Frequently Asked Questions about the Broome Developmental Center Project

Background on the Repurposing Project

In the Fall of 2016, in response to the ongoing heroin epidemic across the Southern Tier and the state, Senator Fred Akshar, Assemblywoman Donna Lupardo and Assemblyman Cliff Crouch approached the New York State Office of Alcoholism and Substance Abuse Services (OASAS) and asked whether there was any possibility of repurposing one of the buildings at the former Broome Developmental Center for addiction treatment.

OASAS then began a process at the state level for determining the viability of this project. In 2017, OASAS determined that there was indeed an opportunity to repurpose part of the facility, so they developed a program model to make that happen.

OASAS then worked with Broome County to develop a procurement Request For Proposal (RFP) for a private provider to provide addiction treatment services at the former Broome Developmental Center. The RFP was released in 2017 and left open for over a month. Three proposals were submitted and Syracuse Behavioral was selected by a team that included experts from OASAS, Broome County Health Department, Broome County Social Services as well as County Executive Garnar, Senator Akshar, Assemblywoman Lupardo and Assemblyman Crouch.

Will the new treatment Center be state operated or private?

The new treatment center will be privately operated by Syracuse Behavioral Health (SBH), but the New York State Office of Alcoholism and Substance Abuse Services (OASAS) will oversee operations.

Who owns the building?

New York State maintains ownership of the former Broome Developmental Center (BDC) and will lease the facility to SBH.

How was the RFP scored?

It was rated based on experience and geography.

What is Broome County's role in the addiction treatment project?

Broome County will act as a pass-through for the state funding. For the project to move forward, the Broome County Legislature must pass a resolution to accept the funding from New York State.

Why is the State using Broome County as a pass-through?

The vast majority of OASAS's state funding for addiction treatment goes through county governments. According to OASAS, county governments are better and more efficient at moving procurements through than the State of New York, which often can take over a year and a half to move.

"We're making up for lost time and trying not to wait any longer," said Rob Kent, Chief Counsel for OASAS. "The heroin epidemic is not even a public health crisis, it's just a crisis on every level - economically, from a health perspective, criminal justice, you name it. While we are deliberating in board rooms at the state level, more people die."

Will Broome County be responsible for the renovation and future upkeep of the former BDC building when SBH opens the facility?

No. The State will maintain ownership of the facility and is responsible for any renovations and upkeep.

Who pays for initial refurbish of BDC to house treatment center? How much? Is this enough?

OASAS is paying for the capital costs to prepare the space for treatment services. To establish the initial Phase 1 of 50 beds, the capital costs are anticipated to be $570,000. Costs and scope of work for Phase 2 to establish the remaining 50 beds is being established via a feasibility study.

Who pays for continuing repairs and upgrades to physical structure? What is the budget?

OPWDD will continue to maintain the facility. There will be some shared costs which will be included in the lease (utilities, service contracts, etc. The budget is to be determined, however, all costs will be borne by NYS.

Is there a MOU from OASAS?

OASAS will provide the county with a state aid funding authorization letter, there is no MOU. There will also be is an operating certificate to SBH to run the program

Have there been instances where SBH opened a Supervised Withdrawal and Stabilization facility and because of this, local SUD providers went "out of business"?

No.

Is there an annualized amount set aside to maintain other parts of the facility, like the: swimming pool, gym, kitchen facilities, etc.?

The program will be contained within building 1/1G and will only be responsible for shared costs associated with the space it's occupying. OPWDD will maintain the rest of the property.

How much funding will Syracuse Behavioral Health receive to operate this program/center?

SBH will receive $1.5 million for the first phase, then $3 million for the second phase.

Does that amount depend on the level of care they fulfill (treatment vs. residential)? Is all of the money for all of the treatment and residential services from state aid or will any portion of any of these services come from local tax support?

OASAS will provide up to $1.5 million in deficit funding for the initial 50 Medically Supervised Withdrawal Inpatient beds. The amount of funding is based on $30,000 per bed. The provider is expected to collect all appropriate revenues related to services to support the operational costs of the program. Such revenues may include Medicaid, private insurance, Medicaid Managed Care, patient fees or other contributions.

