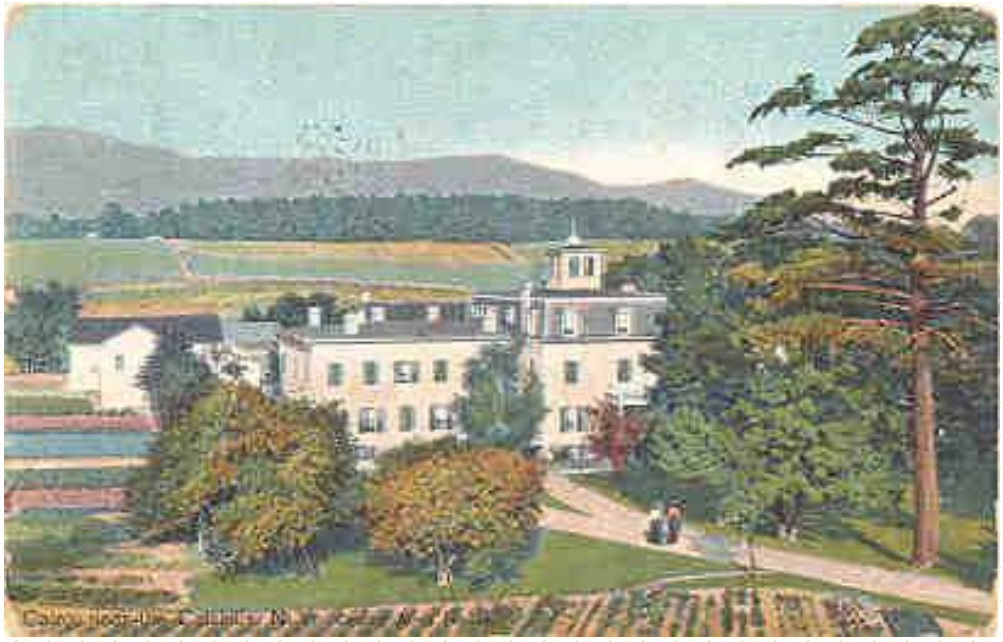
Greene County Mental Health Center

905 GREENE COUNTY OFFICE BUILDING
CAIRO, NY 12413



2019 Annual Report

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Director of Community Services
& Mental Health Center Staff

INTRODUCTION

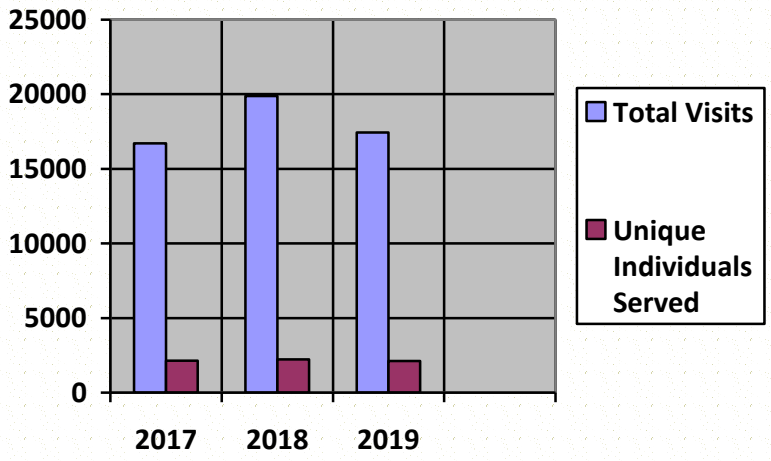
The Greene County Mental Health Center is an Article 31 community mental health clinic licensed by the NYS Office of Mental Health. It employs a full contingent of professional staff, including Psychiatrists, Nurse Practitioners, Psychologists, Social Workers, and Mental Health Nurses. Our staff is dedicated 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 2019, Greene County Mental Health Center (GCMHC) served a total of 2,115 unique individual clients; 1,468 Adults and 647 Children & Adolescents. We provided 17,443 billable direct service contacts

3 Year Data Comparison

2017	2018	2019
Total Visits - 16,713	Total Visits – 19,878	Total Visits- 17,443
Adults – 11,580	Adults – 14,292	Adults – 12,107
Children – 5,133	Children – 5,586	Children – 5,336
Total Unique Individuals Served 2,141	Total Unique Individuals Served 2,222	Total Unique Individuals Served 2,115
Male 41.8%	Male 46.17%	Male 46.44%
Female 58.2%	Female 53.83%	Female 53.56%
Adults 75.4%	Adults 71.24%	Adults 69.4%
Children 24.6%	Children 28.76%	Children 30.6%



EVALUATION OF 2019 GOALS

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

   Accomplished: 2019 began with the new Director of Community Services taking the helm of the agency in January. He was formerly in the position of Director of Clinical Services so the search for backfilling that position began immediately but still took several months to fill. By May, Heather Buffa, RN, MSN was promoted from within to the role of Director of Clinical Services. Her previous position of SPOA Coordinator then needed to be backfilled, which also took several months. During that time, Ms. Buffa was fulfilling the demanding task of continuing in the role of SPOA coordinator while gradually taking on the responsibilities of Director of Clinical Services. Eventually however, we backfilled her previous position. Over the course of 2019, numerous other positions were created and/or officially re-defined. Details of those positions are covered in the" Staffing News" section of this report.

