Greene County Mental Health Center

905 GREENE COUNTY OFFICE BUILDING
CAIRO, NY 12413

2018 Annual Report

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& Mental Health Center Staff

INTRODUCTION

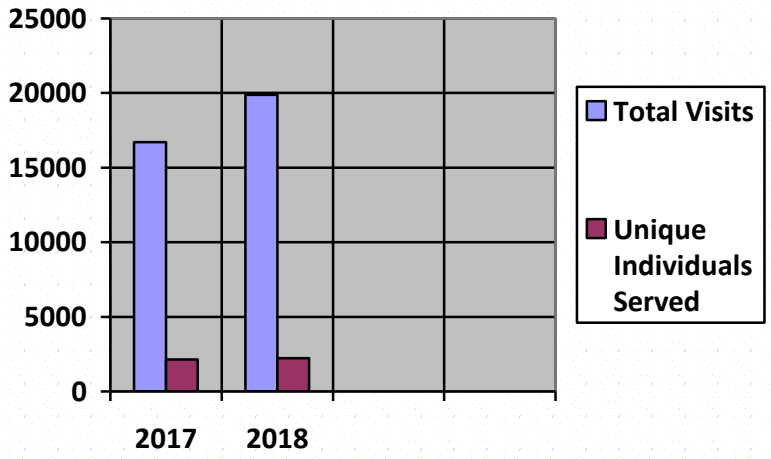
The Greene County Mental Health Center is an Article 31 community mental health clinic licensed by the NYS Office of Mental Health. It employs a full contingent of professional staff, including Psychiatrists, Nurse Practitioners, Psychologists, Social Workers, and Mental Health Nurses. Our staff is dedicated to serving the residents of Greene County struggling with a variety of mental health disorders. Our compassionate and experienced staff members work together to provide a high level, comprehensive system of care that is patient centered.

CENSUS INFORMATION

Over the course of 2018, Greene County Mental Health Center (GCMHC) served a total of 2,222 unique individual clients (an increase of 81 patients since 2017) to 1,583 Adults and 639 Children & Adolescents. We provided 19,878 billable direct service contacts compared to 16,713 in 2017.

2 Year Data Comparison

2017	2018
Total Visits - 16,713	Total Visits – 19,878
Adults – 11,580	Adults – 14,292
Children – 5,133	Children – 5,586
Total Unique Individuals Served – 2,141	Total Unique Individuals Served – 2,222
Male 41.8%	Male 46.17%
Female 58.2%	Female 53.83%
Adults 75.4%	Adults 71.24%
Children 24.6%	Children 28.76%



EVALUATION OF 2018 GOALS

1. **Revise Corporate Compliance Manual.**
   2018 saw significant changes to the way in which GCMH handles, manages and monitors Corporate Compliance duties. The manual, however, has not yet been updated. Therefore, this will remain a Goal for 2019. During 2019, the Corporate Compliance Officer will also change as the former Officer has changed roles and a new officer must be designated.

2. **Revise GCMHC Policy & Procedure Manual.**
   A few updates were made the Policy and Procedure Manual during 2018, but it was not fully updated. This endeavor is poised to occur in the coming months of 2019. The clinic will be purchasing and transitioning to a new Electronic Medical Record, which will necessitate new policies and procedures which will be created and recorded throughout the course of the transition.

3. **Complete the RHIO connectivity which permits data sharing.**
   The unilateral connection is complete. We are currently sending band nursing notes and associated CCD's (collaborative care documents) to HIXNY

4. **Optimize the use of our current EMR software to track quality measures as it relates to patient centered care.**
   Documentation changes were made to account for quantifiable measures. This included changes to formatting of plans of care, prescriber notes and clinical documentation, additional requests from medical records for laboratory results, and also the additional of new reportable fields. By adding additional reportable fields we were able to create reports that can be adjusted monthly to account for the newly added tracking measures.

   GCMHC will be purchasing a new Electronic Medical Record System in 2019. One of the features we are requiring in the new system is a more effective and efficient way to track quality measures, as well as many of the other data we've wanted and needed to extract and track but have been limited by our antiquated Electronic Medical Record.

5. **Building improvements: Installation of handicapped accessible bathroom for clients and upgrade the waiting room area.**
   In 2018 the Buildings and Grounds Dept. renovated a several areas of the clinic. Old tile floors were replaced with laminate flooring in two upstairs offices. A medical office was renovated with new cabinetry, sink, and laminate flooring. The waiting room carpeting was also replaced with laminate flooring allowing for easier cleaning of this high traffic area. The restroom off of the waiting room was renovated with a wider entrance (making it handicapped accessible), new fixtures, wall paneling, and flooring.

6. **Completion of client satisfaction survey.**
   Client Satisfaction Survey was administered to all patients receiving services during the time period 7/23 /18 – 8/03/18. Results were shared with staff and the Greene County Community Services Board.
   (See Results of Survey on Pages 11 & 12)

GOALS FOR 2019

1. **Hire for essential positions, starting with the Director of Clinical Services, and backfill any positions vacated by filling this position internally.**

2. **Purchase and implement a new Electronic Medical Record System.**

3. **Re-write Policy and Procedure manual to reflect and include new changes that come from anticipated workflow re-design.**

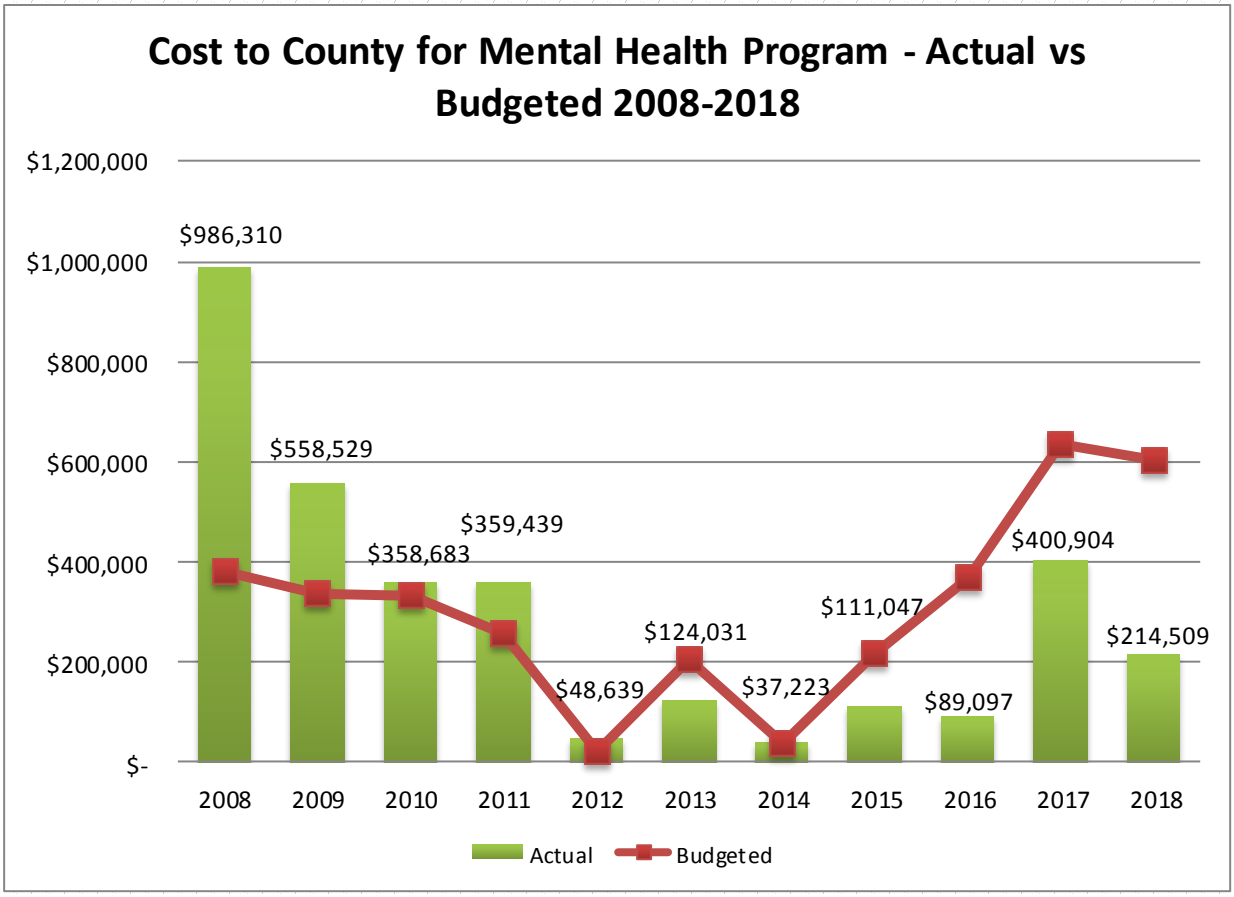
4. **Revise Corporate Compliance Plan.**