Ongoing funding for the program is contingent on the program's performance and need for State Aid as determined during the annual performance and budget review process by OASAS staff that all funded providers are subject to.

Will funding be diverted from local substance abuse disorder providers to pay for this facility?

No.

What services will be offered at the facility?

Phase 1: Medically Supervised Inpatient Withdrawal and Stabilization - This service is physician directed and staffed 24 hours a day 7 days per week with medical staff and includes 24 hour emergency medical coverage. Medically supervised withdrawal services provide: bio-psycho-social assessment, medical

supervision of intoxication and withdrawal conditions; pharmacological services; individual and group counseling; level of care determination; and referral to other appropriate services. Medically supervised withdrawal and stabilization services are appropriate for persons who are intoxicated by alcohol and/or substances, who are experiencing, or who are expected to experience, withdrawal symptoms that require medical oversight. Individuals who have stabilized in a medically managed withdrawal service may step-down to a medically supervised outpatient service.

Phase 2: Inpatient Rehabilitation & Stabilization - OASAS-certified 24-hour, structured, short-term, intensive treatment services provided in a hospital or free-standing facility. Medical and individualized treatment services are provided to individuals with substance use disorders **who are not in need of medical detoxification** or acute care and are unable to participate in, or comply with, treatment outside of a 24-hour structured treatment setting. Individuals may have mental or physical complications or co-morbidities that require medical management or may have social, emotional or developmental barriers to participation in treatment outside of this setting. Treatment is provided under direction of a physician medical director and the staff includes nursing and clinical staff 24 hours 7 days per week. Activities are structured daily to improve cognitive and behavioral patterns and improve functioning to allow for the development of skills to manage chronic patterns of substance use and develop skills to cope with emotions and stress without return to substance use. People who are appropriate for inpatient care have co-occurring medical or psychiatric conditions or are using substances in a way that puts them in harm. Many experience decreases in ability to reason and have impaired judgment that interferes with decision making, risk assessment, and goal setting and need a period of time for these consequences of substance use to diminish.

What would be the average length of stay for someone receiving Supervised Withdrawal and Stabilization Services at the proposed facility?

Patients will stay an average of 3-5 days with an additional variable length of stay, depending on placement at the next level of care. Discharge placement planning begins when the patient first enters the facility.

Will there be on-site assessment for those seeking treatment?

Yes.

Will SBH accept those in need of treatment outside of normal business hours?

Yes: 24 hours a day, 7 days a week.

What is the longest someone could stay in this facility? What is the shortest?

It is individual, based on the patient's presentation of symptoms and demonstrated need for this level of care.

What clinical criteria is used to determine if this facility is the right one for the patient?

Syracuse Behavioral Healthcare (SBH) uses a comprehensive person centered biopsychosocial assessment followed by the NYS OASAS LOCADTR 3.0 to determine if this is the right level of care for the patient.

My understanding is that someone would need an assessment and LOCADTR Gateway? If so, where will it be? How much money will be allocated to creating this? How much will be budgeted yearly to sustain it?

LOCADTR access is free and web-based and SBH already has access as an existing OASAS provider and there is no cost to maintain.

Can other agencies use a LOCADTR to qualify someone for this facility?

Yes. All OASAS providers have access to LOCATDR.

How are patients evaluated? Who decides when they leave this facility?

Each patient is evaluated by a Medical Professional and Credentialed/Licensed Clinical Professional at admission, and daily thereafter to determine appropriate length of stay and readiness to be discharged. Discharge planning begins at admission which includes coordination for a warm hand-off to the next appropriate level of care.

Can a patient simply sign themselves out of the facility at any time?

NYS regulates that admission to a NYS OASAS treatment program is voluntary. Medical and Clinical staff are skilled in motivational interviewing, an evidence based practice intended to meet patients where they are and motivate them to reach person centered goals which increases retention rates. SBH will connect patients intent on leaving against medical advice with an appointment at the most appropriate level of care and connect them to medical and community support services as needed. Most often, patients who leave this level of care return to the home of a significant other or family member.

Where does a patient go when they leave the facility?

