improve the focus on diversity by having an Office of Diversity as well as a diversity specialist in each division.
    a. Transparency and institutional racism must be addressed
    b. Inherent biases need to be acknowledged
    c. Staff should be more representative of individuals being served
    d. Maintain focus on what we have in common while focusing on diversity
4. Develop a shared language and understanding
    a. Including common recovery language and mission statement
    b. Launch public campaigns about language
    c. Assist providers in learning about each other and dispel myths
    d. Develop an awareness of microaggressions
    e. Address differences
5. Create an inclusive culture through the development of a technology committee dedicated to inclusion and the creation of educational material.
6. Maintain an emphasis on serving individuals with disabilities
    a. Funding and staff training should be available to ensure that people with disabilities are effectively engaged.
    b. Investment in technology and adaptive services
7. Create a culture focused on best practices and evidence-based interventions
    a. Prescriptive Recovery rather than descriptive recovery - address the complex nature of integrated and recovery-oriented work by establishing policies/regulations that allow for the flexible/individual care that is needed.
8. Include individuals with lived experience in the development of a person-centered culture.
    a. Develop a mechanism for recipient feedback and encourage that feedback
    b. Create a diverse Statewide Consumer Council
    c. Ensure that that everyone, no matter what race, color, creed, or disability has an equal say in implementation of the new agency and its continued operations
    d. Peer specialists should be integral to all levels of care in the system.
    e. In addition to having an Office of Consumer Affairs, establish hiring practices to increase representation of peers and service recipients in the state agency workforce.
    f. Replace the hierarchical structure with a more trauma informed and collaborative system- which impacts

treatment spaces- waiting rooms, counseling offices, etc.

g. Use of surveys to obtain feedback
h. Determine terminology for recipients of service

9. Emphasize the value of training (A culture that values ongoing provider education to provide relevant, person-centered services in a changing world)
    a. Develop a mechanism for extensive cross-training between OMH and OASAS
    b. More training support for community providers -including language
10. Develop a culture of wellness
    a. Focus on organizational wellness from the top -down
    b. Focus on workforce wellness by creating time, space, and funding for wellness activities
    c. Looking at safety culture and reducing the following: Insufficient support of patient safety event reporting, Lack of feedback or response to staff and others who report safety vulnerabilities
11. Address regulatory changes to improve culture
    a. Focus on quality care
    b. Respect program evaluation and implication for change
    c. Consider providing more time to prepare for audits – encourage strengths-based atmosphere
    d. Eliminate micromanagement
    e. Add transparency
    f. Reduce documentation requirements
12. Emphasize the focus on children and families
    a. We need to address sexual abuse, adverse childhood experiences when we discuss children and families.
    b. Train staff on trauma-informed care
    c. Adolescents and transitional aged youth are particularly at risk in this space particularly for developing co-occurring disorders. Prevention, early intervention (particularly on MH side) and then integrated treatment.
    d. There is a need to focus on getting children and families access to care in an easy and non-stigmatizing way. Helping to address issues in children/adolescents can help to prevent more significant problems in adulthood.
13. Continue ongoing forums to obtain feedback from the field as was done during COVID-19.

Prevention

1. Recognition of both the opportunities for integration while also preserving the expertise attributable solely to SUD and MHD prevention services.
    a. Identify and integrate knowledge and programs that overlap (i.e., trauma work)
    b. Emphasize community based environmental prevention strategies, a universal approach.
2. Streamline tools and strengthen cross systems communication to ensure an appropriate continuum of services.
    a. Develop a mechanism for cross training to increase understanding and resources.
    b. Emphasize the importance of utilizing evidence-based/research-based programs.
    c. Develop a language cross walk between prevention systems.
    d. Consider a consistent language between prevention systems – to include gambling.

e. Cross train peers who deliver prevention services, include a recovery focus.