5. **Expand school-based services.**

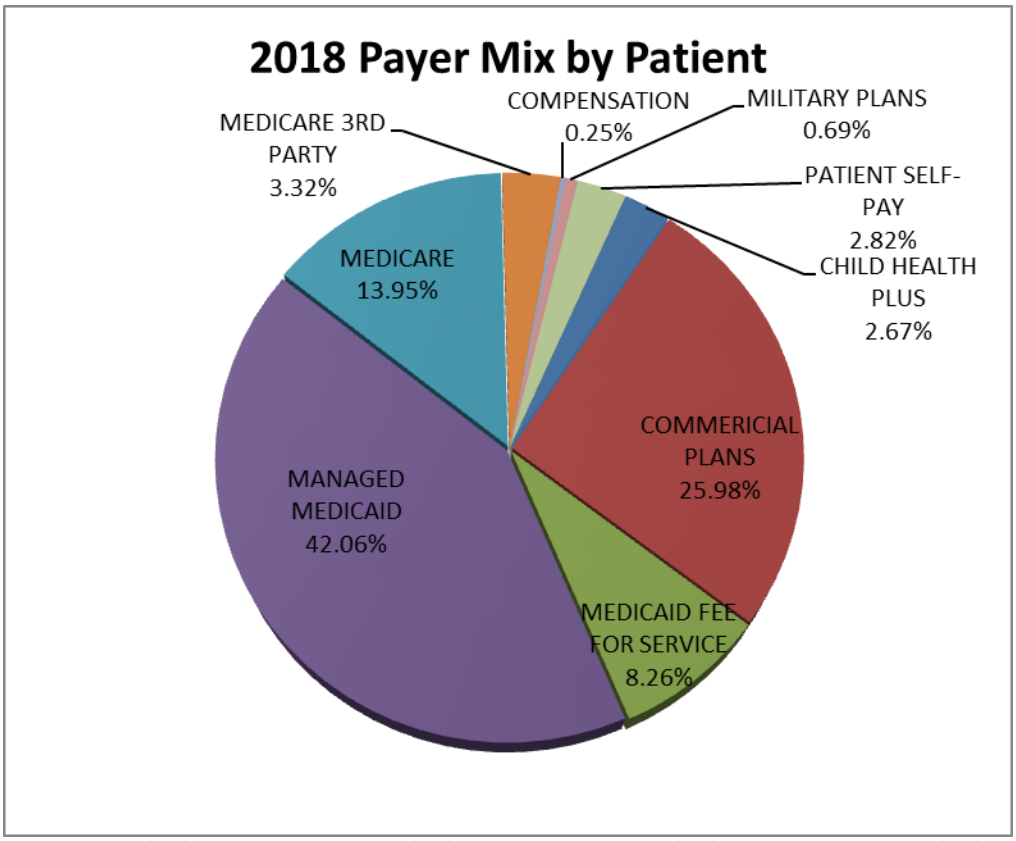
Fiscal Developments

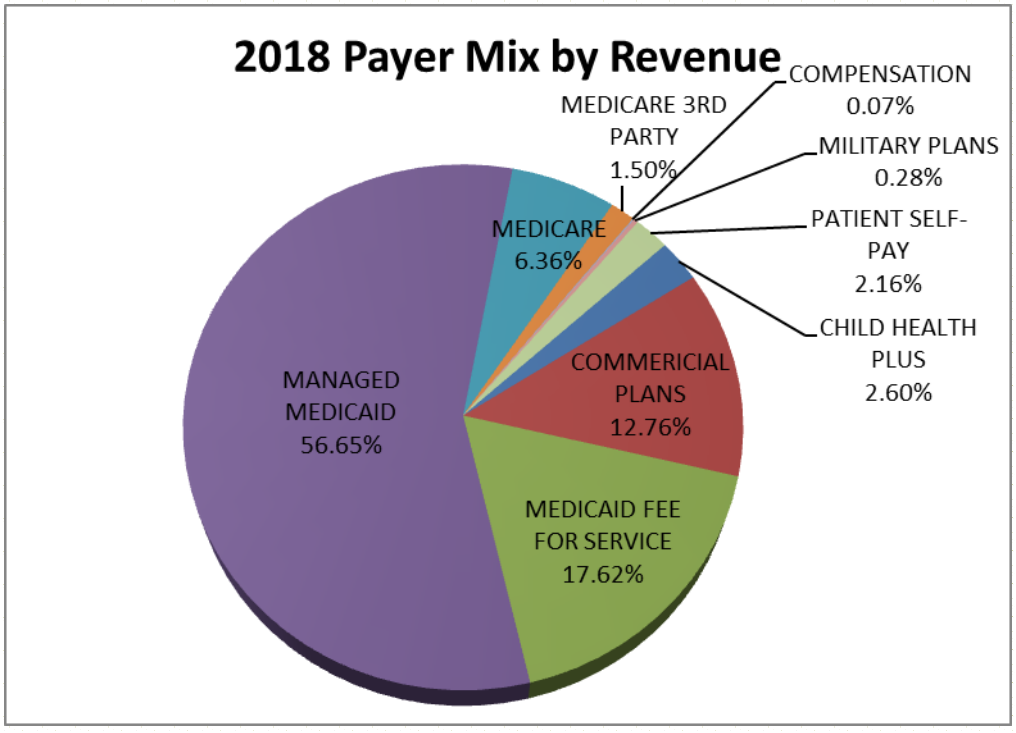
The clinic continues to balance the provision of evidence based, clinically relevant service while being mindful of the tax burden on Greene County tax payers. Clinical, fiscal and support staff have remained diligent in their efforts to keep costs low. In 2018 the department's cost to the county was $214,509, approximately $390,472 below our anticipated budgeted cost. In 2018, thanks to participation in DSRIP Performance activities, enhancements made to our practice management software, automatic real-time eligibility reports, and timelier claims payments our overall expense to the county dropped by $186,395.

Areas where the department still faces financial strains is in the cost for commitments of those who are currently serving jail terms at the state psychiatric forensic unit. In 2018, there was a significant contract increase at the state level for these services which resulted in additional expenses for the county. Additionally, with the CSEA bargaining agreement passed in March 2018, our personnel related expenses have also increased significantly for 2019. We are hoping that emphasis on meeting individual productivity goals will help offset these added costs.



Payer Mix by Patient vs. Revenue Received





Delivery System Reform Incentive Payment (DSRIP)

Greene County Mental Health took a more active approach to participation in the DSRIP (Delivery Systems Reform Incentive Payments) Program mid-year 2018. The program funded by New York State and managed by BHNNY (Better Health for Northeastern New York), is a community-level collaboration that focuses on reducing overall costs associated with the Medicaid program while improving population health and clinical treatment.

Participation in this program not only requires additional training and participation in required meetings, but it also required the clinic to make workflow changes and documentation changes to account for quantifiable measures. This included changes to formatting of plans of care, prescriber notes and clinical documentation, additional requests from medical records for laboratory results, and also the additional of new reportable fields. By adding additional reportable fields we were able to create reports that can be adjusted monthly to account for the newly added tracking measures.

From June 2018 until year end GCMHC received $59,960 ($39,133 received in 2018, $20,827 received in 2019). Participation in this program helps us provide better quality of care to our clients, but also prepares us for value-based contracts in the future and while giving us a modest financial reimbursement for our participation and submission of data on a monthly basis. At this time all submissions are handled by the Director of Fiscal and Business Operations so there is no imposition on our direct care services rendered.

The Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES)

The Psychiatric Services and Clinical Knowledge Enhancement System for Medicaid (PSYCKES-Medicaid) is a Health Insurance Portability and Accountability Act (HIPAA)-compliant, web-based portfolio of tools designed to support quality improvement and clinical decision-making in the New York State (NYS) Medicaid population. Providers with access to PSYCKES are able to access a portfolio of quality indicator reports at the state, region, county, agency, site, program, and client level to review performance, identify individuals who could benefit from clinical review, and inform treatment planning. Quality reports in PSYCKES are updated monthly, and clinical information is updated weekly. Developed by the New York State Office of Mental Health (OMH), PSYCKES uses administrative data from the NYS Medicaid claims database to generate quality indicators and summarize treatment histories. This administrative data is collected when providers bill Medicaid for services. All states are required by the Federal Government to monitor the quality of their Medicaid programs, and many states are using administrative data such as Medicaid claims to support quality improvement initiatives. Quality indicators were developed in consultation with a Scientific Advisory Committee of national experts in psychopharmacology and a Stakeholder Advisory Committee of providers, family members, consumers, and professionals.

Greene County Mental Health receives an enhanced Medicaid rate per visit per client for its participation in the PSYCKES QARR (Quality Assurance Reporting Requirements) Program aimed to promote better provider awareness and performance on key behavioral health measures monitored by Managed Care Organizations. The clinic is currently focused on 7 Quality Assurance measures:

1. Follow up after mental health hospitalization within 7 days
2. Client enrolled in a HARP (Health and Recovery Plan) managed Medicaid insurance, but not enrolled in a Health Home (care management agency)
3. Antipsychotic Medication Adherence
4. Antidepressant Medication Adherence
5. Metabolic Monitoring for children and adolescents on Antipsychotics
6. Diabetes screening for clients with Schizophrenia or Bipolar diagnosis on Antipsychotics
7. Follow up care for children newly prescribed ADHD medication (follow up visit with prescriber at 30 and 90 day mark)

Technology Developments

Greene County Mental Health continues to struggle with quantifying quality of care with the current Electronic Medical Record (EMR) system, which was initially implemented in 2013. All clients, whether they're seen at the clinic or at a satellite, have records within the EMR system and it's our responsibility with the changes in healthcare to quantify our services and the impact they are making on a person's overall health.

With that said, after Greene County Mental Health's transition to a cloud-based EMR we have recognized that there are fewer connectivity issues and increased data protection. We would like to enhance our system by moving to a more robust platform (also cloud based) designed for long-term healthcare tracking and a model that incorporates the ability to electronically transmit care plans and labs with external sources.

By making this upgrade we'll be better aligned with larger healthcare systems and utilizing a person centered care approach which is the direction healthcare and behavioral health plans are moving. Value based contracts beginning in 2020 will require Mental Health providers to show linkage between treatment of a client's mental health disorder and their physical health. Our future plans will include HL7 interfaces with local labs and direct real-time feeds from HIXNY (Health Information Exchange of New York) into our medical record for all services rendered by providers outside of the clinic who also have established HIXNY connectivity.

Corporate Compliance, Quality Assurance, and Utilization Review

To assure that all Medicaid and Medicare Billing requirements are fully followed, the Office of the Medicaid Inspector General (OMIG) requires that all clinics such as Greene County Mental Health to have a Corporate Compliance Plan in place. The County has adopted a Corporate Compliance Plan as it relates to both Greene County Mental Health and Greene County Public Health, but each department also has their own plan as it relates to them.

The Corporate Compliance Plan for Greene County Mental Health requires that all staff members go through annual training to refresh and update them on the plan. It also requires that we conduct self-audits, which are conducted quarterly. The purpose of the self-audits is to ensure that all medical documentation is completed, to ensure that billing practices are followed and to eliminate any chance for fraud, waste, or abuse of Medicaid or Medicare funds.

Each quarterly self-audit has resulted in some returned funds but they were always due to documentation errors. Never were they the result of intentional attempts at fraud or abuse of funds. Each return is addressed with the individual staff member who was responsible for the oversight or mistake. Additional training is provided whenever necessary. GCMH continues to conduct quarterly self-audits to ensure high quality of care is provided, documentation and billing is done properly and in accordance with applicable regulations.

In 2018 we continued to focus on, monitor, and track the 7 key areas of compliance risk (billing, payment, medical necessity and quality of care, governance, mandatory reports, credentialing and other risk areas. The staff has been trained in this, new procedures for tracking and monitoring have been put in place.

The GCMH fiscal office continues to employ various procedures to ensure that all billing is done properly and ethically. Further, GCMH also transitioned to new Practice Management software that is better integrated with the Electronic Medical Record. This will allow for much more accuracy as well as data collection and monitoring for all clinical documentation and billing activities.