Discharge planning begins at admission. The patient collaborates with the medical and clinical team on a discharge plan which includes housing status, medical, clinical and support services needed. The medical and clinical team meet with the patient daily during their stay and schedule appointments at needed services.

In 2016, SBH treated 2,403 individuals in this level of care. The average length of stay was 3-5 days. 78% of individuals in this level of care at their current facilities completed treatment and accepted a referral to another agency. 10% chose to leave against clinical advice and accepted a referral to another agency. 10% chose to leave against clinical advice and refused a referral to another agency. 1% could no longer participate due to medical/psychiatric reasons. 1% were discharged due to noncompliance with program rules.

Can a patient stay at this facility for multiple levels of care?

Phase I of this program encompasses one level of care, Medically Supervised Inpatient Withdrawal. Phase II does not have a definite start date, but will encompass the NYS OASAS Part 820, Residential elements of care to include Stabilization and Rehabilitation.

Could any of the beds be considered 'flex-beds"? If so, how is that determined and by whom? I don't recall that being part of the original RFP.

There will be no "flex beds" under Phase 1 of the program. However, some of the beds under Phase 2 may be utilized as "flex" or "swing" beds.

Are the patients going to need to have to pay for the services if they do not have insurance?

Yes, based on an income-based sliding-scale fee structure. Those without insurance or income will be treated due to New York State funding.

I've heard that the County might be responsible for the Medicaid payment to the Residential beds – meanwhile, I've also heard that there's a law saying that the provider cannot bill Medicaid if the facility resides on state-owned property. What is the truth here? How would it impact BC?

The district of fiscal responsibility for a Medicaid enrolled individual is the individual's county of residency at the time of enrollment. The county of fiscal responsibility is responsible for the county share of that individual's Medicaid costs, regardless of where they receive services within the state.

Medicaid billing is permissible for services provided at a state-owned facility.

What is the volume of people that SBH projects to provide services to on an annual basis?

Between 1,500 and 2,000 in this initiative. Broome county population 197,000 people, 365 days*50 beds (90%utilization) = 16,425 bed days/5day average L.O.S.=3,285 patients – assume some recidivism and start-up phase (roughly 1500-2000)

Phase 1: 50 MSW Beds
50 beds X 365 days/year = 18,250 bed days possible per year.

If an average length of stay ranges from 3-5 days in a mature program, and you assume there are beds that turn over each day, sometimes after people have stopped seeking an admission (usually earlier in the day) there is a vacancy factor each day/night.

The vacancy factor NYS allows for planning purposes is 10%.

In other words NYS expects a 90% utilization plan for budgeting purposes. This is a tough number to achieve, especially in a start up mode, but for planning purposes, let us assume 90% utilization.

18,250 bed days x 90% = 16,425 bed days/year.

If we take the 16,425 bed days/year and divide that by an average length of stay of 5 days (mature program):

16,425/5 = 3,285 visits/ year

Some patients will not accept their treatment recommendation after their first visit, or will struggle with relapse which is like with any disease (patient non-adherence to protocols or medication) happens. In those instances some patients will visit treatment more than once, like a patient that is re-hospitalized for an exacerbation of a heart condition or surgical complications, etc.

Additionally, factors such as staffing levels, being a new program, time to establish linkages with other levels of care, etc can affect utilization, especially in a new program location.

There is also a factor that is hard to predict, which is that for some patients, the length of stay may be longer than 5 days if we are working on their discharge plan and do not have the connection/plan of care at the next level of care squared away, we may serve them longer to make sure they have a safe plan.

A more likely length of stay average in a new operation would be 7 days.

16,425/7 = 2,346 visits/year

The above factors are why we estimate we will treat 1,500 - 2,000 patients in the first year.

Phase 2: 50 Stabilization and Rehabilitation Beds

50 beds x 365 days/year = 18,250 bed days possible/year.

The Stabilization and Rehabilitation beds are two different levels of care that will both have variable lengths of stay based on patient needs an treatment/recovery plan goals.

These beds will likely be certified by NYS as swing beds which means their use can flex with patient volume and need. We will not know what this need level mix is until we are operating the 50 MSW beds (phase1) and have experience with how well the local treatment system absorbs the patients that are medically stabilized. In other words it is very hard to predict the exact number of patients that will stay past an MSW bed for either a Stabilization and/or Rehabilitation bed.