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

   Accomplished: In 2019, GCMH purchased a new Electronic Medical Record (EMR), to replace our former EMR which was becoming obsolete. The new system, Medent, allows for more efficient and user-friendly documentation, and also provides for new features for practice management with billings, scheduling, reporting, etc. The system also provides the ability for telehealth/video sessions which, unbeknownst to us at the time, would serve to be invaluable in 2020 during the COVID-19 pandemic.

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

   In Progress: As new procedures were developed associated with the new EMR and other changes within the clinic, new Policies were created to update the Policy and Procedure manual. Likewise, old policies that needed to be modified and updated were also re-written and updated. The primary responsibility for this job has been assigned to one staff person who is spearheading this project. This is an ongoing project which will continue into the future as we endeavor to update the Policy and Procedure manual and keep it current.

4. **Revise Corporate Compliance Plan.**

   In Progress: During the course of 2019 and into 2020, the Corporate Compliance Plan was revised in practice with regards to updating some of our compliance procedures. The actual written Plan, however is still needing formal revision and will continue to be a goal in 2020.

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

   Accomplished: Over the years, GCMH's school-based services program has enjoyed increased popularity and demand. The services provided are extremely well regarded and because of this, 2019 saw a continued expansion of this program. One new district contracted with GCMH to begin school-based services while an existing contracted districted increased the amount of services they were contracting for.

GOALS FOR 2020

1. **Address the needs of the Greene County community with respect to the COVID-19 pandemic.**

2. **Improve the staff's ability, expertise, and possibly the range of services offered to address the opiate epidemic and other substance abuse problems within the County.**

3. **Increase collaboration with other agencies to better address mental health, physical health, and substance abuse issues within the community**

4. **Continue to update and revise GCMH's Policy & Procedure Manual.**

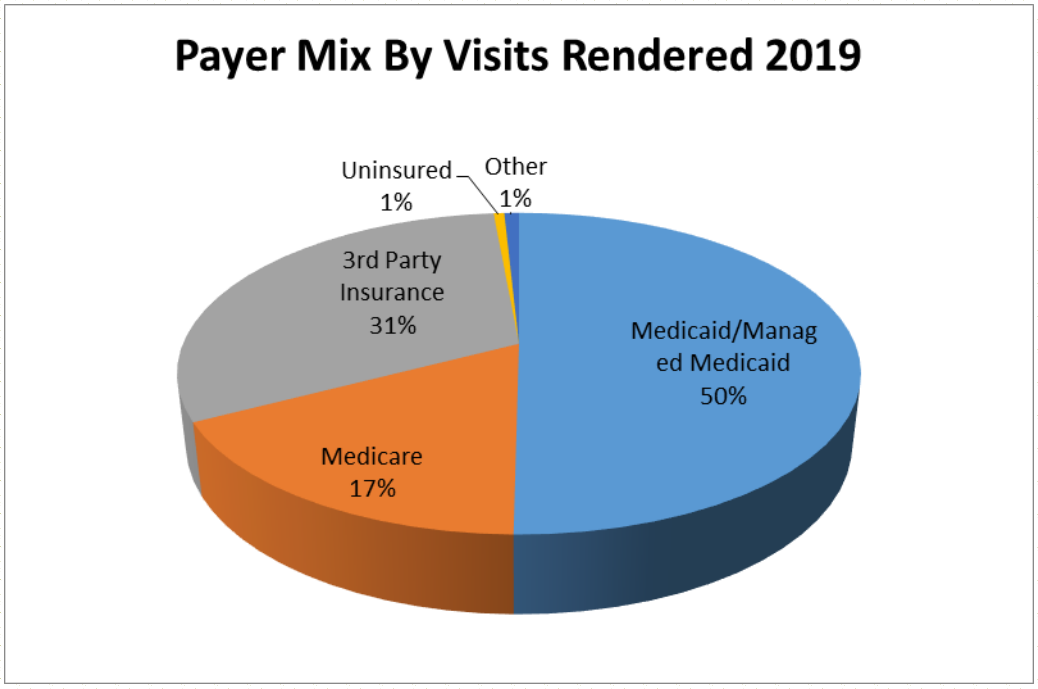
5. **Continue to update and revise the GCMH Corporate Compliance Plan.**