3. Increase family awareness and engagement.
   a. Educate parents on early warning signs, awareness, and access to information on both primary/universal prevention and secondary/selected intervention services.
   b. Family support to enhance wellness and resiliency and awareness to break the cycle of addiction.
   c. Emphasize the importance of COA access to services without a diagnosis.
   d. Educate families on the stigma surrounding both addiction and mental illness.
   e. Preserve intergenerational prevention services that reach across the lifespan.
   f. Bi-directional referral of preventative services.
4. Focus on Wellness across the lifespan – another universal approach.
   a. Support a wellness culture – increased focus on health, healthy decision making.
   b. Increase all aspects of early prevention and early intervention.
   c. Provide referral, resources to assist in outreach.
   d. Provide referral to vocational, transitional, and occupational specialists.
5. Engage the NYS Education Department to increase prevention in the schools, improve the school environment, and increase(teach) awareness of MH and SUD.
   a. Emphasize the link between academic success and mental health and to substance free choices.
   b. Support education/awareness to provide youth with a better understanding of mental health, a better understanding of the substance use risk and protective factors, teaching decision making and healthy coping skills, and how to access support.
   c. Emphasize with SED/schools aspects of integration of MH and SUD education stressing the importance of their actively partnering with MH and SUD providers who are professionally trained to provide prevention programs that meet SEL requirements.
6. Prevention tools and EBPs need to be culturally appropriate and educational resources should be made available in multiple languages based upon community need.
   a. Assist in outreach to marginalized communities.
7. Measure program effectiveness through evaluation of prevention programs and strategies – including their effectiveness in culturally diverse communities to allow for targeting culturally appropriate prevention strategies. Consider the creation of a more uniform data collection system to evaluate that is funded by the state.
   a. School/Community data beneficial to help determine prevention needs.
   b. Emphasize the value in the sharing of data between schools, provider partners and communities for the purpose of better addressing needs and improving outcomes.
   c. Consider the consolidation of surveys, creating a uniform single survey encompassing mental health and substance use risk and protective factors.
   d. OASAS uses almost exclusively evidence-based interventions. We need to ensure the prevention tools are diverse and not limited by what is already evidence based. Evidence based strategies that are national tools may not meet the needs of the specific communities being served.

e. We need a more uniform data collection system (e.g., a single survey where the agencies do their own research and data collection).

8. Increase the investment in prevention – (both infrastructure and workforce)
   a. Retain critical deficit funding for prevention with modifications and enhancements.
   b. Identify sources to expand prevention funding, while recognizing the challenges involved in billing for prevention services.

Budget

1. The new agency should follow some general principles related to budget and fiscal issues:
   a. Any changes to the system should occur gradually
   b. Actions should be transparent
   c. Changes should increase flexibility and reduce administrative burden
   d. Justice, Equity, Diversity, and Inclusion should be considered in all funding decisions
   e. All available sources (e.g. block grants, settlement funds) should be considered to increase flexible funding to providers
   f. Prior to system/reimbursement changes, agencies need time to update EMRs and include provider feedback in the process of updating billing.
2. Any savings resulting from the development of a single agency should be reinvested in the community.
   a. Crisis Stabilization Centers
   b. Additional funding to target strategies to better engage special populations
   c. Flexibility for local needs that don't fit the state mandate
   d. Provide relief to address lack of increase in base funding
   e. Address the cost increase of operations
3. Address the workforce shortage and improve workforce retention:
   a. Explore the development of tuition assistance and/or loan forgiveness programs
   b. Make COLAs permanent recurring and adequate to the entire budget
   c. Increase Allocation for Direct Care Staff
4. Standardize the role of the LGU – and the relationship to the regional field office- reduce regional inconsistencies.
   a. LGU can ensure maximum funding for communities and program providers – responsive to the needs of the community and funding gaps that may exist
   b. LGU is responsible for ensuring that treatment and services are delivered in a culturally appropriate manner
   c. LGUs fill information gaps - how to do a budget, fiscal reports, directing to correct guidance, interpretation.
   d. Examine the inherent conflict in the role of the county as the LGU and provider of service (in some counties)
   e. County operated services often serve as a safety net for high risk/high need individuals.
   f. Funding through the LGU can sometimes lead to cumbersome cash flow issues
5. Maintain or improve reimbursement strategies for aspects of services currently provided (which may not be currently reimbursed)
   a. Provide State aid for Uninsured/underinsured individuals

b. Provide assistance for individuals in need of accessing insurance
c. Services which are not billable or difficult to quantify (e.g. Prevention services – currently funded via net deficit funding OASAS)