Having said that we know we are capped at 18,250 bed days/year.

Traditionally utilization runs at or slightly over 90% for this level of care so we can again assume 16,425 bed days/year. Here is where it gets more challenging to predict as we do not know for sure what the average length of stay will be.

For planning purposes, lets say 30 days, which may be a good estimate taking into account a 2 week stabilization stay and a 30-60 day rehabilitation stay (all rough estimates).

16,425 bed days / 30days = 547.5 patients/year (this number is based on numerous assumptions that are likely to change)

The above math is based on planning estimates and is subject to change based on final capacity certification by NYS, and or staffing plan budgets to be approved by NYS.

We've heard that OASAS is proposing to allocate $30,000 per bed. Is this correct? Does that amount depend on the level of care they fulfill (treatment vs. residential)? Is ALL of the money for all of the treatment and residential services from State Aid? Or, will any portion of any of these services - especially the long-term Congregate Care Level II beds - come from local tax support?

OASAS will provide up to $1.5 million in deficit funding for the initial 50 Medically Supervised Withdrawal Inpatient beds. The amount of funding is based on $30,000 per bed. The provider is expected to collect all appropriate revenues related to services to support the operational costs of the program. Such revenues may include Medicaid, private insurance, Medicaid Managed Care, patient fees or other contributions.

Ongoing funding for the program is contingent on the program's performance and need for State Aid as determined during the annual performance and budget review process by OASAS staff that all funded providers are subject to.

Is this a regional facility? If so, then what does the region include? Specifically, which counties of origin would be included?

All OASAS funded facilities are open to those in need. Given that this level of treatment is short-term and for people in need of immediate care, most patients will come from Broome County and the surrounding counties.

What happens if a bed is unfilled? Does the facility need to keep the beds filled in order to collect the State Aid?

The OASAS net deficit funding is intended to support program operations. Payments to the provider are not based on filled beds. The program will have certain performance metrics including utilization. Continued failure to meet the performance metrics may impact future funding, as with any other OASAS-funded service.

If so, does that mean the facility would be seeking individuals from out of the County/identified Region to fill those beds?

No. As stated above, we fund to support program operations and monitor utilization.

Does the facility collect the money even if the bed is not filled? Does that apply to the treatment beds? Does that apply to Residential Beds?

As noted previously, OASAS net deficit funding is not contingent on every bed being

filled at all times, regardless of the level of service. The program will have certain performance metrics which will include utilization. Continued failure to meet the performance metrics may impact future funding, as with any other OASAS-funded service.

We've heard that State Aid tends to stay flat - is there a Cost of Living Adjustment (COLA) built into this amount?

The amount of funding granted to a program is contingent on the program's operating needs and may change based on operational costs and revenues. If the NYS Enacted Budget includes funding increases for Cost of Living Adjustments or other adjustments, the program would be eligible for those increases.

I've read that this is to be a 25-year contract. Is this true? Why not an initial 5-year contract with four 5-year optional extensions?

A 25-year lease is required to secure OASAS-bond funding to undertake the alterations anticipated under the Phase 2 expansion.

If the contract will be between the County and the Provider – how will we be able to monitor or hold the provider accountable if the State has already bargained away any leverage for a contract by promising 25 years?

The 25-year contract is a lease for the property, not an operational contract. Operational funding will flow through the County's contract with the provider and is subject to the County's contractual terms, including performance monitoring and fiscal reporting.

Additionally, the LGU provides important feedback and information to OASAS staff for the annual performance and budget review of every funded program, including this new service.

Finally, if the provider is not meeting performance expectations, OASAS will work to replace them.

It seems like OASAS has gone around the Local Government Unit (LGU) and made this proposal without enlisting the help of LGU professionals. Why didn't this proposal go thru the LGU?

The development of this project was supported by the LGU. While OASAS provided some technical review of the Request for Proposals (RFP), the RFP was developed and issued by Broome County.

LGU endorsement is a component of the OASAS certification application process and

SBH has obtained LGU (signature on application) approval supporting the proposed program.