2018 Client Satisfaction Survey

Greene County Mental Health Center

CLIENT SATISFACTION SURVEY RESULTS

Facility Ratings

Clients rated the following 0 – 5 out of 5

Ease of scheduling appointments	4.60
Return calls in timely manner	4.37
Prompt and courteous reception	4.76
Time in waiting room	4.27
Cleanliness and comfort of facility	4.60
Staff professionalism	4.37
Staff understanding of your presenting concerns	4.76
Knowledge of competency of staff	4.60
Quality of care	4.37
Overall satisfaction of service	4.76

OVERALL RATING FOR THE FACILITY 4.59

KEY MEASURES OF CARE & SERVICES

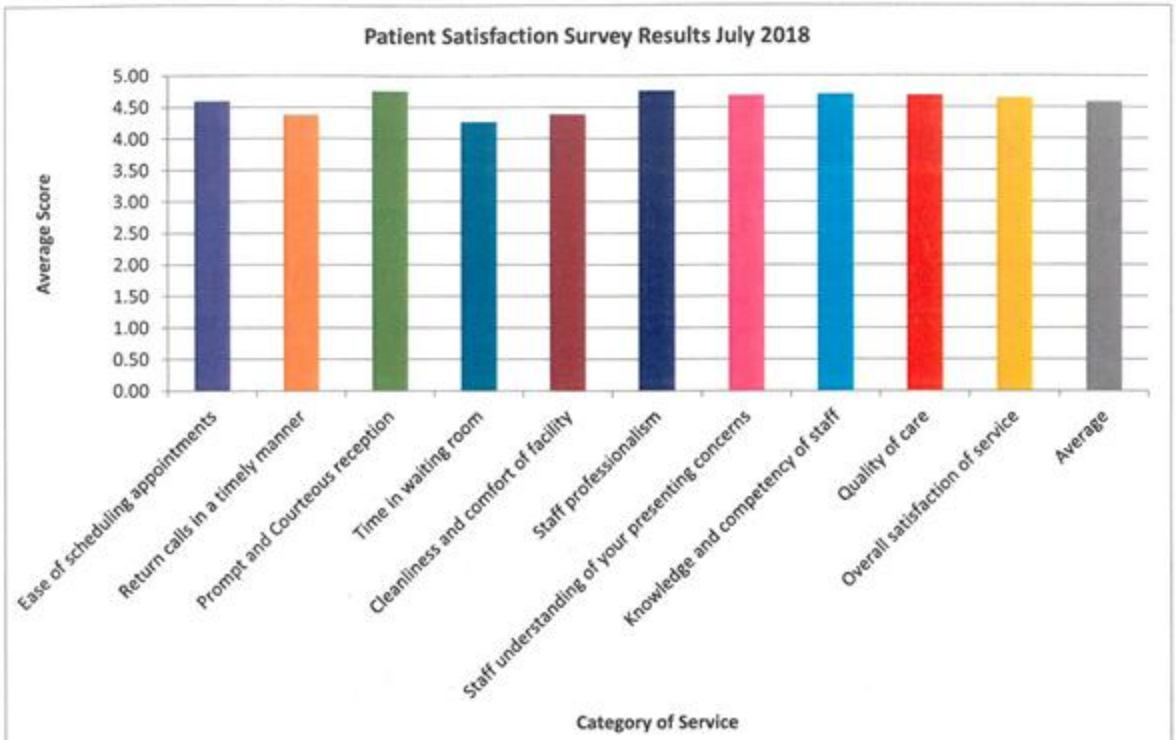
83% Of survey takers expressed their favorite thing about GCMHC is the STAFF and the care they receive.

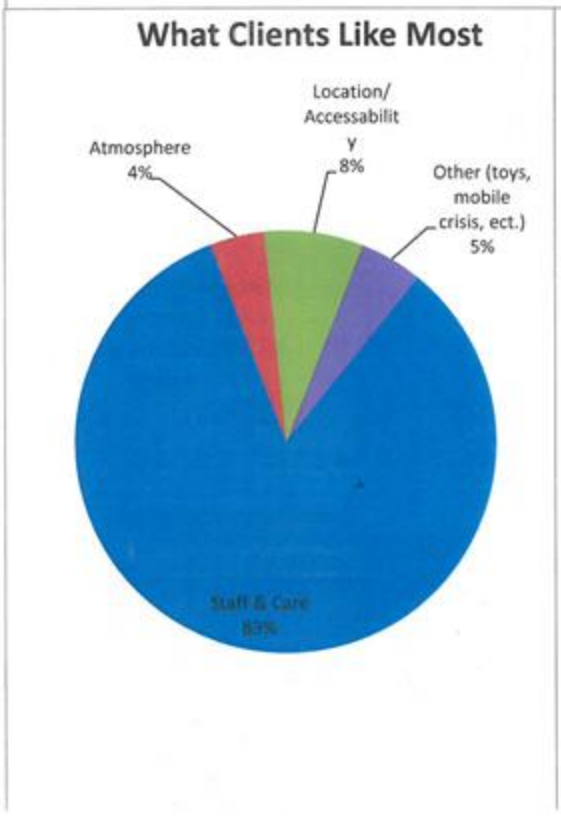
Mentioned by name:

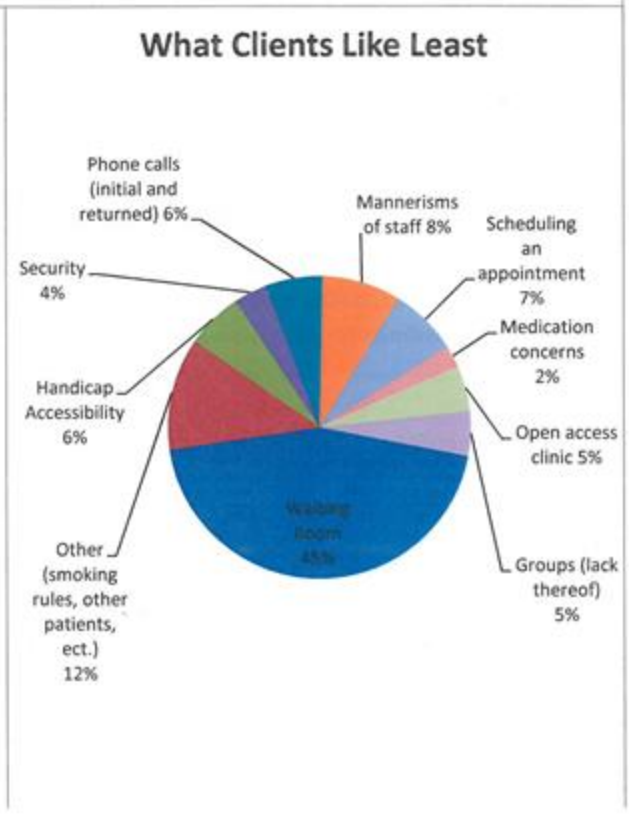
K.B. - NP
H.B. - RN
M.M - LMSW
S.S. - LCSW
S.K – LCSW-R
F.D. - LPN
M.C. - LMSW
S.T. - LMSW
D. R. – LCSW-R

#1 Answer for a patient's LEAST favorite part of GCMH was the waiting room.

98% said they would refer a friend to CGMHC


Patient Satisfaction Survey Results July 2018
Average Score
5.00
4.50
4.00
3.50
3.00
2.50
2.00
1.50
1.00
0.50
0.00
Ease of scheduling appointments
Return calls in a timely manner
Prompt and Courteous reception
Time in waiting room
Cleanliness and comfort of facility
Staff professionalism
Staff understanding of your presenting concerns
Knowledge and competency of staff
Quality of care
Overall satisfaction of service
Average
Category of Service


What Clients Like Most
Location/ Accessabilit y 8%
Atmosphere 4%
Other (toys, mobile crisis, ect.) 5%
Staff & Care 83%


What Clients Like Least
Phone calls (initial and returned) 6%
Mannerisms of staff 8%
Scheduling an appointment 7%
Security 4%
Medication concerns 2%
Handicap Accessibility 6%
Open access clinic 5%
Waiting Room 45%
Other (smoking rules, other patients, ect.) 12%
Groups (lack thereof) 5%

Staffing News

Greene County Mental Health Center experienced several staffing changes during 2018 due to employee retirement, pursuit of private practice, and career advancement.

In January 2018 GCMHC filled a vacant Medical Claims Processor position and a Medical Receptionist position. In February a vacant Mental Health Specialist position on the Children's Team was filled. In April our Principal Clerk Typist in Medical Records retired and one of our Medical Receptionists was able to be reached via civil service list to fill the position. In June another Medical Receptionist was hired. In late August a clinic-based Mental Health Specialist transitioned to a school-based position at the new Coxsackie-Athens school district satellite. In October we filled a vacant Mental Health Specialist position on the Adult Team.

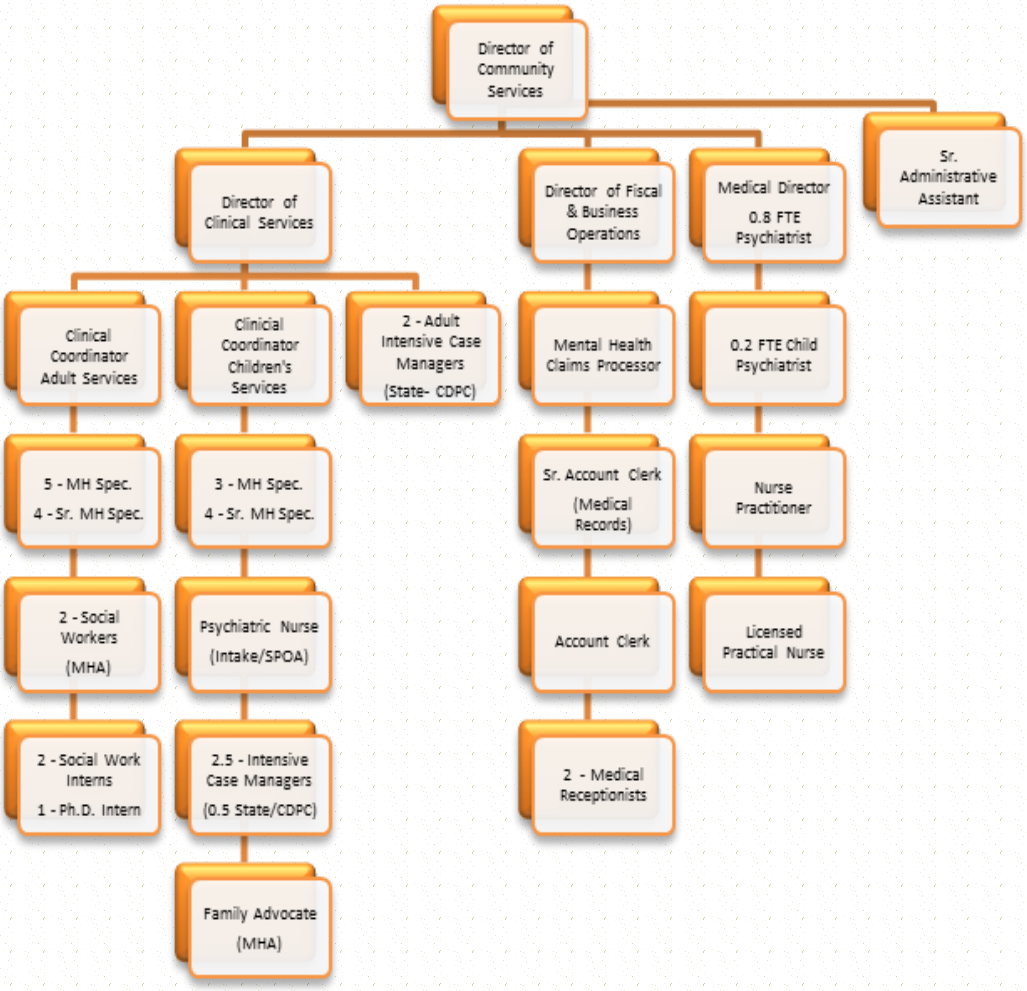
A doctorate in psychology intern from SUNY Albany completed her internship with GCMHC in July. In September GCMHC welcomed 2 interns from SUNY Albany's Master in Social Work program. They are with us until they graduate in May 2019. We also hosted 4 students from Columbia Greene Community College's Nursing program for their rotation through mental health services.