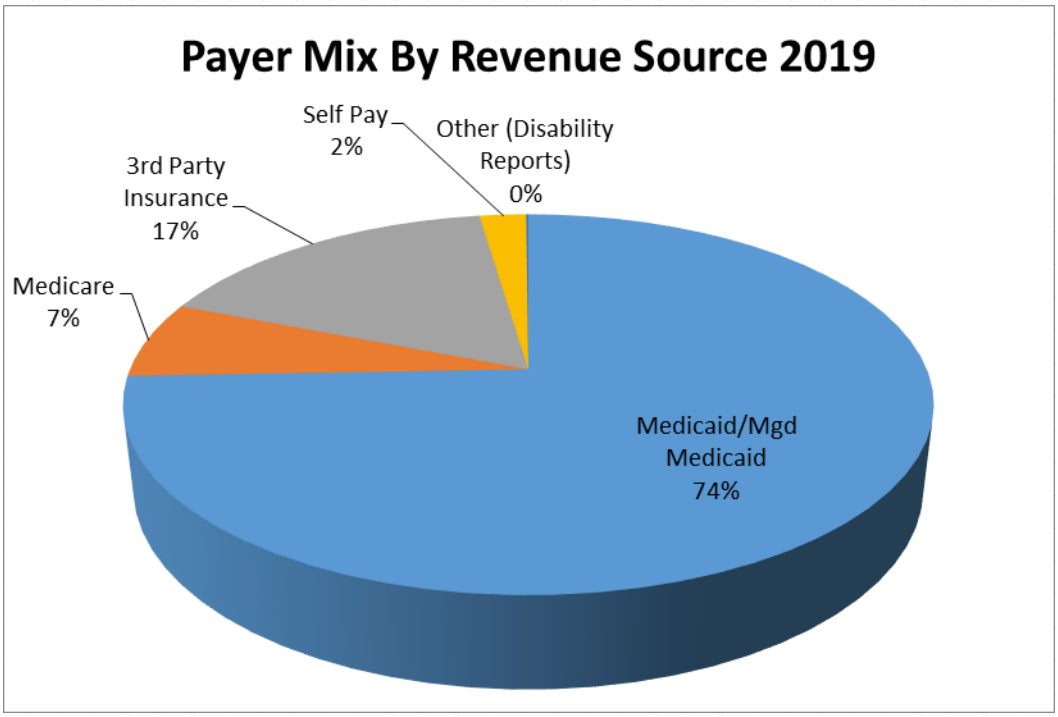
Fiscal Developments

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 2019 the department's cost to the county was $306,668, approximately $397,319 below our anticipated budgeted cost. In 2019, thanks to participation in DSRIP Performance activities, The Healing Communities Study Grant from Columbia University, and receipt of outstanding Federal Salary Sharing payments we were able to stay below our budgeted cost to the county.

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 2019, there was a significant contract increase at the state level for these services which resulted in additional expenses for the county with that expense expected to double as of April 2020, when NYS OMH no longer contributes 50%. Additionally, with the CSEA bargaining agreement update in spring of 2020 and COVID related losses in the 2nd QTR of 2020, we are facing many unforeseen revenue reductions. 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 actively participated in the DSRIP (Delivery Systems Reform Incentive Payments) Program in 2019. 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 addition 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.

Greene County Mental Health received a total of $ 155,984 from DSRIP funds for meeting and at times exceeding performance metric requirements reported monthly to DSRIP in 2019. This was a substantial increase from June 2018 until year end 2018 when GCMHC receive $39,133. Participation in this program continued to 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 data extrapolation, submissions, and required participation in meetings are handled by the Director of Fiscal and Business Operations and MH Quality Assurance/Agency Compliance Officer so there continues to be 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 remained 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)

In January 2020, the clinic submitted its final PSCYKES QARR (Quality Assurance Reporting Requirements) report for December 2019 as this program came to an end. Greene County Mental Health continues to actively participate in the planning of new PSYCKES programs. Participation, all planning, reporting and meeting requirements are completed by the MH QA/Agency Compliance Officer in collaboration with the Director of Mental Health Department/DCS, Deputy DCS, and the Clinical Director.

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 all clinics such as Greene County Mental Health to have a Corporate Compliance Plan. 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 2019 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 and procedures for tracking and monitoring these areas 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.

In 2019, a new position and title was created for the agency; Mental Health Quality Assurance Coordinator & Agency Compliance Officer. This position will work closely with the Director of Clinical Services to monitor and assist in many of the activities that are essential and required to enact Greene County Mental Health's Corporate Compliance Plan.

Staffing News

Greene County Mental Health Center experienced several staffing changes during 2019.

In early 2019 the Acting Director of Community Services was permanently appointed Director of Community Services. A Director of Clinical Services was then hired to take his former position.

We saw the resignation of 2 Mental Health Specialist positions and a retirement of a long time Sr. Mental Health Specialist. These positions were refilled. In April a position was added to accommodate a new school-based social work contract with the Coxsackie Athens School District.

During the year 3 new titles were created: Single Point of Access (SPOA) Coordinator, Community Mental Health Peer Support Case Manager, and Mental Health Quality Assurance Coordinator & Agency Compliance Officer. All of these new positions were filled.

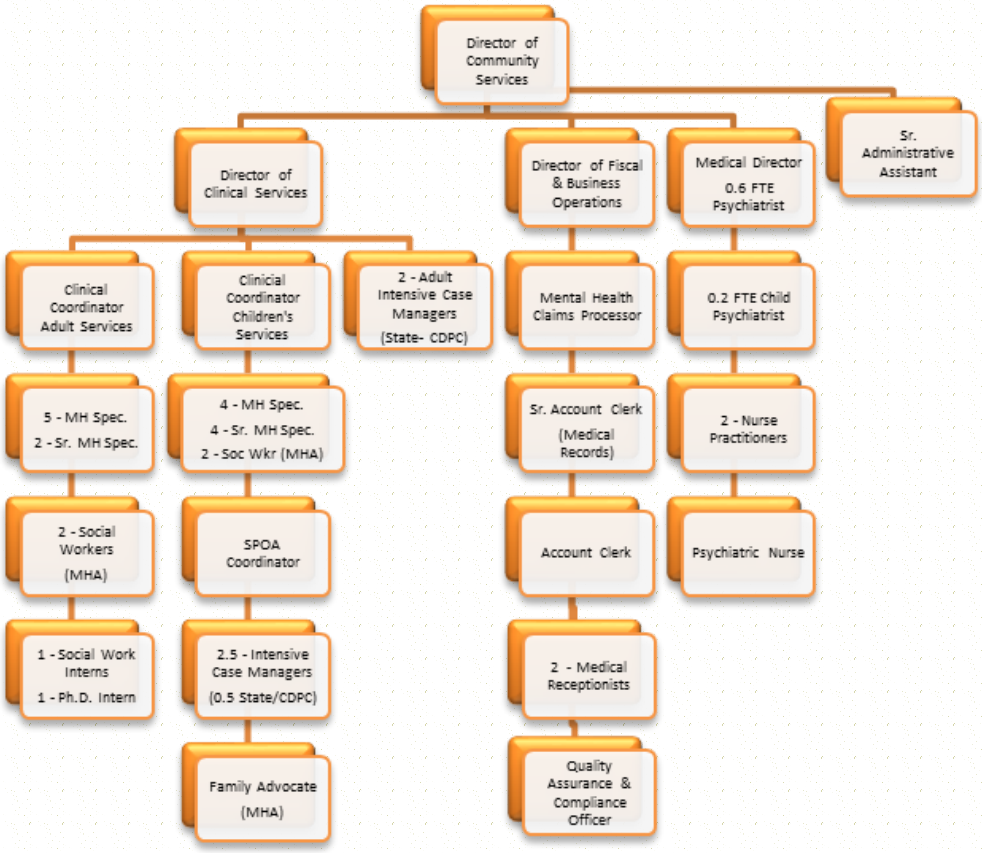
In June a vacated Mental Health Claims Processor position was filled and a Medical Receptionist position was then backfilled.