Why hasn't BC's Community Services Board (CSB) and its subcommittees, specifically the Alcohol and Substance Abuse Committee, evaluated the proposal?

I understand that was the protocol when the Walsh Group sought to open a private-pay treatment facility just a year ago.

At the CBS meeting, Commissioner Nancy Frank states Lourdes had to go through the LGU process when they were looking to state outpatient mental health treatment services licensed by OMH.

Given the current heroin/opioid epidemic and the needs in Broome County, combined with the request of the County Executive and all of the elected state representatives, OASAS moved forward to make this opportunity available. From the beginning the LGU has supported and worked to bring this opportunity to fruition.

Was the legislature involved in the RFP process or early discussions of the repurposing of BDC?

Senator Akshar and his staff met with Chairman Reynold and staff on August 3rd. They also met with the Chairman, County Executive, OASAS and other local representatives on August 9th to review concerns with the process. The Legislature was invited to sit on the review committee but no one attended. This was also discussed at the Broome County Community Services Board in June, 2017. Legislator Jason Shaw was in attendance at that meeting.

Ultimately, does the data demonstrate that BC needs this level of care in this quantity?

Yes. Hundreds of Broome County residents left the county over the years to access this level of care. Further, given that the OASAS system of care serves only 1 out of every 10 individuals who need Substance Use Disorder (SUD) treatment, untold other Broome County residents who would benefit from this level of care, never received nor sought any treatment. Combined with this level of care not being available in any of the immediately adjacent counties, we believe that level of care and size of the program is necessary.

ER Visits for 2014
7,832 Medicaid visits in 2014 for substance use disorder
2,173 Medicaid visits in 2014 for opioid use disorder

Almost half of Broome County Residents in need of treatment must leave the County to find treatment.
A full 45% of clients are leaving the county for withdrawal and detox services.

Broome County overdoses continue to rise
473 total overdoses have occurred in Broome County in 2017 through September 31 (Source: Broome County Emergency Services)

Overdose deaths remain high in Broome County
76 people have died of a heroin overdose in 2017. (Source: BC District Attorney)

More statistics on the opioid crisis:

OASAS Statistics:
· www.oasas.ny.gov/ODR/CD/PplAdmOpioids.cfm
· www.oasas.ny.gov/ODR/CD/ADE2015.cfm

Rockefeller Institute of Government:
· www.rockinst.org/observations/malatras/2017-11-10_malatras.aspx

Joint Senate Task Force on Heroin and Opioid Addiction 2016 Report:
·
www.nysenate.gov/sites/default/files/joint_senate_task_force_on_heroin_and_opioid_addiction_-_2016_report_-_05-17-16.pdf

State Comptroller's Report on Prescription Opioid Abuse and Heroin Addiction in New York State:
· www.osc.state.ny.us/press/releases/june16/heroin_and_opioids.pdf

Governor Cuomo's Heroin & Opioid Task Force Report:
·
www.governor.ny.gov/sites/governor.ny.gov/files/atoms/files/HeroinTaskForceReport_3.pdf

U.S. Surgeon General's Report on Addiction in America:
· https://addiction.surgeongeneral.gov/surgeon-generals-report.pdf
· https://addiction.surgeongeneral.gov/system/files/report-highlights.pdf

CDC's Drug Overdose Statistics:
· www.cdc.gov/nchs/data/databriefs/db273.pdf

Why is it better to treat locally rather than sending clients out of Broome County?

Broome County must still pay Medicaid costs for residents receiving treatment elsewhere. Health insurance claims made by residents seeking treatment out of state can be as high as $750,000 in states like Florida.

What's the cost of ER overdose treatments?

Study noted that people who admitted to hospital for RX overdose was generally a 3.8 day stay and $29,497. ER treat and release was almost $4000. 55% were admitted. (Source: Journal of American Medical Association) - where is this source?

Why aren't those with addiction being incarcerated instead of treated?

Addiction is a disease, one which we cannot "arrest our way out." 80% of the inmates at the Broome County Jail are incarcerated due to substance abuse related crimes and personally struggle with addiction.