In late 2018, eight Senior Mental Health Specialist (grade 15) positions were created in order to provide a promotional career ladder to those who have been in a Mental Health Specialist position for 6 years or more. Two Clinical Coordinator positions were also re-classified from a grade 16 to a grade 17.

At the end of December 2018 the Director of Community Services retired after having served 8 years in her position. GCMHC's Director of Clinical Services, was appointed Acting Director of Community Services until.

One staffing challenge GCMHC experiences is that some of our social work hires in recent years are new to the social work field, with limited clinical experience, that require weekly clinical supervision and support in transitioning to their new role. It can also affect case assignments and revenue generation as Medicare and select commercial insurance companies will not reimburse for services provided by a Licensed Master's Level Social Worker. This takes coordination and oversight at the front door in the assignment of clients.

Staff Organizational Chart



Staff Trainings

During the course of 2018 employees took part in several in-house trainings as well as mandated County trainings:

In-House Staff Development Trainings:	
NYS Kinship Navigation	1/2/18
Greener Pathways (Opioid Use)	1/30/18
EMR Documentation Overview	2/27/18
AED's (usage instructions)	3/27/18
CPR – Nursing Staff	5/16/18
Motivational Interviewing	11/27/18
Corporate Compliance	12/11/18

County Mandated Trainings:	
HIPAA	4/17/18
Blood-Borne Pathogens	6/12/18
Workplace Violence Prevention / Active Shooter	10/09/18
Sexual Harassment / Discrimination	12/3/18 & 2/4/18

ADULT SERVICES

Open Access Clinic

The Open Access Clinic was created in September 2015 when GCMHC overhauled the way adult clients are seen at the clinic for the first time. The purpose of this change was multi-faceted; we wanted to reduce the amount of time it took for a client to be seen after first contact with the clinic, reduce the number of missed appointments for intakes, and maximizing the chance to engage clients that might otherwise be hesitant to engage or drop out of treatment prematurely.

The Open Access Clinic (OAC) works by having drop-in hours for all new adult patients desiring services from GCMH. They walk into the clinic any time between 9:00am-11:00am on Monday, Wednesday and Thursday. No appointment is necessary. They are then evaluated and the proper level of service is determined by a small treatment team of clinicians who staff the Open Access Clinic.

The OAC also allows for more efforts for engagement of clients who might be hesitant to engage. It quickly and effectively refers out clients who are looking for services that we do not provide. The OAC also allows for clients who are truly ready and prepared for counseling to be assigned to therapists to begin their more intensive treatment. In contrast, those clients who are hesitant to engage in treatment or those that require more frequent contact than what a therapist can provide can continue to be seen in the Open Access Clinic. Essentially, the OAC was created to meet the needs of our clients, rather than trying to make the clients fit a treatment model that does not entirely meet their needs.

In April 2018 the clinic began performing Health Screening on all new clients 18 and older as part of the intake process as per OMH regulations. All new clients meet with the clinic nurse who obtains a medical history, list of current health providers, performs a tobacco screening and willingness to quit question set, obtains baseline vitals, records allergy and medication lists and makes appropriate health referrals if needed to primary care services as needed. This service is billable and reimbursed, brining additional revenue to the clinic. 598 Health Screenings were preformed from April 2018 – December 2018

Since its implementation, the OAC continues to meet the needs of our clients and the clinic itself. Clients are now able to access services without an appointment and the clinic no longer experiences no-shows for intake appointments. Further, there is no longer an extensive waiting list for services. The OAC continues to be a great success for the clients, clinic and community.

2018 OAC Statistics

Health Screenings	**598**
Clients Scheduled for OAC Following Hospital Discharge	**323**
Total Number of Client Visits to OAC	**1,572**

Insight-Oriented Psychotherapy/Supportive Counseling

Adult therapists assess and treat individuals who are age 18+. Our Open Access Clinic is staffed by a team of clinicians who complete intakes and assessments. Additionally, we schedule appointments for people who need court-ordered mental health evaluations. We formulate initial diagnostic impressions and treatment recommendations. The adult team clinicians meet with their individual clients to assess their needs and develop a comprehensive treatment plan. This treatment plan may include a referral to medication management in which clients meet with our staff psychiatrist or nurse practitioner. We also provide specialized counseling services for clients with trauma histories; 3 of our clinicians are certified Eye Movement Desensitization and Reprocessing (EMDR) therapists. The adult team has regular meetings to discuss high-risk cases and activity within our Open Access Clinic. Clinical supervision is provided on a regular basis and continuing education is encouraged to maintain licensure and continued growth in the field of social work.

The Adult Team often refers clients to additional supportive services within and outside of our clinic. They coordinate with collateral agencies including:

- Primary Care Physicians / Public Health
- Care Managers/Care Coordinators
- Hospitals
- GCDSS/APS
- Mental Health Association- PROS, MCAT
- Twin County Recovery Services/Greener Pathways
- Greene County Drug Treatment Court
- Greene County Probation and NYS Parole
- Single Point of Access/ SPOA

At any given time, the adult team serves anywhere from **750-900** active clients. Full time adult therapists carry a caseload of **50-70** clients.

Adult Group Offerings

Coping Skills Group - A co-ed adult psychoeducational group that focuses on assisting individuals develop skills for life. The curriculum includes information about mindfulness practice, how to deal with criticism, developing an assertive communication style, and being effective in social interactions. This group is appropriate for 8-10 participants. It is held weekly for 8 weeks and new members can join at any point in the curriculum.

Men's Group- A bi-weekly support group for adult men with mental health disorders. This group is currently closed to new members.

MICA Ceramics Group - A weekly co-ed adult psychoeducational group. This group is focused on adults who are both in recovery from substance use disorders and have a mental health disorder. Ceramics projects are worked on as different themes are introduced in the group (i.e.; creating a mask that represents the identity we reveal to the world). The focus of the group is largely about using work with clay as a means of exploring living a meaningful life while remaining sober. This group is appropriate for 7-8 members and new members can join at any time. Each cycle is 13 weeks. Materials are provided by the facilitator.

Sewing and Social Skills - A weekly co-ed adult psychoeducational group that focuses on social skills. Members of this group utilize effective problem-solving and cooperation to complete various sewing projects. Each group allows members to practice communication skills such as listening to instructions and asking for help. The group is appropriate for 5-6 members. Materials are provided by the facilitator. New members can join at any point.

Community Health Integration Program

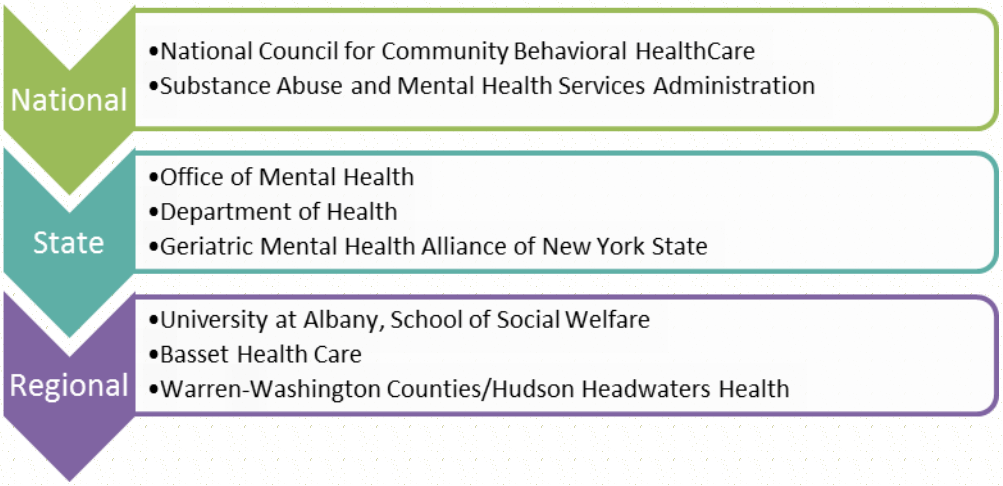
With its roots in prevention and crisis management, Community Health Integration Program continues to operate throughout Greene County and provide vital outreach services to residents.

In 2018 CHIP maintained three satellite offices in Greene County. CHIP clinicians provide mental health assessment and treatment services directly to clients at the satellite locations, as well as linkage and referral to other programs and services.

At its inception, Rural Health Network had provided support of this program. This included grants, which included a small portion of the salary for the coordinator and a budget for supplies, such as billboards, educational pamphlets and materials. RHN grant funding was phased out in 2016, at which time the Mental Health department fully supported this program.

Materials for each office are provided once annually by the coordinator. Materials were selected based on the relevance to the program, population interest and office requests/need. This included new, updated copies of the screening instrument, brochures, fliers, and mental health education materials.

With the success of the program, the coordinator has received requests from other organizations to inform program development in their area. Requests for consultation, collaboration, in-person educational seminars and presentations have increased as similar models around New York State have been developed. Presentations have been completed for:



Presentations and other materials on CHIP are posted on the State Office of Mental Health website. CHIP was featured in a National webinar (available online) by the Office of Mental Health and SAMHSA in 2013. Presentations to local Graduate social welfare students occurred in 2013 - 2016.

CHIP Annual Data Summary

Service Description	2012	2013	2014	2015	2016	2017	2018
Kept Appointments (face to face contacts: brief assessment, crisis intervention, referral, etc.)	882	781	958	506	783	471	460

Assisted Outpatient Treatment Program (AOT)

In 1999, New York State Enacted Legislation that provides for assisted outpatient treatment for certain people with mental illness who, in view of their treatment history are unlikely to remain safe in their community without supervision. The law is commonly referred to as "Kendra's Law" and is set forth in 9.60 of the Mental Hygiene Law. It is a civil and not a criminal law. This state wide initiative has been developed to assist clients who are non-compliant with treatment to obtain the mental health treatment they need and live safely in their community.