6. Streamline the reporting and audit process
   a. Streamline the CFR process – and provide additional education to community providers
   b. Streamline any applicable forms
   c. Consider substituting audited financial statements for CFR (allow agencies to submit DMH 2 claiming schedule and audit)
   d. Eliminate OASAS ratio value method of administrative calculation (overly cumbersome and hard/impractical to implement)
   e. Allow year to year roll over of funding when completing CFR
   f. Standardize reporting periods across agencies
7. Improve the budget process by:
   a. Creating a default option (previous year's information); and
   b. Change the timeframe of preparation and/or due date; and
   c. Allow for flexibility in terms of applying funds across multiple programs
8. Engage payers and provide education related to payment requirements (e.g. changes in APG rates)
   a. Modify APG rates to accurately reimburse for the cost of services
9. Develop a system that allows more fee for service while addressing the gap for individuals who are uninsured/underinsured.
   a. Allows an agency to adopt a business model
   b. Returning unused funds is not required (as with net deficit funding)
10. Standardize billing expectations and align timeframes:
    a. Currently there are differences between OMH and OASAS services.
    b. The new agency should adopt unified billing standards, so that agencies have a consistent approach, with uniformity across all payers.

Workforce

1. Consider the development of a universal peer certification process which includes training in integrated care.
   a. Determine the method of training (in-person or self-directed modules)
   b. Allows for continued specialty practice
2. Formalize the supervision of peers to ensure continued training, coaching, and support.
3. Address the challenges in obtaining certification renewals for CASACs and Peer Specialists.
   a. Consider providing reimbursement for required trainings and credentialing for Peers and CASACs.
4. Provide training to assist staff in obtaining a baseline understanding of integrated care, while continuing specialty practice. There are workers who fear losing specialty credentialing.
5. Enrich training opportunities and ensure availability to all staff at all levels.
6. Address staff recruitment and retention through pursuing tuition reimbursement and loan forgiveness options.

a. Address workplace exclusions for loan forgiveness (e.g. residential programs)

7. Increase salaries in the field to provide salary equity with state/county employment and consider alternative ways to provide incentives for staff to remain in the field.
    a. Explore opportunities to provide fringe benefits which would create more equity with State employment
8. Develop trainings to assist organizations in improving/enhancing clinical supervision and developing a culture of mentoring young staff.
9. Develop a pathway for individuals without formal education to advance in the field.
    a. Provide trainings that could expand scope of practice
10. Increase reimbursement rates to allow for decreased caseloads (to allow staff to provide a higher quality of treatment and/or service).
    a. Eliminate units of service as a measurement of staff performance.
11. Apply Justice, Equity, Diversity, and Inclusion principles to staffing at all levels.
12. Consider providing training and support for members of Boards of Directors – a volunteer workforce with tremendous responsibility.
13. Develop a framework focused on wellness that can support staff.
    a. Leadership framework should be clinically based to ensure trauma informed care for staff and clients.

Recovery and Stigma

1. The new agency should use core recovery and empowerment principles to promote self-directed decision making (i.e. starting where the person is in terms of their priorities and goals, ensuring strong choice, rights, and privacy protections).
    a. Nothing About us without Us (i.e. Build the agency from the ground up by including those in recovery and including peers at all levels)
    b. Focus on a strengths-based perspective
    c. Self-directed care and shared decision making.
2. Encourage a holistic approach.
    a. No wrong door
    b. Focus on healthy living and wellness, including the use of alternative treatments
    c. Increase the focus on trauma
    d. Prioritize addressing the social determinants of health, e.g. housing, employment, culturally responsive social supports, hunger insecurity and poverty.
3. Cross education (as opposed to cross training) webinars/in-services should be provided to ensure a well-integrated comprehensive service approach
    a. Improve understanding of philosophy and service menu of other system
    b. Address biases
    c. Develop uniform recovery language to improve communication between systems
        i. Consider creating a “living dictionary”
    d. Acknowledge challenges in each system

e. Develop terminology clarifying that addiction is not a choice and that recovery is the expectation for everyone
f. Encourage a holistic approach to individuals (to include the provision of accommodations for individuals with physical disabilities)