There have been studies that show detox alone actually increases a person's risk of death. How will you ensure the person receives the next level of care and how fast will that hand-off be, because any lapse in treatment or a hand-off typically means a person will not continue with treatment. What will be done to ensure we are not increasing a person's risk of death?

Recovery/discharge plans will include resources to help people engage in healthy recovery.

Will any re-entry support services such as relapse prevention be offered by this center for those formerly incarcerated due to crimes related to their addiction?

This is not a re-entry program, but people with criminal justice history will have appropriate counseling for the substance use disorder.

Will they be treating those with co-occurring diagnoses (substance use and mental health disorder) like Fairview does? Most of those in recovery do have both diagnoses, so it would be beneficial if they were both treated.

Yes, the program is preparing for co-occurring disordered patients. The staffing plan includes a Nurse Practitioner, preferably with a psychiatric background, and a part time Psychiatrist.

What are staff titles being employed in the facility?

Service Director, Clinical Director, Team Leader, Nurse Manager, Nurse Practitioner/Physicians Assistant, Continuing Care Coordinator, Counselor II, Counselor I, Counselor Aide, Guest Services Specialist, RN, LPN, Receptionist, Driver/Facilities Aide, Property Maintenance, Admissions/Outreach Specialist.

When will staff hiring begin?

As soon as the Broome County Legislature accepts the resolution to receive funding from New York State.

Where will SBH obtain the trained staff to operate this facility? For instance, there are not that many certified Credentialed Alcoholism and Substance Abuse Counselors (CASACs) in the community and most of them are employed at existing treatment services. If they move from their existing agency to work for SBH, who will fill their positions? Could this staffing shortage undermine the new program or cause hardships for our existing programs? Have our leaders from our existing treatment services been asked for their input into this new facility?

SBH has its own Training Institute and is certified by OASAS to offer the 350 hour training course for individuals to become certified as Alcoholism and Substance Abuse counselors. Our Training Institute is open to the public. SBH will host Staff Recruitment Events and we welcome the area providers to join the event as hosts. SBH has attended meetings with the leaders from the existing providers and welcomed their input.

This is a large program and is likely to pull individuals from across the region and perhaps the entire state. When they are done with their treatment, some will return to their home communities. I understand that SBH will strive to provide a "warm handoff", connecting treatment recipients back to their home communities. One must anticipate, however, that many will choose to reside in Broome County. Many of those will relapse and require further treatment services locally. Many will experience financial, housing, legal and medical challenges. Many will seek services through DSS. Remember that over the decades the Binghamton Psychiatric Center (GBHC) had a large catchment area and many individuals discharged from this center continued to reside in our community and put a strain on our mental health system and services in general. The same is likely to happen with this new center at BDC, perhaps not immediately but year after year, the numbers will add up. We have a drug epidemic now. It could be much larger a decade from now. What plans are being made to anticipate this unattended consequence?

It is the intent of SBH to serve Broome and contiguous counties and return individuals from other regions back to their home region. Our medical and clinical staff will work with the DSS in home regions as well as clinical and medical providers in home regions as part of the discharge planning process which begins on the day of admission.

How many other counties has SBH expanded out-patient service to? They will attempt to take over all services.

SBH has expanded outpatient services to 2 counties. There are too many clients for one agency to serve.

In your other facilities: where do people seeking services come from and are the majority placed from the home county and contiguous counties? Or are they from long distances?

Due to OASAS' universal placement tool LOCADTR 3.0, 90% of patients come from their home county and others from immediate contiguous counties.

Once people are stabilized, who will be prescribing them suboxone?

SBH's priority will be working with existing providers in this community. If they're unable to provide the service this person needs that was agreed upon in the treatment plan, SBH will provide the service. They have a great relationship with Fairview and going forward will not overlap or duplicate those services.

How does SBH intend to work with local providers in the delivery of services? What is your vision to include them?

SBH will be coordinating care with local providers from discharge to admission. SBH will be invited to be a member of the Provider Advisory Group (PAG) and Alcohol/Substance Abuse Sub-Committee (ASA) of the Broome County Community Services Board (CSB). This will facilitate ongoing communication regarding referrals and other issues which impact services delivery.

Does Broome County have the capacity to do a "warm hand off" to the next level of care?