There are clear and precise AOT eligibility requirements. One of the seven eligibility requirements are clients having two or more hospitalizations due to non-compliance within the last 36 months or clients having one or more acts of violence toward self or others within the last 48 months. These clients can be high risk in the community because of danger to oneself or others secondary to non-compliance with treatment. In 2018, there were no Greene County residents released from prison on an AOT status. In 2018, one Greene County AOT client had to be transferred to another county because there was no Community Residence bed available; Greene County could not provide the level of residential housing that the client required. Individuals under AOT receive priority access to case management, outpatient services and residential housing options.

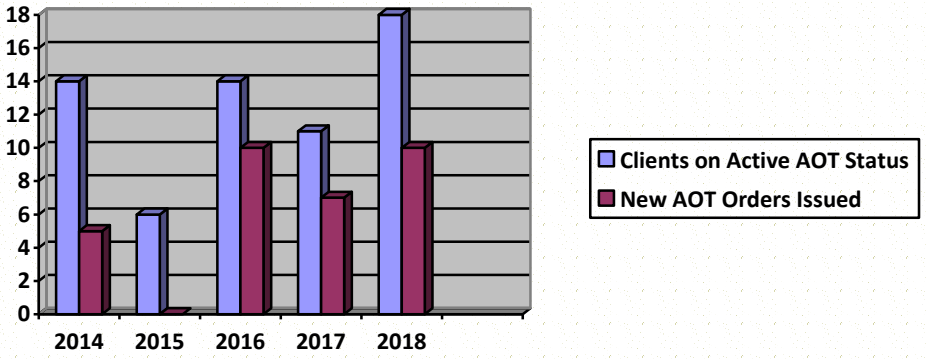
Enhanced AOT or Enhanced Service Program is a less restrictive program. It is used prior to getting an AOT order or used in stepping a client down from an AOT order. This program does not involve court orders but is helpful when a client is at high risk in the community and noncompliant with treatment. It allows for increased monitoring of the client and is less restrictive than the AOT order.

Significant Event reports are reports filed with OMH when a client is on an AOT order and is noncompliant with treatment, or demonstrates other high risk behaviors in the community such as criminal activity, whether it is being accused, committing a criminal act, or being a victim of crime; danger to self or others; non-compliance with mandated treatment; homelessness; psychiatric inpatient hospitalization or emergency services used; psychiatric decompensation; death; substance abuse; risk of non-delivery of mandated services; and if an AOT client is missing. In 2018, 16 significant event reports were filed with OMH. Five (5) of the significant events filed were due to noncompliance with treatment. Five (10) were related to substance use, one (1) was related to the client being a danger to others.

Many of these AOT clients have co-occurring diagnoses, severe mental illness and substance use disorder. Seven (7) of the eighteen (18) active AOT clients Greene County Mental Health is responsible for monitoring have these co-occurring diagnoses. This is a trend being seen statewide that a large percentage of the AOT population have substance use disorders. Another trend noted for the upper Hudson Valley Region is the shortage of appropriate housing for AOT clients. This may be related to the acuity of the client, the need for licensed housing support, or the lack of affordable low income housing in an area.

To date eighty nine (99), Greene County residents have been referred to the AOT program. In 2018, ten (10) new AOT orders were issued. Fourteen (14) pick-up orders were issued to AOT clients due to non-compliance with treatment and/or an increase in symptoms. Five (5) of the pick-up orders resulted in inpatient psychiatric hospitalization. Currently there are fourteen (18) clients on active AOT status.

Assisted Outpatient Treatment Statistics	2014	2015	2016	2017	2018
New AOT Orders Issued	5	0	10	7	10
Moved to Enhanced Status	1	2	0	1	2
Discharged from Enhanced	1	6	1	1	1
Active AOT Status	14	6	14	11	18
Active Enhanced Status	3	3	2	2	1
Pick Up Order Issued due to Non-Compliance	12	15	10	10	14
Inpatient Hospitalization resulting from Pick Up Order	5	8	5	3	5



Greene County Jail Services

Services provided by Greene County Mental Health Center (GCMHC) in the Greene County jail were discontinued with the jail closing May 20, 2019.

Prior to the Jail closing, the Greene County Jail had seen a trend of inmates presenting with increasingly significant psychiatric needs. As the Jail began closing tiers, service days to the Jail were decreased. At the time of closing, Greene County Mental Health continued to respond to this need with the following measures:

- Improving suicide screening and prevention
- Providing a Licensed Clinical Social Worker 3 days a week to provide evaluations and counseling services to inmates as well as "as needed" services during the week
- Providing 2-3 hours per week of psychiatric medication therapy by GCMHC's contracted Psychiatrist
- After hour services through the GCMHC's on-call service for weekend and holiday needs
- Follow-up services for inmates upon release
- Case management services during incarceration
- Discharge planning when indicated
- Providing the staff to complete Court Ordered Evaluations and 730 Competency Exams

These services were provided with the intention of lowering the risks of psychiatric and behavioral emergencies, to increase the safety of inmates and staff, as well as facilitate ongoing care for inmates needing Mental Health follow-up services.

One inmate remains in Central New York Psychiatric Center (admitted 2016). Court Ordered Mental Health Evaluations and 730 competency exams continue to be provided by the GCMHC when ordered through the Courts.

GCMH's Forensic Worker, with GC Jail's Training Officer, attended a Train-the Trainer program 'Suicide Prevention in County Jails and Police Lockups'. The training was presented to Correction Officer Recruits jointly by the

Forensic Worker and the Corrections Training Officer last year. There are plans for presenting the program to the Correction Officers at the Jail in the near future. Recently, they also attended a training "Responding to Emotional Crisis," with plans to present this with the Suicide Prevention program.

Family Court Services

Greene County Mental Health continues to provide succinct mental health evaluations to Greene County Family Court to assist the Judges in their decisions. These services are billable to insurances while also serving the needs of the court. It has been reported by the Judge's that they find these evaluations very helpful in their deliberations in Family Court.

Drug Court

Greene County Mental Health has collaborated with Greene County Drug Treatment Court since the inception of the alternatives to incarceration program. The clinic's Director of Clinical Services represented GCMH on the Drug Court team. However, when the Director of Clinical Services was took the position of Acting Director of Community Services, he could no longer fulfill that commitment. At that point, the Clinical Coordinator for Adult Services was asked to represent GCMH in Drug Court. The roll entails weekly attendance and participation in the Drug Court Team meeting followed by the weekly appearance in Drug Court. The entire weekly commitment is expected to last from 9:00am - 12:00pm.

The NYS regulations for Drug Treatment Courts require a representative from Mental Health to participate and hold a permanent role on the Drug Treatment Court Team. The purpose of the Drug Treatment Court Team is to monitor and discuss the weekly progress of the Drug Court participants and to collectively determine treatment recommendations, sanctions and rewards for the participants. The Team also discusses and makes decisions on new referrals to the program. The representative from Greene County Mental Health fulfills an important role on the team with regards to educating the team on mental health issues and psychotropic medications that relate to the participants. The representative also serves an important role in evaluating most of the new participants to the program and providing initial and ongoing treatment recommendations. Because many of the participants also end up engaging in services through GCMH, the representative also serves as a liaison between the treatment providers and the Drug Court Team.

Single Point of Access for Residential and Care Management/Coordination Services

The Greene County Single Point of Access for Adult Services is a Committee comprised of a coordinator from Greene County Community Service Board, as well as members of community supports and services, such as the Greene County Department for Social Services, Greene County Adult Protective Services, and the directors of residential services and community program management from Mental Health Association of Columbia and Greene Counties. When appropriate or necessary, additional community stakeholders are invited to participate, such as The Arc of Ulster/Greene, Catholic Charities, or WillCare agencies. In 2018 no additional representative supports were requested from other community agencies or entities other than those listed above.

2018 saw an increase in the use of the unified referral form as well as an increase in the number of referrals reviewed by the committee. Organizational and tracking measures continued, including that each client's file is now scanned and available electronically for committee members; each file is assigned a date of receipt (for tracking); case summaries continue to be completed in 2018.

The Adult SPOA Assistant position previously a part time position in 2017, was not filled in 2018. Duties formerly managed by the assistant were completed by the coordinator. Duties assigned to this role included scanning clinical records, creating electronic charts, meeting minutes, distributing minutes and agenda schedules.

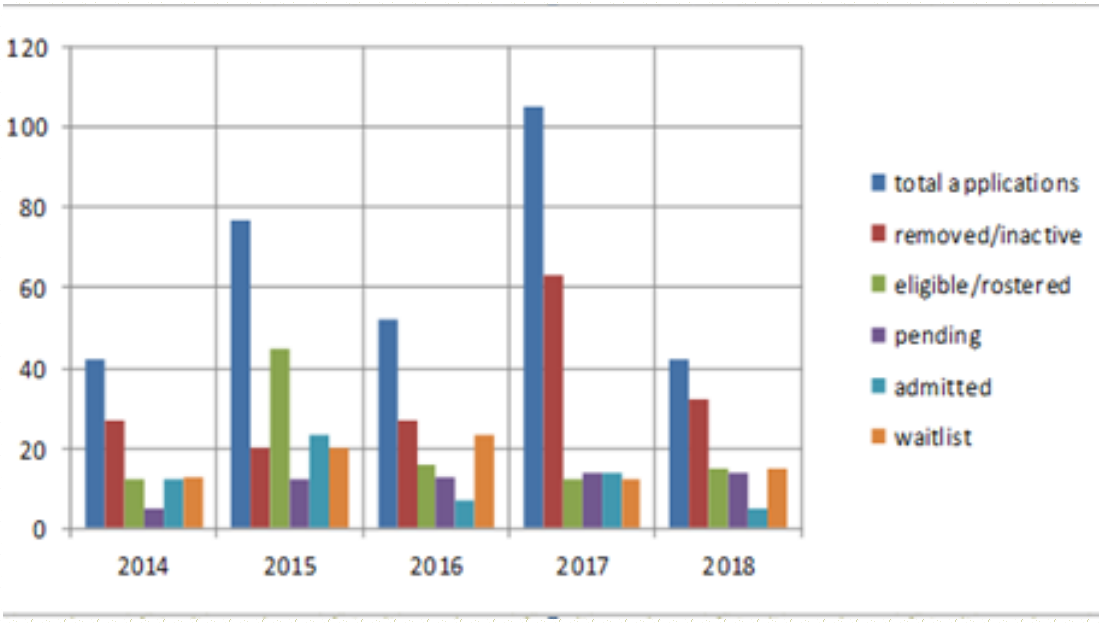
Residential Services

The Mental Health Association (MHA) of Columbia and Greene County provides housing for Greene County adult residents who have a psychiatric disability. There are three distinct levels of housing that are reflective of the distinct levels of residential need.