In the fall of 2018 GCMHC welcomed 2 interns from SUNY Albany's Master in Social Work program who were with us until May 2019. We also had an additional social work intern from SUNY Albany from July-December 2019. From June-August 2019 GCMHC hosted a student intern from RPI to work on social determinants of health screenings. Throughout 2019 we also hosted 4 students from Columbia Greene Community College's Nursing program for their rotation through mental health services.

Later in the year GCMHC saw the resignation of a Psychiatric Nurse Staff Associate, which was then backfilled. Our contracted Psychiatrist reduced his hours resulting in a contracted Nurse Practitioner being hired on a full-time basis as a Psychiatric Nurse Staff Associate. In October a vacant Psychiatric Nurse position was filled.

GCMHC was fortunate to hire 3 former student interns (2 social work, 1 NP) this year. 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 2019 employees took part in in-house staff development trainings, mandated County trainings, outside educational opportunities.

- **In House**

Eye Movement Desensitization and Reprocessing, Suicide Prevention Training, SafeTalk, Tobacco Cessation, Schizophrenia, Documentation & Billing, Presentations from Alliance for Positive Health & Greener Pathways

- **County Mandated**

Workplace Violence Prevention / Active Shooter, Sexual Harassment/Discrimination, Sexual Harassment/Discrimination for Supervisors, Leadership Sessions for Supervisors, Bloodborne Pathogens

- **Outside Educational Training Opportunities**

LGBTQ and Questioning Clients, Clinical Issues and Treatment Strategies, Group Crisis Intervention, Trauma & Attachment, Adverse Childhood Experiences, Eating Disorders, Acceptance and Commitment Therapy, Energy Psychology, Grand Writing and Fund Development, HIV, STI, Hep C in Teens and Young Adults, DSM 5 Differential Diagnosis and Mental Health Documentation.

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. Clients walk into the clinic any time between 9:00am-11:00am on Monday, Wednesday and Thursday. No appointment is necessary. The exception to this are clients who are referred from the hospital who are new to us; they receive follow-up appointments to attend. Our quality assurance staff also makes efforts to engage these new clients to ensure they present for their follow-up appointments. 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 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. 429 Health Screenings were performed in 2019

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.

2019 OAC Statistics

Health Screenings	**429**
Clients Scheduled for OAC Following Hospital Discharge	**316**
Total Number of Client Visits to OAC	**1,475**

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. The Adult Team also provides services for clients who are on Assisted Outpatient Treatment (AOT) status which requires additional collaboration with our AOT coordinator. Additionally, we provide specialized counseling services for clients with trauma histories; 3 of our clinicians are certified Eye Movement Desensitization and Reprocessing (EMDR) therapists, a specialized evidence supported trauma treatment. 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 required to maintain licensure and to ensure continued growth and training 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.

Women's Group- A weekly women's support group proposal has been submitted and approved. It is scheduled to begin in May 2020.

Community Health Integration Program

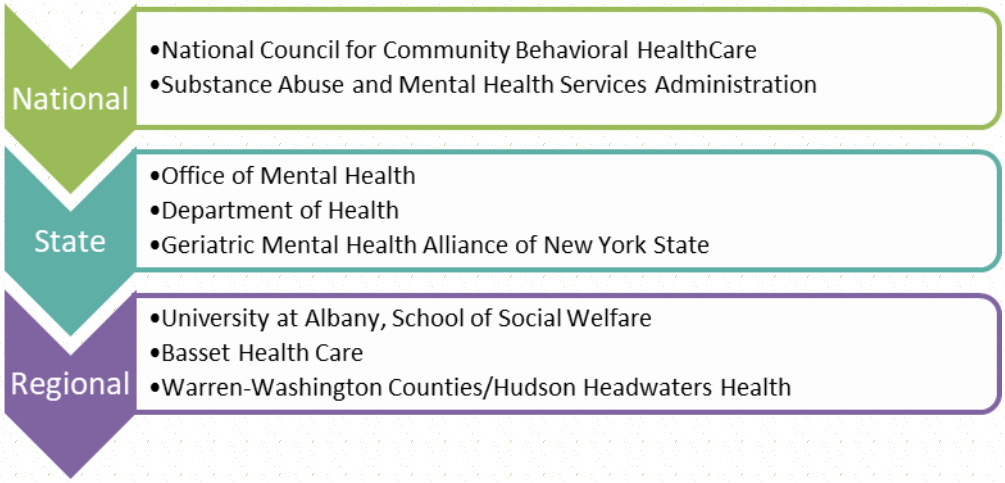
With its roots in prevention and crisis management, the Community Health Integration Program (CHIP) is a program in which clinicians provide mental health assessment and treatment services directly to clients at satellite locations located at primary care doctors' offices.