4. Focus on the provision of training, continuing education, and supervision
   a. Training in which peers and individuals with lived experience have a central role
   b. To reduce stigma
      i. Address stigma within the workforce
      ii. Address self-stigma
   c. Education regarding language and its implications, (e.g. focus on engagement rather than "compliance" and coercion)
   d. Cross training systems staff to provide integrated care and support the "No wrong door" approach
5. Justice, Equity, Diversity, and Inclusion should guide planning
   a. Address racial and ethnic disparities
   b. Advance culturally appropriate engagement, treatment, and support
   c. Address exclusionary criteria within programs (e.g. housing disqualification due to SU, inability to obtain appropriate medication)
6. The new agency should have an integrated recovery bureau in which peers and individuals with lived experience serve a central role.
7. Recovery services should be integrated into the prevention and recovery center models (with opportunity for billable service delivery for program sustainability.
   a. Identify a sustainable model in which Prevention and Recovery Services can be delivered.
      i. A person-centered system requires planning and development on the ground
      ii. Include payers in the planning conversation
      iii. Address the need to sustain core recovery values when considering potential billing
8. The new agency should have a separate department that addresses stigma.
   a. Strategies should be evidence-based
   b. Use social media campaigns (e.g. highlight celebrities and strengths-based approaches)
   c. Educate the community on language and communication
   d. share information about mental health and substance use
   e. Address stigma within the workforce and encourage an increased focus on self-care
      i. Role modeling from leadership
      ii. Continued advocacy from individuals with lived experience
   f. Address stigma within families
9. Develop educational opportunities (webinars, trainings) for medical, judicial and law enforcement personnel to improve their understanding of mental health and substance related challenges and to encourage the use of recovery and strengths based, person centered language for more effective communication and response to the individuals and their support systems.

10. Engage NYS Education Department and DOH on recovery work in schools and encourage having youth peers in schools.
11. Advance the use of peers in every program and setting including primary care settings, ensuring that they meet fidelity level standards.
12. In a value-based system, emphasize measures that demonstrate increased community tenure and connection to community resources, housing and financial stability and decreased hunger insecurity and isolation and incarcerations and other contacts with the criminal justice system.
13. Ensure that funding and regulatory requirements enhance rather than limit the provision of person-centered and recovery-focused care. Medicaid reimbursement should be flexible to support person-centered and recovery-focused care.

Justice, Equity, Diversity, & Inclusion

1. Make a commitment to continual learning pertaining to JEDI.
    a. Commitment should start at the highest agency level (i.e. Executive Staff)
    b. Develop a standard definition and understanding of JEDI
    c. Require new agency staff to receive JEDI training at onboarding and throughout their tenure
    d. Create an environment of self-awareness and recognition of implicit bias
    e. Encourage a culture of openness and communication
2. Develop a JEDI Committee comprised of staff at all levels.
    a. To ensure JEDI principles are included at every level of the agency
    b. To ensure that evidence-based practices are implemented
    c. To ensure sustainability of efforts to incorporate JEDI principles
3. JEDI should be a component of staff supervision.
    a. Individuals are required to adhere to principals and are recognized for furthering the growth of JEDI within the agency.
4. Engage State partners to include JEDI training as a requirement for licensing and credentialling.
5. Funding should be allocated to advance JEDI principles.
    a. Include funding for ongoing training (e.g. cultural humility, supervisory training – having challenging conversations, anti-racism, motivational interviewing, etc.)
6. Support JEDI principles in the community.
    a. Require all RFP responses to include a description of how JEDI principles will be incorporated to address physical disabilities as well as MH and SUD
    b. Engage law enforcement
    c. Partner with community faith leaders
    d. Improve crisis intervention – ensure that it is culturally competent
    e. Enhance tele-health (build on COVID-19 expansion)
    f. Support increased (equitable) access to technology