High Cliff Terrace, a ten (10) bed, twenty-four hour supervised community residence, provides housing to individuals with a higher level of need for monitoring and who require a supervised setting as a first step toward learning skills for a step up to more independent living arrangements. High Cliff Terrace also has one (1) bed designated as Respite for any psychiatrically disabled adult of Greene County who is in need of respite due to escalation of psychiatric symptoms; family/significant other's need for respite; temporary homelessness.

The Comprehensive Apartment Program (CAP) provides a less intense level of supervision allowing individuals to further develop skills for an even more independent level of living in their own apartment. Residents are assigned a case manager through MHA who provides at least weekly (more when needed) contact to assist the resident with learning of independent living skills. The CAP Program has a total of twenty-five (25) beds shared between Columbia and Greene Counties.

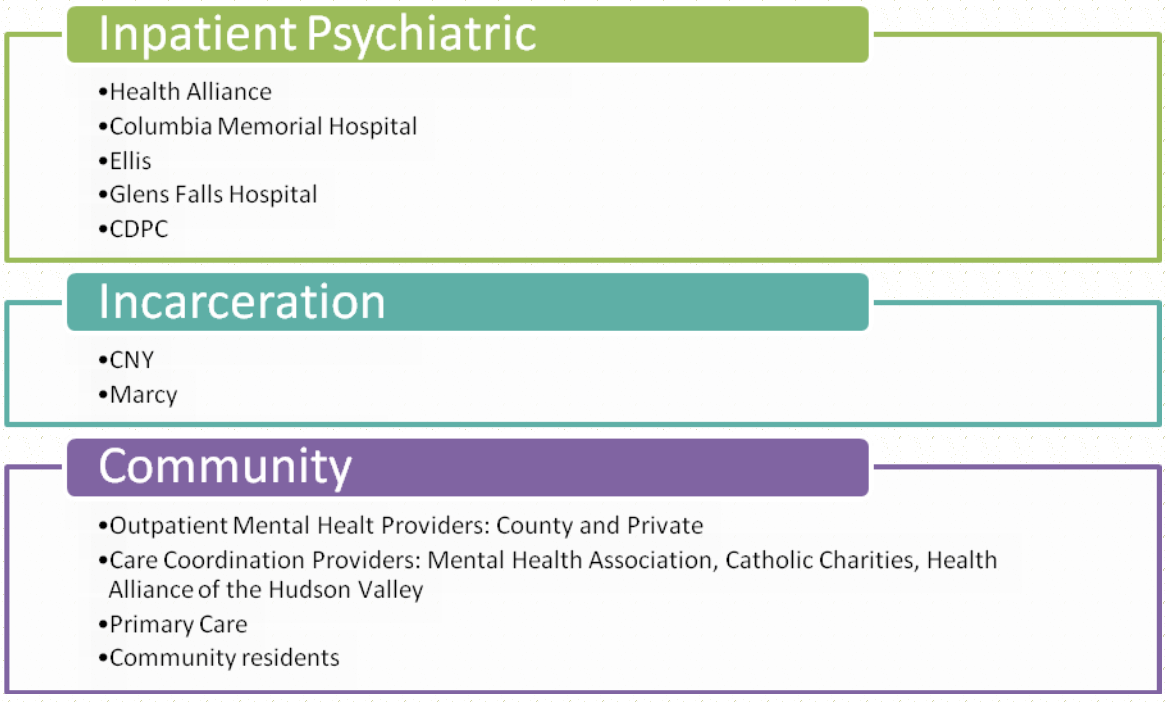
The Supportive Housing (SHUD) Apartment Program is the most independent residential setting wherein an individual receives a housing stipend similar to a Section 8 entitlement. They are assigned a case manager from MHA who is required to provide a single monthly contact in direct conjunction with housing issues: collection of rent, monitoring ongoing condition of the apartment and negotiations with landlord re: repairs, tenant concerns, etc. There are a total of thirty (38) SHUD apartments. Five (5) of these beds are designated specifically for homeless families / individuals. 3 additional beds were added in 2016. All recipients of a SHUD grant must also demonstrate eligibility with a psychiatric disability.



Residential Applications	2014	2015	2016	2017	2018
Total applications	42	77	52	105	42
Removed/Inactive	27	20	27	63	32
Eligible/rostered	12	45	16	12	15
Pending	5	12	13	14	14
Admitted	12	23	7	14	5
Wait List	13	20	23	12	15

There may appear to be a discrepancy between number of applications eligible, the number admitted and the number remaining rostered to the waitlist. This is due to (1) while an individual may be deemed eligible for the service, while awaiting an available placement the life circumstances and residential needs may have changed. Clients were removed from the Wait List as a result of moving out of the county, incarceration, moving in with a significant other or other family member, death; (2) some individuals on the wait list from 2018 were placed in housing in 2019; individuals are carried over from other years; (3) internal moves occur within each residential program that are not tracked here.

Applications are received primarily through the following sources:



Applications or referrals that were submitted but found to be incomplete are returned to the referral source and placed on a pending waitlist for 90 days. If, following this three month period, there was no contact with the referral source or applicant, or if there was no response to the requested documentation, the application would be made inactive and removed from the pending list. Applicants that are determined inappropriate for housing resources above by the committee will be referred, if possible, to more appropriate placements, at which time the application would be returned to the applicant and referral source.

The Future of Residential Services

Appropriate, stable residential environments are a social determinant of health. Housing instability remains one of the strongest predictors for poor quality of life, recidivism, unemployment, incarceration, and high use of emergency supports, such as emergency placement funds, shelters, and emergency medical service; frequent use of law enforcement and first responder services, including mental health mobile crisis. Housing instability often results in an increase in involvement from Adult Protective Services and Child Protective Services, and trickles down into the judicial system as well.

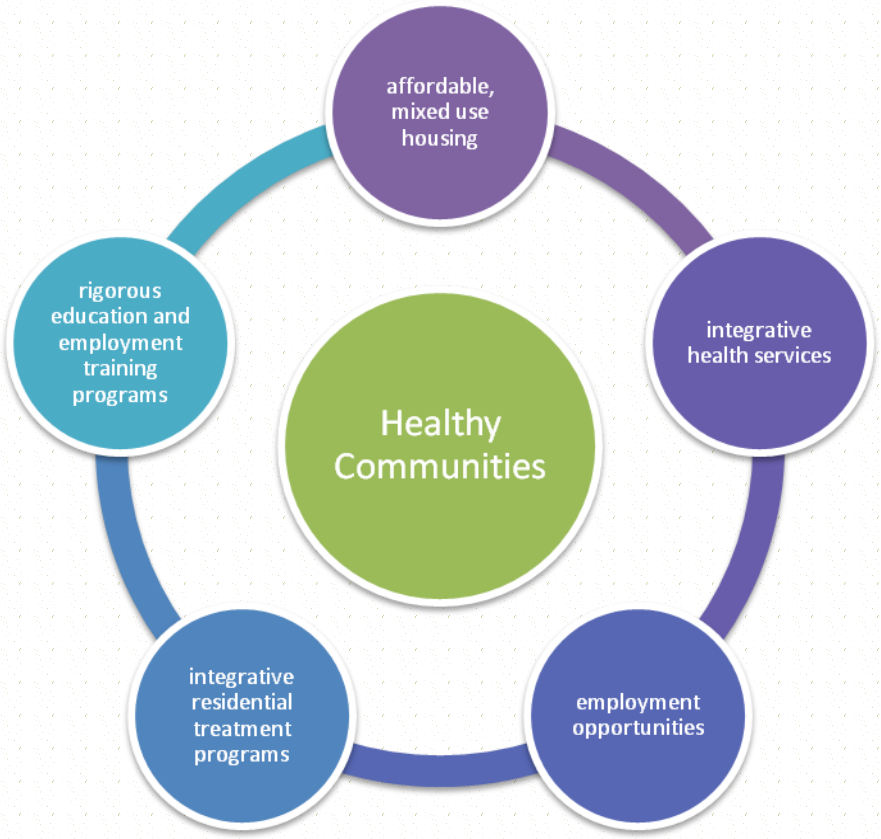
There are an increasing number of psychiatrically impaired individuals finding their way into the judicial system. Many of these individuals are severely psychiatrically impaired, and as a result of their illness become involved with the legal system. It is routine for referrals to be received from facilities seeking placement for individuals upon release. However, applicants are often ineligible due to a lack of structured settings in this area. Referrals from the justice system are usually directed to out of county for residential services.

Many recently released inmates, psychiatrically impaired or not, have limited, if any, family or social supports. Upon incarceration, many individuals lose their housing, as well as their belongings, and find it necessary to start over upon release.

Post-release incarcerated and AOT clients are typically placed at the top of the housing list. Clients on the list have been bumped in favor of an AOT client, leaving them waiting for housing for two or more years.

Challenges that community members face when seeking housing include low housing stock; lack of affordable housing; housing located in inaccessible areas or in areas without public transportation; lack of structured, skill building and restorative programs.

Greene County could benefit from the addition of new development and increased services in the following areas:



Specifically, there remains a significant need for **permanent supervised housing** for the segment of the psychiatric population in Greene County that is aging and/or has multiple health issues and/or personality disorders which seriously compromise their ability to live independently, even with the assistance of an Intensive Case Manager. This subset of clients requires permanent and safe housing accommodations that provide medication oversight and assistance with ADL's beyond the scope of the current apartment programs.

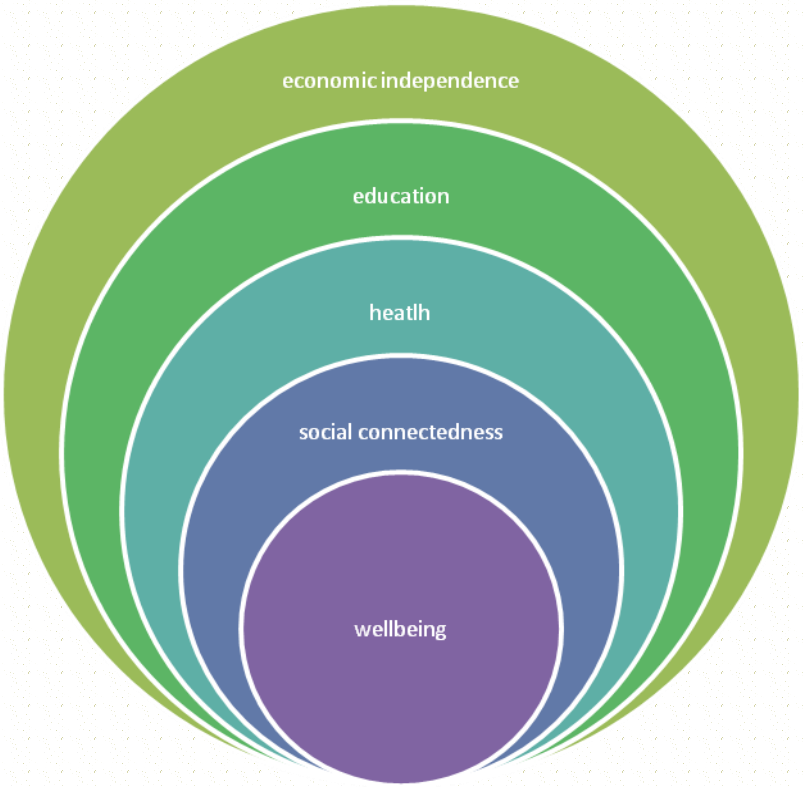
There remains a growing need for **permanent supervised housing** that transitions to permanent independent housing for individuals age 18 – 24 years old transitioning from residential or foster placements, or are no longer able to reside with family. This subset of clients requires permanent safe housing accommodations that provide oversight and assistance with learning independent living skills beyond the scope of the current apartment programs.