In 2019 CHIP maintained three, then two satellite offices in Greene County (Catskill-JHFC, Hensonville - Dr. Samadov, the Coxsackie office is not presently staffed). CHIP

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. Over the years, 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	2019
Kept Appointments (face to face contacts: brief assessment, crisis intervention, referral, etc.)	882	781	958	506	783	471	460	420

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 statewide 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 2019, there were no Greene County residents released from prison on an AOT status. In 2019, 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.

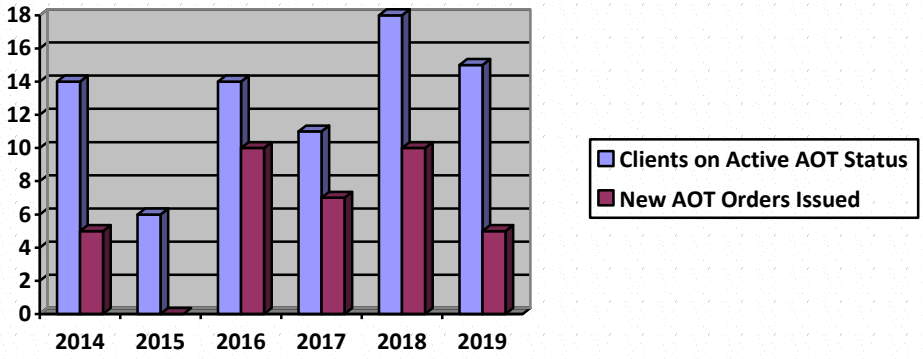
Enhanced AOT or Enhanced Service Program is a less restrictive program. It is used prior to getting an AOT order or used in stepping a client down from an AOT order. This program does not involve court orders but is helpful when a client is at high risk in the community and noncompliant with treatment. 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 2019, 20 significant event reports were filed with OMH and all 20 were due to noncompliance with treatment.

Many of these AOT clients have co-occurring diagnoses, severe mental illness and substance use disorder. Seven (7) of the fifteen (15) 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 one hundred and two (102), Greene County residents have been referred to the AOT program. In 2019, five (5) new AOT orders were issued. Eight (8) 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 (15) clients on active AOT status.

Assisted Outpatient Treatment Statistics	2014	2015	2016	2017	2018	2019
New AOT Orders Issued	5	0	10	7	10	5
Moved to Enhanced Status	1	2	0	1	2	1
Discharged from Enhanced	1	6	1	1	1	1
Active AOT Status	14	6	14	11	18	15
Active Enhanced Status	3	3	2	2	1	0
Pick Up Order Issued due to Non-Compliance	12	15	10	10	14	12



Greene County Jail Services

Prior to the point when the Greene County Jail closed in May 2018, Greene County Mental Health provided the following services to the Jail:

- 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
- Suicide screening and prevention
- 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

Since the Jail has been closed in May 2018, many of those jail-based services have been discontinued. GCMH continues to provide follow-up services for inmates upon release. We also continue to provide the staff to complete the Court Ordered Evaluations and 730 Competency Examinations.

One inmate remains in Central New York Psychiatric Center (admitted 2016). This individual that was deemed "not competent to stand trial" so in accordance with the law and state regulations, this person was remanded to Central New York Psychiatric Center (a forensic facility) for restoration. As recently as December 2019, he was still deemed not restored and therefore remains there for treatment. It is important to note that up until 2019, Counties in New York State were responsible for 50% of the cost to house and treat the inmate at that facility.

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 Treatment Court

Greene County Drug Treatment Court is an alternatives to incarceration program to engage legal offenders who were arrested on alcohol or drug related charges, or who have a demonstrated history of substance abuse, in treatment as an alternative to incarceration. Greene County Mental Health has collaborated with Greene County Drug Treatment Court since the inception of the alternatives to incarceration program.

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

Prior to 2019, the clinic's Director of Clinical Services represented GCMH on the Drug Court team. However, when the Director of Clinical Services took the position of 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.

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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, 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 Greene County Department for Social Services, Greene County Adult Protective Services, The Arc of Ulster/Greene, Catholic Charities, or WillCare agencies. In 2019 no additional representative supports were requested from other community agencies or entities other than those listed above.

2019 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 scanned and available electronically for committee members; each file is assigned a date of receipt (for tracking); case summaries continued to be completed in 2019.