7. "Justice" should address:
    a. Safety
    b. Input from all (i.e. recognition of "invisible communities")
    c. Expand language services
    d. Fairness in administrative processes (e.g. BIPOC are administratively discharged at higher rates)
8. "Inclusion" should address:
    a. Hiring process (e.g. use of blind hiring, peer review)
    b. Creating a safe space
    c. Emphasize bias training and self-awareness
    d. Access (including adaptive technologies)
    e. Expand language services beyond top 6 languages. For example, ASL should be available. The deaf and hard of hearing community are often left out.
    f. All policies and procedures
    g. Redemption philosophy that creates a safe space for self-awareness and improvement

Priority Issues*

*(Not in order of priority)

1. Restructure Funding to provide greater flexibility across funding categories, incentivize innovation and simplify agency mandates. Any savings from the merge should be reinvested.
2. Advocate for fair reimbursement in rate setting (a top priority)
    a. Increase funding for rising costs of agency operations
    b. Review funding disparities across upstate counties
    c. Consider net deficit funding flexibility
    d. Eliminate unfunded mandates
    e. Standardize the CFR and CBR
    f. Funding from the Opioid Settlement or potential marijuana legalization should be reinvested in services
    g. Savings from the new agency should be reinvested in the community
3. Improve Communication and Community Partnership.
    a. Create a unique platform for recipient input
    b. Provide clear agency contacts for provider questions
    c. Be transparent
    d. Ensure inclusion
        i. Elicit stakeholder feedback at the onset of strategic planning initiatives
        ii. Ensure that recipients and peers share in the decision-making authority
    e. Convey information/guidance via written communication
4. Address workforce challenges (a top priority)
    a. Assist field with recruitment and retention

b. Address need for increased pay rate / ensure annual COLAs
c. Define scope of practice for each discipline in an integrated setting (e.g. CASAC)
d. Provide supervisory training to better support all staff including peers
e. Cross train the workforce of the two systems for integrated care

5. Provide person-centered care across the life span (including prevention services).
    a. Senior services are often overlooked.
    b. Include harm reduction models
    c. Provide services to the children of parents who are in MH and/or SUD treatment (prevention)
    d. Provide more opportunity/flexibility to address the needs of the aging population (including in home services). The elderly often do not have a voice and get overlooked.
    e. Partner with communities to address law enforcement involvement in crisis (MH or SUD) response
6. Expand the use of technology.
    a. Address disparities in access (elderly, some communities of color, rural communities)
    b. Provide information on adaptive technologies
    c. Using technology as a tool in recovery, engaging in daily life
7. Identify lessons learned from the COVID-19 pandemic.
8. Address the challenges of rural counties.
    a. Geographic diversity
    b. Workforce recruitment and retention
    c. Access to available services
    d. Funding disparities
    e. Limited resources (e.g. limited broadband access, transportation)
9. Develop an integrated system of regulations for the two agencies and regulations for the providers. There should be clear guidelines in order to reduce subjective audit findings
    a. Streamline records and documentation to the extent possible
    b. Reduce required documentation in order to increase time for providing quality care
    c. Standardize regional boundaries
    d. Address the difference in laws governing confidentiality in SUD and MH settings
    e. Improve existing models
10. Integrate mental health and substance use disorder housing models to provide increased fluidity
11. Include peers in the staffing structure for all program models.
12. Infusing JEDI in all aspects of our work and the new agency structure is critical important.
    a. Policies should promote the hiring of people of color in leadership roles.