There has been an increased need for **permanent housing** for the growing segment of the population released from County Jail or other incarceration.

Adult Case Management Services

Adult Case Management is targeted to seriously mentally ill individuals in hope of increasing community tenure by decreasing the necessity for psychiatric inpatient admissions and ER visits. Generally, the targeted population consists of individuals who are at high risk of re-hospitalization, homelessness and at times involvement with the criminal justice system. Often their involvement with the aforementioned systems results from non-compliance with recommended outpatient services and lack of community supports to monitor functioning and needs. Additionally, as a result of Kendra's Law, passed by the NYS Legislature in 1999, Adult Intensive Case Managers are required by law to give priority to individuals who are court mandated to receive outpatient mental health treatment: Assisted Outpatient Treatment (AOT). These are individuals who have been assessed to be at risk in the community for danger to themselves or others; resulting from non-compliance with prescribed treatment.

Case Managers focus on:



Case Management staff members assist individuals in developing and maintaining viable living, working and social situations in the community by helping them to identify their needs and formulate realistic and attainable goals for self- sufficiency, support and economic independence. The Adult ICM's visit their clients minimally once (1x) per week. In the newly formed Hudson River Health Home, Case Managers provide linkage between the individual and health care providers. Greene County now has both Case Managers and Care Coordinators, both of whom meet with their clients in the community, on psychiatric inpatient units, at mental health centers and in their homes to provide support, advocacy, linkage, coordination of care; monitoring compliance with treatment and diverting crisis by seeking to resolve identifiable stressors/triggers as they arise. Precipitants to crisis may include non-compliance with medication, onset of symptoms due to housing, financial, family and social stressors.

The Adult Case Managers maintain ongoing communication with all providers who are mutually working with the individual in order to assure adequacy, access and continuity of care; as well as to coordinate/negotiate and refer to assure provision of services. This process of collaboration includes, but is not limited to: DSS, Mental Health, Adult Protective Services, Probation/Parole, ACCESS-VR (formerly VESID); MHA PROS and Supported Employment, medical providers, family, significant others, landlords, etc. The overall intent of all case management is to enhance the individual's quality of life (recovery) and tenure in the community of Greene County.

Greene County Mental Health Center supervises two (2) Adult ICM's for Greene County, and they operate and bill Medicaid and Medicare in the traditional model. In this new role as Care Managers, both are providing traditional services through the use of legacy slots while also enrolling new applicants in the Health Home Services, a lower intensity service, for Medicaid recipients. Rosters between the two Adult ICM's for 2018 total 23 Clients, 14 of those being on AOT's. Eight referrals were received and opened.

A procedure was developed to link the referral process for Care Coordination and Case Management. When an individual requires a higher level of care, multiple reviews are requested by clinical teams representing individuals in the community who are at risk for hospitalization. The procedure has been utilized, and appropriate care was provided. In 2017, it was noted that some care coordination clients who were not eligible for the transfer to Case Management were still high utilizers of services. As a result, a program was established in 2018 called Health Home Plus, which allows for a care coordinator to have billable increased contact with a client to provide the higher level of service needed.

Data management for Care Coordination has now fully transitioned to the Hudson River Health Home who is also responsible for reporting to the State of New York.

Care Coordination

Care Coordination Services are a less intensive form of Care Management. For this service, individuals need to have a mental health or medical diagnosis and higher-than-average contacts with service systems, such as the ER, psychiatric inpatient and outpatient, and primary care. The Mental Health Association of Columbia-Greene Counties employs between four and six Care Coordinators with full time caseloads averaging 40 - 60 clients each.

Over the course of this service year, applications for this less-intensive program were forwarded directly to MHA, by-passing the SPOA process in many instances, to facilitate enrollment into this program. The Care Coordination program works within the Hudson River Health Home, who assists with tracking and reporting to New York State, as well as monitoring outcomes. Therefore, while some data is available through the SPOA for this program, the figures here represent a small fraction of the numbers of individuals served.

It should be noted that applicants for Care Coordination do not go through the typical SPOA review, and are instead referred directly to Care Coordination under the presumption of eligibility. The SPOA committee continues to review a small number of applications for this service when the request is for multiple service areas within the same application. The reduced numbers in individuals applying for a single service is demonstrated below.

Enrollment and engagement in this service is not tracked by the SPOA for several reasons. It is at the time of intake for MHA Care Coordination program that some applicants are found to have relocated or refuse the service, or ineligible due to primary payer. Below are figures provided by the Mental Health Association for referrals received in 2018:

2018 Greene County
Care Coordination Referrals

Month	# of Referrals	Enrolled	Inactive	Not Eligible
January	2 GCMH	1	1	
February	2 GCMH/1 SPOA	3		
March	3 GCMH/4 SPOA	5	1	1
April	4 GCMH/1 SPOA	2	1	1
May	1 GCMH		1	
June	7 GCMH	3	3	1
July	2 SPOA	1	1	
August	7 GCMH/1 SPOA	4	3	1
September	7 GCMH	6	1	
October	1 GCMH		1	
November	3 GCMH/4 SPOA	2	4	1
December	2 GCMH/1 SPOA	2		
Total:	**41 GCMH/12 SPOA = 53**	**29**	**17**	**5**

CHILDREN'S SERVICES

At GCMHC we pride ourselves on providing responsive and comprehensive treatment to the children and families of Greene County. Our team of experienced children's therapists, case managers, prescribers, and family support worker offer families a collaborative network of services and support. Children's services are accessible and family driven, provided in the clinic, in the home, and in school satellite offices.

Initiating children's clinical services at GCMH:

Parents are asked to call our children's intake and crisis coordinator to initiate mental health services for their child. Our intake coordinator will triage the situation and schedule an intake with either a clinic based therapist or refer to a school based satellite depending on a child's school district. If a family is in crisis or an urgent assessment is needed, the intake and crisis coordinator will determine if they need an expedited intake, or may refer to the Mobile Crisis Assessment Team (MCAT) or the ER if the child is in imminent danger of hurting themselves or others. Our intake workers complete a thorough bio-psychosocial assessment including clinical diagnosis and treatment recommendations. Our clinic has minimal waits for intake and assignment.

Referral sources include:

- parents
- hospitals
- schools
- probation
- social services
- MCAT

It is expected that the parent/guardian contact the clinic to initiate services regardless of referral source.

Referral reasons: in 2018 the majority of new referrals made concerned:

- depression
- anxiety
- behavioral difficulties
- ADHD
- adjustment issues
- school avoidance

Many high risk referrals indicated concerns about self-harm/cutting, suicidal thoughts & behavior, and aggression or threats. Younger children have been referred to address issues with significant family loss/change including witnessing violence, family disruption, and parental separation. The opioid epidemic has contributed to an increase in referrals related to foster care placement, parenting/safety concerns, and adjustment to parent death by overdose.

Verbal Therapy/Supportive Counseling

Children's therapists provide both individual and family therapy to a case load of children and transitional age youth (18-21.) Clinicians engage clients and families, assess immediate and long term needs, and develop a treatment plan that is family driven and youth guided. Our clinicians are trained in evidence based practices, and regularly seek continuing education to enhance their skill set. The clinic provides ongoing clinical supervision, professional development opportunities, and clinical case discussion to support our seasoned therapists in the challenging work they do.

The children's team often refers clients to additional supportive services within and outside of our clinic. They coordinate with collateral agencies including

- schools
- case managers
- medical professionals
- law guardians
- DSS/CPS
- hospitals
- probation

At any given time, the children's team serves anywhere from **220-300** active clients. Full time children's therapists carry a caseload of **45-50** clients.

Medication Management

The children's team has a Children's Psychiatrist who is in the clinic 5 days per month for assessment, consultation, and ongoing medication management. At the end of December 2018, the clinic recruited a new nurse practitioner 2 days a week who will see primarily adolescents. There continues to be a large demand for medication evaluation and medication management in our region with limited prescriber availability. The clinic often refers out to primary care offices and specialists if a client is less complex or unable to wait for assessment. The children's psychiatric prescribers prioritize the most severe and complicated cases, with the goal of transferring medication management to one's primary care provider once stabilized.

Children's Health Home Care Management

Community Services Board/Mental Health has a Care Management agency within GCMHC. We employ 2 full time Health Home Care Managers. The clinic also has a half time state item care manager shared between Greene and Schoharie County who carries a smaller caseload of Greene County youth.

Starting in December of 2016, the New York State care management model changed from targeted case management, to Health Homes serving children. Health Home services are now available to any Medicaid eligible children who meet certain criteria including a significant mental health diagnosis, two qualifying health conditions, HIV, or complex trauma. Once deemed eligible, the care manager determines a child's acuity by completing regular assessments, which drive the number of contacts per month as well as the problems and goals in the plan of care. Most referrals for care management come from SPOA, but can also be expedited after a hospitalization, parent referral, or other outside source. Care Management including assessment of needs and progress towards goals, ongoing service coordination, individual and family support, and referrals/linkage to community resources.

Prior to 2017, case management was provided by an intensive case manager who served 12 youth 4 xs per month, and a supportive case manager who served 20 youth 2 xs per month in a bundled billing model.

Under the new Health Home model, both care managers are now serving a blended acuity caseload of 14-18 (average) clients each. In our county, the majority of each of their caseloads demonstrated "High" acuity based on the Children & Adolescents Needs & Strengths (CANS) assessment, which requires 1-2 contacts per month in addition to assessment and care planning. While the role of care manager has become less hands-on and more data driven, our care managers strive to engage families and meet their needs under the new health home guidelines. They continue to be creative and supportive in their ability to connect families with available services in an area with limited resources.