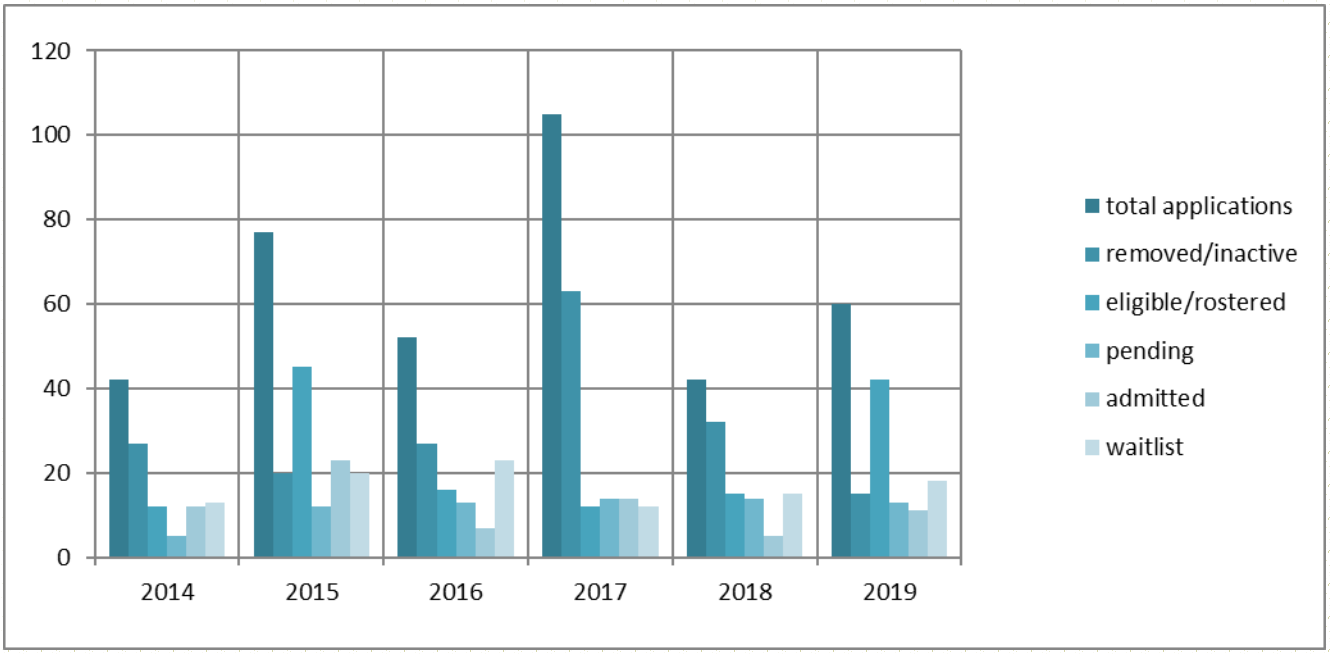
Residential Services

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.

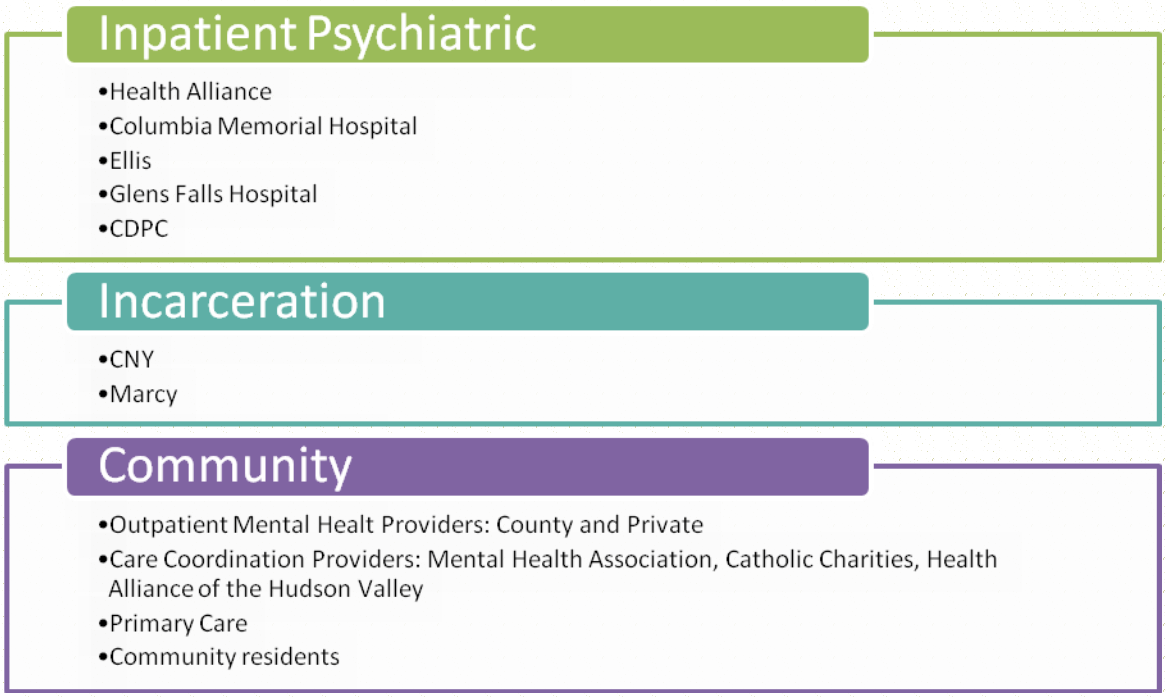
The Supportive Housing (SHUD) Apartment Program is the most independent residential setting wherein an individual receives a housing stipend similar to a Section 8 entitlement. They are assigned a case manager from MHA who is required to provide a single monthly contact in direct conjunction with housing 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. Three 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	2019
Total applications	42	77	52	105	42	60
Removed/Inactive	27	20	27	63	32	15
Eligible/rostered	12	45	16	12	15	42
Pending	5	12	13	14	14	13
Admitted	12	23	7	14	5	11
Wait List	13	20	23	12	15	18

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.