Notes from the Steering Committee/ Workshop Facilitators: Additional Discussion

The following notes were recorded during three conversations on March 29, April 9, and April 16 among Steering Committee members and facilitators that followed the workgroup meetings. Their inclusion in this report is intended to reflect additional points that may help to strengthen recommendations made during the 30 workgroup meetings. The Steering Committee/Facilitator meetings were held to give each facilitator the opportunity to discuss the process and outcome of their workgroup's deliberations, and for the Steering Committee to make sure all meeting notes captured the essence of the work done by every workgroup. The Steering Committee/Facilitator meeting notes are as follows:

Structure

- The Workgroup focused on recommendations for specific function, structure and policies.
- We discussed the need for the new agency to address the unique urban and rural issues. There are some common challenges and some that differ between the rural and urban settings. Inner city services have their own issues (e.g., culture, stigma, urban access, support of services etc.). The rural settings tend to not have as much political clout in policy, so our intent was to ensure that rural issues are not an afterthought or correction afterwards.
- Housing is an area that both agencies support and have providers delivering services. It wasn't clear that having the single agency focusing on housing would be enough. A think-tank notion, as well a regulatory and funding focus, with structural changes could bring great benefits.
- The Workgroup tried to anticipate issues that might arise from a fiscal perspective. For example, an influx of Federal funds shouldn't just be used to replace state funding, but rather to enhance services. NYS Medicaid policy and Managed Care Organizations reimbursement methodologies need to align to facilitate integrated care, co-occurring disorder treatment etc.
- We concurred that regulatory change for specific programs is not enough. OMH and OASAS should address regulatory change for the combined systems.
- The goal of no wrong door for access to services came up in the regulatory workgroup also and the workgroup recommended that all aspects of implementing a "No Wrong Door" approach should be addressed. If an individual enters the system of either agency, the agency should, at a minimum, be able to complete the "welcome" and referral/coordination process to make the connection to the needed services. Staff in both systems need to have training to welcome individuals and connect them to the services they need. It is important to support through technology and other resources how these goals will be achieved.
- Children and families, peers and other stakeholder groups should be meaningfully included in planning changes to the behavioral health structure. JEDI should be a priority in all planning and policy development.

Regulatory

- Recommendations for a "No Wrong Door" approach were made by the Structure, Regulatory and other workgroups.
- The workgroup feedback outlined the many challenges/obstacles with the current process for obtaining an integrated license (operating certificate). There was also another process through DSRIP (waivers), which was different from the integrated OMH/OASAS/DOH process (licenses).
- As integrated care and a "No Wrong Door" approach become more available, attention should be paid to staff certifications (peer specialists, CASACs, etc.) in both OMH and OASAS programs with goal of ensuring needs for specialty expertise (MH and SUD) are met. Modifications to existing certifications or creation of new integrated credentials should be explored.

Access to Integrated Care

- There were tensions in the workgroup between those who wished to keep OMH and OASAS services somewhat separated and those who wanted a more integrated, "No Wrong Door" policy.
- There are different OMH and OASAS titles for programs and workforce roles. Titles should be aligned with rationale for differences and similarities clearly defined.

Agency Culture

- The culture of the combined agencies and culture of those served by that agency should both be addressed.
- It is important that agency culture incorporate participation from service providers, service consumers, family members and peers. Culture is understood to incorporate race/ethnicity, as well as the culture of those with lived experience and their families. Many definitions of culture are captured in the workgroup's feedback. Culture can mean many things to many people. It is important that there are people who act, look like and talk like you involved in the conversations. Families, children, people with lived experience with mental illness and/or substance use disorder, and racially/ethnically diverse stakeholders all need to be part of the planning process and conversations.
- New York has a system that acts both as the government regulator and as a provider of services. Staff with the same credentials in the state system are paid very differently than staff in community settings. Typically, the state/county service system is better financed and staffed than the community-based service providers. County agency staff get paid more than community agency staff providing the same services. Consideration should be given to supporting parity and equity in the salary and benefits structure.
- There needs to be a culture of true collaboration between government and the provider community. This is a unique opportunity to put into place a collaborative culture where providers have a seat at the table and are not just brought in after the fact to trouble shoot.
- A more robust package of tuition/loan assistance for behavioral health sector staff needs to be further explored.
- When bringing two agencies together, a new combined culture is created. It is not a simple tweaking of one or the other's culture.
- Government has its own culture. This new organization and planning process is asking people to think outside of the usual way of doing business. The goal is to have a structure that is very influenced by community partners.