Yes, to the extent we utilize the capacity of existing resources and prioritize the patients. It's going to require cooperation and coordination between SBH and existing providers.

The Broome County Health Department, New York State Department of Health and United Health Services are working on a waiver training program in December to get more physicians prescribing suboxone to prevent post-detox overdoses.

When the announcement was made about the project, it was said that people can obtain this treatment even without insurance. Will the staff at this facility help a person get on medicaid or other insurance while they are there?

Yes.

Will clients from other Counties end up on Broome County Medicaid if they receive services at the SBH facility?

No. Their home County will still be responsible for Medicaid costs.

People will come from out of town for treatment and will not leave. Will they end up using local Social Services and our Medicaid dollars will go up? What is the Medicaid cap?

SBH's experience in other communities shows that across the board, the vast majority of patients return to their home communities after short term treatment.

Applicants for Temporary Assistance must apply in person at the Local Social Services Office. There are income and resource limits based on household size.

Every Temporary Assistance applicant is screened for substance abuse at application by a Credentialed Alcoholism and Substance Abuse Counselor. If substance abuse is indicated, that counselor will refer to the appropriate treatment.

That treatment will then become mandatory for the applicant or recipient for continued receipt of assistance.

Proof of residence is required. Applicants must also provide former address and complete an attestation as to their residences for the past 12 months, to determine if they came from another county. Examples of proof of residence is a landlord form, statement from landlord.

If an individual leaves treatment against medical advice, the district of fiscal responsibility will close the case and/or sanction the individual. Broome County will be able to see that in the Welfare Management System if the individual applies in Broome County. If there is no break in need, the former district remains responsible.

If a patient leaves against medical advice and stays in Broome County and applies for Public Assistance, they would not be able to jump on local DSS rolls, there would be a sanction for noncompliance preventing this.

Broome DSS also asks for their former address and finds out if they are receiving assistance elsewhere.

Will clients from other Counties end up on BC Medicaid if they receive services at the SBH facility?

No. the county from which they come is financially responsible.

Who pays for out of county individuals who come to Broome County to access SBH who also receive Public Assistance?

Phase I of the SBH project (Part 816) would be considered a medical facility according to OTDA (Office for Temporary and Disability Assistance) so assistance during and immediately after would be the responsibility of the "home" county of that individual. If a recipient leaves Against Medical Advice then the individual would be sanctioned by their home county. Our local DSS would be alerted if the individual applies for Temporary and Disability Assistance in Broome County which would be grounds for rejection of their application until such time as the individual is back into compliance.

Does SBH or OASAS track the financial impact on local DSS where they are currently providing services?

It is not the responsibility of SBH or OASAS to track the financial impact of the local DSS. However, DSS already tracks these statistics.

Will local community groups and educational programs be able to get involved with this project?

Yes. The facility has four large classrooms that will be used with group/learning rooms. SBH looks forward to partnering with local organizations to deliver educational and support programming for clients.

What type of alternate therapies will SBH combine with traditional clinic services? Is SBH considering any new types of therapies?

On the non-pharmacological side of treatment, SBH also utilizes individual counseling, group counseling and peer discussions. SBH has also a utilized acupuncture and yoga in their facilities. SBH is currently working with OASAS to make part of the space at the former Broome Developmental Center available as a studio where yoga and other mindfulness exercises can be done.

SBH feels that holistic approach to treatment is necessary. Their treatment model is not simply medication and rest. Medication is a complementary therapy for patients who need it on a case by case basis. Not every patient needs medication and not every patient needs the same medication. SBH believes in the use of medication, but only when clinically indicated by a doctor, lab results and experience from patients in counseling.

SBH also employs staff looking at new research on a regular basis. Their Chief Clinical Officer looks at new research and meets with a team of physicians and psychiatrists on a regular basis and, in conjunction with counseling groups, are constantly providing feedback to her. She then reviews literature and consults with the Medical Director at OASAS on new treatment options. OASAS must approve of any new treatment protocols that the program would use. If SBH plans on introducing a new treatment, they would submit the proposal it to OASAS, who would then review it and make sure it's consistent with accepted literature and research before authorizing SBH to deploy it.