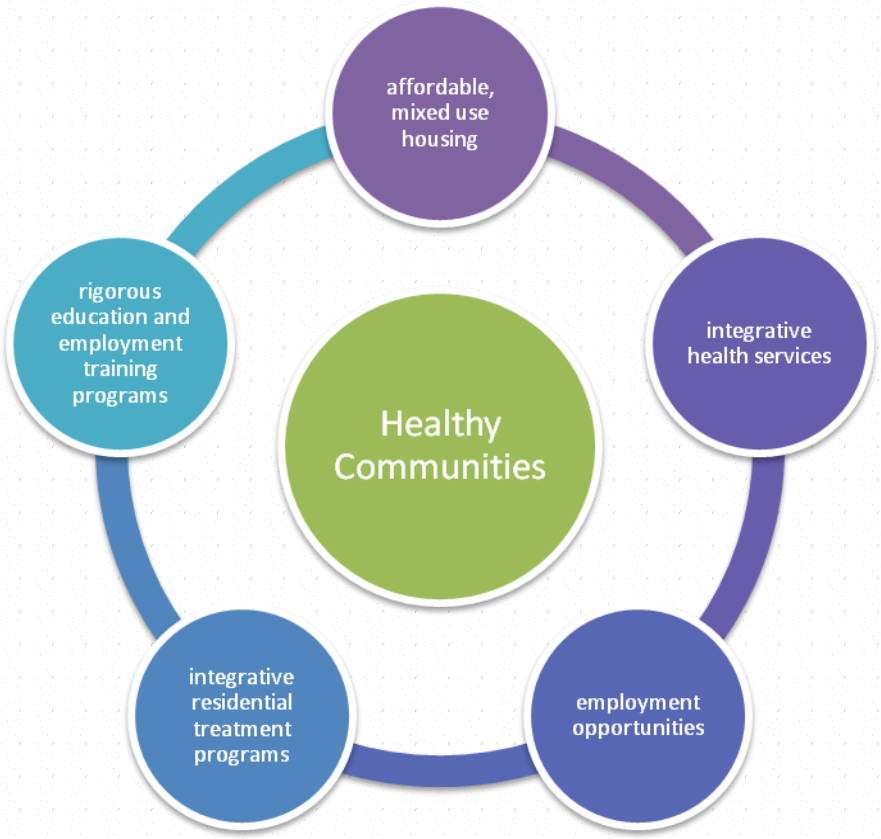
Many recently released inmates, psychiatrically impaired or not, have limited, if any, family or social supports. Upon incarceration, many individuals lose their housing, as well as their belongings, and find it necessary to start over upon release.

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.

The U.S. Department of Housing and Urban Development (HUD) estimates that over 50 percent of the individuals living in supportive housing programs had either a substance use disorder, a psychiatric disorder, or both. Drug overdose is becoming the most common cause of death among the homeless population, surpassing HIV/AIDS.

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 their Activities of Daily Living (ADL's) beyond the scope of the current apartment programs.

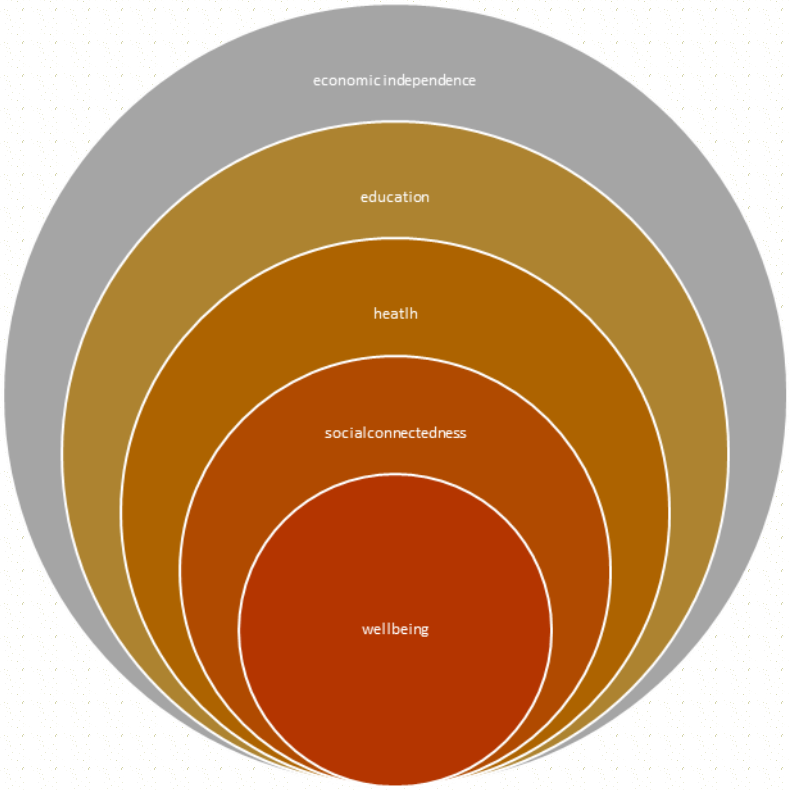
There remains a growing need for **permanent supervised housing** that transitions to permanent independent housing for individuals age 18 – 24 years old transitioning from residential or foster placements, or are no longer able to reside with family. This subset of clients requires permanent safe housing 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 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 2019 total 32 Clients, 14 of those being on AOT's.