Prevention

- OASAS has a systemic prevention response, while OMH has some preventative programs (e.g. First Episode-On Track program).
- Prevention services are funded by net deficit and county/state funding. Fee for service reimbursement and diversification of funding should be explored. Private insurance and Medicaid reimbursement should be explored for prevention counseling, which is the prevention service most closely aligned with other billable services.
- There are challenges with meeting the community need when government funders require agencies to solely offer evidence-based services but fail to pay for them.
- Managed care organizations are only concerned with "covered lives" and not necessarily "the community". Prevention services could also be provided to family members/others at risk. The investment in prevention for families/others could save money in the long run. There should be bi-directional referral pathways between treatment and prevention providers.
- For evidence-based youth services in schools, the curriculum must address substance use and mental health issues. Entire zip code data should be regularly tracked to measure the efficacy of prevention efforts.

Budget

- There are differences in philosophies between OMH and OASAS as to how funding should be managed.
- For OASAS, there are very specific schedules that are cumbersome to the providers. Some are monthly, quarterly and yearly. There are many differences and conflicts currently.
- The rate structure should be streamlined and standardized, with adequate rates. (Currently, rates are inadequate to support adequate pay for the workforce.)
- Any savings from blending the agencies should be returned to the systems, rather than NYS.
- The workgroup did not discuss capital funding of community agencies, it focused on funding of operating costs. This is an issue that needs to be further discussed. The current process for capital locks providers in and does not work. The number of years it takes to do a capital project should change. Currently there is time lost in the decision/approval process. People would get services sooner and the project cost less if the approval process was expedited. The capital financing process used by NYS is unique to NYS. Other states do not generally support capital financing of behavioral health agencies.
- The Workgroup dd not specifically discuss budget/billing needs for integrated service delivery, but all the same principles apply.
- There needs to be a way to get funding for non-funded services, such as uninsured persons, to help level the playing field. There are unfunded providers in every area of the state that are providing the same services as funded providers. COLA was added to state aid, but that does not assist others. The CFR process leads to OMH or OASAS "owning" your whole agency even though they only fund a portion.
- County (LGU)-operated services and NYS-operated inpatient psychiatric centers often serve as the safety net for high needs individuals. Many LGU providers participated in the workgroup discussions. Many different opinions were represented and there was not a consensus on the view of and need for LGU providers. Regional differences came up quite a bit during this topic. There should be consistency across regions because this is a big issue. LGUs

are more susceptible to local/political pressures. "Provider of last resort" is in statute. There are areas where there are no other provider options. There is a potential to consolidate county programs so that not every county has its own system.

Workforce

- The workforce is often looked at as the center of everything we do, however, there is little attention paid to how we will maintain, attract, recruit and attract workers. Without having a diverse, well trained workforce, we will not be successful.
- The workgroup recommended an emphasize on JEDI in training. A need for cross training for substance use and mental health are imperative. Strategies to include workforce JEDI training were not discussed.
- Services provided by peers should be billable (e.g. OASAS CASAC-G-specific to gambling)
- Creation of new positions that would reflect the new organization's combined approach were not discussed by the workgroup. New positions with credentials for both systems should be explored and recommended.
- No specific certification for supervisors was discussed. Training for supervisors was discussed. Some states have specific certification for supervising peers.
- There was not a specific conversation regarding the state agency workforce, but it should occur in the future.
- There is a need to focus on attracting workforce to the field. Staff talked about workload, paperwork, non-competitive salaries, need for student loan reimbursement/forgiveness, good fringe benefits and salary equity.