Family Support

GCMHC, through the Mental Health Association, employs one full time family support worker. Family Peer Advocates have 'lived-experience' as the parent (biological, foster, adoptive) or primary caregiver of a child/youth with a social, emotional, behavioral, mental health, or developmental disability). They receive training to develop skills and strategies to empower and support other families. They foster effective parent-professional partnerships and promote the practice of family-driven and youth-guided approaches.

The family support worker receives referrals through Children's SPOA and directly from clinic therapists. Clients are provided both formal and informal services which may include:

- Outreach and Information
- Engagement, Bridging and Transition Support
- Self-Advocacy, Self-Efficacy and Empowerment
- Community Connections and Natural Supports
- Parent Skill Development, and Promoting Effective Family-Driven Practice

Children's Team Staffing

- The clinic currently employs 3 clinic based therapists and 5 school based therapists.
- A Masters level nurse as the children's team intake/crisis coordinator, and SPOA coordinator.
- The clinic has a Children's Psychiatrist who works 5 days per month providing consultation and medication management services.
- New to the clinic will be a 2 day per week psychiatric nurse practitioner prescribing for primarily adolescents.
- The clinic employs 2 full time Health Home Care Managers and one half time State item Care Manager.
- The clinic has a full time Family Support Worker who provides family support, advocacy, skill building, and community outreach.
- The Clinical Coordinator for Children's Services supervises most of the children's therapists, the children's Care Managers, and Family Support Worker. She acts as a liaison with other child serving agencies in the county and sits on various committees related to children's services. She acts as team leader and carries a personal caseload of children and transitional age youth.

School-Based Mental Health Services

GCMHC continues to provide school-based satellite programs in several school districts. A new district initiated a school based satellite starting in the fall of 2018 with plans to increase to two school based workers for the 2019-2020 schoolyear. School-based services increase access to services many families would not be able to easily utilize. Participating districts include:

- Windham/Ashland/Jewett school district 3 days per week,
- Cairo/Durham Middle/High School 4 days per week,
- Cairo Elementary 3 days per week, and
- Hunter Tannersville Central Schools 3 days per week.
- Coxsackie Athens Middle School/High School 4 days per week (new this year)

School districts support these collaborations with approximately 20% funding (adjusted based on the number of days the clinician is at the school). Our Director of Community Services meets with school superintendents each spring to discuss satellite programs and has received consistent positive feedback about this service. School-based services are overseen by the Clinical Coordinator of Children's Services. The clinic continues to collaborate with school staff in districts not participating in the school-based program to accommodate referrals, manage crisis, communicate about high risk students, and provide trainings when requested.

School Avoidance Task Force/At Risk Youth Task Force

GCMHC has hosted and helped facilitate the School Avoidance Task Force. This task force has shifted over time to address a broader range of at risk youth and community issues for the 2018-2019 schoolyear. This monthly meeting is attended by representatives from Greene County School districts and community providers. It is a forum to discuss a range of issues and trends affecting youth in our community. These include mental health issues, trauma, interface with the justice system, substance use issues, and improving communication and collaboration between agencies, schools, and families.

In-services/Trainings

Representatives from the Greene County children's team have offered formal and informal supports to the community in a variety of ways in 2018. School based workers have provided trainings/education on mental health needs to their host school districts on topics such as trauma informed care in schools, emotional wellbeing, and accessing resources in the community.

Our family support worker is available to provide trainings in the community including mental health first aide, hosting the OPWDD front door training, and representing our clinic and mental health awareness at various open houses, fairs, and community events.

High Risk Clients/Crisis Response

The clinic has a children's crisis coordinator who will respond to calls from parents, schools, and community providers to help triage and problem solve the needs of high risk youth. The clinic works with families to provide:

- Expedited intake or safety assessment, often within the same week of first contact.
- 5 day follow up appointments to children coming out of an inpatient hospitalization.
- Health home care management for hospital and residential discharges
- SPOA involvement for service assignment and tracking

The children's team maintains a **watch list** of high risk clients, reviewed regularly in supervision and in children's team meetings. There is ongoing discussion of how to best safety plan and meet the needs of these children and family systems to help prevent future hospitalization and placement. The children's team maintains positive working relationships with the Mobile Crisis team, area hospitals, and all child serving agencies so that response and collaboration is smooth in the event of a crisis.

Greene County Mental Health will continue its endeavors to provide children in our community with meaningful and individualized mental health services that promote emotional wellbeing. Our goal is to help children become successful in their home environments and communities and to prevent higher levels of care. We have developed a reputation amongst our clients and collateral agencies as a knowledgeable, reliable, and responsive team of mental health professionals who provide quality and comprehensive care.

Child & Family Single Point of Access (SPOA)

The Greene County SPOA Committee continues to work diligently to identify and provide supportive services to high risk children and their families so that they can successfully meet goals and avoid hospitalization and placement. The committee meets every other Thursday morning at Greene County Mental Health with one meeting per month dedicated to a census update and utilization review. The working committee is made up of representatives from Greene County Youth Bureau, Parsons Home and Community Based Waiver program as well as their Health Home Care Management Agency, Greene County Mental Health Clinic as well as their Health Home Care Management Agency, Mental Health Association of Columbia and Greene Counties, and a Family Peer Advocate. Area school districts, Greene County Probation, Ulster/Greene ARC, the Reach Center, and Catholic Charities continue to work with the committee on an "as needed" basis as well as other collateral agencies that may be invited depending on need and family involvement. The Tier I/II quarterly meetings bring together management personnel from all of the above mentioned agencies and local schools to discuss county-wide issues and initiatives involving children and families in need.

The eleven Home and Community Based Waiver (HCBW) slots for severely emotionally disturbed children continue to be utilized to full capacity. Greene County was able to receive two additional slots within the past two months and accommodate children on the waitlist. Currently there is one child on the wait list. Waitlist are reviewed on a regular basis to ensure the highest need families are prioritized. The New York State Office of Mental Health continues to fund these slots which are contracted through Parson's Child and Family Center. The goal of this intensive program is to provide children, at the highest risk of placement and/or hospitalization, and their families, an enriched service plan while remaining at home in their communities. Beginning of 2019 Home and Community Based Waiver will join the Health Home arena. Families will be offered this voluntary service.

SPOA is encouraged to be the conduit for all care management referrals. Starting in December of 2016, the New York State care management model changed from targeted case management, to Health Homes Serving Children. Health Home services are now available to any Medicaid eligible children who meet certain criteria including a significant mental health diagnosis, two qualifying health conditions, HIV, or Complex Trauma. This service may include ongoing assessment, care planning, care coordination and health monitoring, linkage and referrals, and family support. For the year 2018, 45 out of 60 case management referrals qualified for Health Home Case management.

The SPOA committee has been a referral source and tracking entity for both planned overnight and day respite, and Parent Advocacy services. Greene County has access to 10 respite slots which are assigned to children and families needing time/healthy connections outside of the home on a weekly basis. This service is provided through the Mental Health Association and lasts an average of 6 months at a time, with assignments monitored at monthly SPOA census meetings. Greene County Mental Health through MHA has employed a full time Family Peer Advocate who has a caseload of parents and families identified through SPOA and the mental health clinic. This service is provided by phone, in the office, and in the home and community to meet families where they are at, and to promote healthy linkage and engagement in services. 2018 had a brief interruption of service related to vacancy of the position. Position has been filled and referrals are active.

SPOA has also served as a referral mechanism for other services and support programs including Pre-PINS, Prevention, IAPP (Intensive Aftercare Prevention Program), mediation, Twin County Substance Abuse Services, Parent Support, Autism Connection, and the Reach Center. SPOA is the referral source for two out of home placement options: Community Residences and Residential Treatment Facilities, both administered by the Office of Mental Health.

In 2018 the committee completed 60 SPOA initial meetings with families and collateral agencies as well as 3 SPOA reviews to follow-up on previous SPOA meetings for a total of 63 meetings. These referrals came from many different sources including Mental Health, local school districts, Greene County Youth Bureau, Greene County Department of Social Service and Psychiatric Hospitals. Case management continues to be the most utilized resource in the county for children and families. There were 60 new referrals made to case management services (combined Health Home Care Management Agencies and Mental Health Association). Other top referrals include Family Peer Advocate Services (29), and Mental Health Association Respite (21) (which currently has a wait list of

16 children) and Parson's Home and Community Based Waiver Program (3), (this program serves the most intense cases which currently has a wait list of 1 child).

	2015	**2016**	**2017**	**2018**
Initial SPOA meetings	68	58	75	60
SPOA Reviews	19	13	8	3
Referrals to Case Management	49	49	61	60
Referrals to Waiver	7	12	6	3
Referrals to Family Peer Advocate	38	40	41	29
Referrals to Respite	20	10	19	21

COMMUNITY SERVICES BOARD

Greene County Community Service Board & Sub Committees

The Greene County Community Service Board (CSB) and its Sub-committees have continued their active role in overseeing the Mental Health, Substance Abuse, and Developmental Disabilities programs in Greene County. The CSB is comprised of members from the following sub-committees; Mental Health, the Office of People with Developmental Disabilities (OPWDD) and the Office of Alcohol and Substance Abuse Services (OASAS) in addition to other stakeholders within the county. 2018 continued to be prove challenging as in past recent years, with all of the changes in healthcare, services, and organizational structure of many NYS governing and service organizations. Areas of focus include the transition to managed Medicaid; Delivery System Reform Incentive Payment Program (DSRIP) part of Medicaid Redesign that focuses on the avoidable use of the ER and hospitalizations over a 5 year period; Regional Planning Consortiums, transition of Children's Case Management into Health Home and enrollment of children into health home; adults with Health and Recovery Plans completing the assessment that determines their eligibility for Home and Community Based Waiver Services. The client experience of care including quality and satisfaction, improving health of populations and reducing the per capita cost of healthcare remain at the forefront.

The CSB and Subcommittees continue to review the programs and agencies in their particular oversight area in order to gain a greater understanding of the programs and service gaps in the county for each disability, prioritized recommendations, and evaluated potential funding streams. Mental Hygiene laws require that OMH, OASAS, & OPWDD formulate a Local Services Plan that is maintained by the OASAS Bureau of Information Technology. Local Services Plans are central to NYS long-range planning and budgeting. The Local Services Plan for 2018 was completed by the Director of Community Services in July in collaboration with the Community Services Board. The following priority needs were identified:

1. Increasing access to safe, stable, and affordable housing for those with mental health and substance use disorders.

2. Improving transportation to the public, disabled, and low income population in Greene County.

3. Targeted messaging and education to the Greene Co Community on available Mobile Crisis Assessment services and GCMHC on call services.

4. Public education on the availability and accessibility of Substance Use Disorder treatment options and other resources in conjunction with increasing both availability and accessibility of treatment options as a result of the State Opioid Response Grant.

5. Increase mental health services, supports and resources available to children and families in Greene County.

6. Meeting the needs of the intellectually and developmentally disabled in community.