Recovery & Stigma

- The workgroup had both small and large group discussions. The culture at the workforce level varied. The discussions and format were geared towards providers and agencies. There was not adequate time spent talking about what people want and looking at the whole. All aspects need to be driven by those served and their families.
- The evidence-based measures that are used by OMH and providers in plans of care are all medically based. The systems do not look at social determinants and holistic needs.
- Culture/Need could be looked at by zip code.
- There should be use of peers at every program level and setting. Peers not only engage people and promote clinical care. The sector should be promoting fidelity of peer service and clarity of their role at every level of care.
- There should be a place for outcomes/perception of care that measures client perceptions with equal status as other outcome measures. The sector should also measure goals achieved for articulated client social determinant needs (e.g., housing, employment).
- There needs to be an understanding across systems about how we think about issues like medication. OMH consumers of service may view medication as "handcuffs", while in the OASAS system people are seeking to get medication. Terminology on both sides needs to be further discussed and understood.
- The workgroup did not have a deep discussion about community education/organizing for police, corrections etc. Some feel that police shouldn't always be the first responders. Perhaps mental health professionals and/or peers can be in this role under appropriate circumstances. The conversations shouldn't stop at training the police.
- Today, the NYS Health Department sets outcomes for Medicaid managed care plans and that is a challenge.

Outcomes need to validate other areas such as housing, stable income and employment. Outcome measures from the Health Department need to incentivize these very important areas.

- The new agency should consider creating an Integrated Recovery Bureau with staffing by people with lived experience. The Bureau should address stigma that has an impact on all areas of recovery.
- Recovery services, including peer services, should be billable to Medicaid.
- There needs to be further work and collaboration in the area of prevention and family supports, including aligning OMH and OASAS initiatives. In the OASAS sector, prevention can sometimes resemble family/child support on the OMH side. Prevention can be in the schools, but families are not in the schools. Parents can sometimes feel judged when there is the perspective that parents are part of the problem, not the solution. There is a culture in the family service sector that there is something "wrong" with the family when there are prevention efforts for the child, but not the family (e.g., prevention programs in schools for addiction may not be culturally competent from the family perspective).
- There are opportunities to utilize housing to provide support to families.

Justice, Equity, Diversity and Inclusion

- We need to be attuned and reflect on what is happening to people of color, women and others in the community today.
- Commitment to ongoing learning and training is a cornerstone and key to making changes. Being clear about what justice would look like in an organization and how this would manifest itself for clients and staff. There needs to be a platform where there is a consistent training regarding JEDI.
- JEDI should not just be a tagline, but it should be part of the "Intentional fabric" of the new agency.
- Forty percent of work group members thought inclusion should be the highest priority of JEDI. Inclusion because it provides everyone the opportunity to voice their opinion and make a change.
- A JEDI Committee would be nice, but a bureau or arm of an organization would be ideal.
- State partners should make JEDI a requirement for licensure and credentials. Perhaps there could also be enhanced reimbursement/funding for incorporating JEDI in an agency. OMH has included CLAS- Culturally and Linguistically Appropriate Services.
- Address what justice should actually look like in a new O-Agency.
- All race is culture; all culture is not race.
- Close the digital divide for low-income and rural communities.
- Future research should prioritize JEDI issues (ex., trends for people of color being discharged from programs more frequently than others.)
- Aspects of JEDI should be incorporated into treatment programs to get better outcomes. What adjustments, changes and enhancements can we make to our treatment programs to make them more diverse, equitable and meet the needs of people of color?

Priority Issues

- The workgroup supports prioritizing system changes for implementation regardless of when the merger may occur.
- There is an overwhelming response from providers/participants that there should be a merger between OMH and OASAS.
- OMH and OASAS should better align regional boundaries across both state agencies. Field Offices have different perspectives. There should be a consistent communication and policy message across all Field Offices.
- There should be a priority for addressing the aging of our clients and where senior services fits in. We don't have capabilities outside of our state agencies for senior services. Are they OMH clients until age 65 and then senior services clients? Does OMH serve individuals across the lifespan after age 65? If OMH will continue to serve them, there needs to be specialized services put into place to meet the more intensive care older individuals will need. It's very difficult trying to find a placement for older individuals.

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