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. History shows that 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 10 Care Coordinators that serve 35-45 clients on their caseload, 2 Enrollment Care Coordinators that average 12-15 clients on their caseloads, as well as 2 supervisors who carry a caseload of 10-12 clients. In 2019, approximately 429 Greene County clients were served in these programs with 394 enrolled in Health Homes and 35 in the Health Home Plus program. Health Home Plus (HH+) is a more intensive Health Home Care Management service that was established for defined populations with Serious Mental Illness who are enrolled in a Health Home. To ensure the intensive needs of these clients are met, HH+ individuals receive more face-to-face contact and more interventions specific to their needs.

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 2019:

2019 Greene County
Care Coordination Referrals

Month	# of Referrals	Enrolled	Inactive	Not Eligible
January	1	1		
February	5	3	2	
March	4	4		
April	3	2	1	
May	5	4		1
June	1	1		
July	6	4	2	
August	4	3		1
September	1	1		
October	1	1		
November	4	3	1	
December	0			
Total:	**35**	**27**	**6**	**2**

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 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 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 children's therapists complete a thorough bio-psychosocial assessment including clinical diagnosis and treatment recommendations. Our clinic does it's best to minimize wait times 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 2019 the majority of new referrals concerned the following main areas:

- 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 continues to prompt many 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

- school staff
- case managers
- medical professionals
- law guardians
- CPS
- prevention/pre-PINS
- hospitals
- probation
- family support workers

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 depending on acuity.

Medication Management

In 2019, the Children's Team had a Child Psychiatrist in the clinic 5 days per month for assessment, consultation, and ongoing medication management. The clinic also employs a full time Psychiatric Nurse Practitioner who sees some adolescent clients. 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 Health Home 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.

Health Home services are 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.

Under the Health Home model, care managers serve a blended acuity caseload of 14-18 (average) clients each. This acuity level is determined by administering the Children & Adolescents Needs & Strengths (CANS) assessment bi-annually. Care managers provide at least 1-2 face to face 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 over time, 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 two full time family support workers. 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 workers receive 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

This year, our family support workers have started to bill Medicaid for their services under the new Child and Family Treatment and Support Services as part of the Children's Medicaid redesign.

Children's Team Staffing

- The clinic currently employs 3 clinic based therapists and 7 school based therapists.

- In 2019 the clinic has a Child Psychiatrist who works 5 days per month providing consultation and medication management services.

- The clinic employs 2 full time Health Home Care Managers.

- The clinic has 2 full time Family Support Workers who provide 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 clinical support for Family Support Workers. 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 Greene County school districts. School-based services increase access to services that many families would not be able to easily utilize. School based workers are an integral part of their host school Pupil Personnel team, collaborating with staff members, and providing behavioral/crisis supports to students. Participating districts for the 2019-2020 school year include:

- Windham/Ashland/Jewett school district 3 days per week,
- Cairo/Durham Middle/High School 4 days per week,
- Cairo Elementary 4 days per week, and
- Hunter Tannersville Central Schools 3 days per week.
- Coxsackie Athens Middle School/High School 4 days per week
- Coxsackie Elementary School 4 days per week
- Greenville School district 2 days per week (pilot started mid-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.

At Risk Youth Task Force

GCMHC has hosted and helped facilitate the At Risk Youth Task Force. This task force has shifted over time, initially addressing school avoidance, and more recently addressing a broader range of at risk youth and community issues. This 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 2019. 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 workers are 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 responds 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 among 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 is scheduled to meet the first and third Thursday morning of every month 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 Mental Health Clinic as well as their Health Home Care Management Agency, Greene County Youth Bureau, Northern Rivers Case 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.

In the Beginning of 2019, Home and Community Based Waiver joined the Health Home arena. This transition allowed any eligible Health Home clients to access the Children and Family Treatment and Support Services (CFTSS) that were previously reserved for waiver. Parson's Child and Family Center merged with Northeast Parent and Child Society to form Northern Rivers. These programs are still Medicaid based. If a child is without Medicaid and is in need of these services, referrals are made to Children and Youth Evaluation Service (C-YES). In 2019, 4 referrals were sent to C-YES in order for them to determine whether these children without Medicaid qualify for the Home and Community Based Services. Once deemed eligible, C-YES also assists in applying for Medicaid and manages the case until it is approved.

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 2019, 33 out of 54 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 day 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. Overnight respite is provided through Northeast Parent and Child Society, coordinating with local therapeutic foster homes. Out of the allotted 100 nights we had in 2019, 100% of them were used to serve 12 different children. 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. On 9/30/2019, the Family Peer Advocate moved from employment by MHA to a county position. At the end of 2019, the Family Peer Advocate had a caseload of 28, with a waitlist of 8 children. In 2020, it is a goal to hire another full-time Family Peer Advocate.

SPOA has also served as a referral mechanism for other services and support programs including Pre-PINS, Prevention, IAPP (Intensive Aftercare Prevention Program), mediation through Common Grounds, Twin County Substance Abuse Services, Parent Support, Autism Connection, Children and Family Treatment and Support Services (CFTSS), 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 2019, the SPOA coordinator completed 54 initial meetings with families to determine eligibility, proper placement, and completion of application. The SPOA committee completed 7 SPOA reviews with families and collateral agencies to follow-up on previous SPOA meetings for a total of 61 meetings. Referrals came from many different sources including Mental Health Clinics, 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 54 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 (39), and Mental Health Association Respite (26) (which currently has a wait list of 11 children). Four children were referred to C-YES for Medicaid eligibility assistance to access the CTFSS services.

	2016	**2017**	**2018**	**2019**
Initial SPOA meetings	58	75	60	54
SPOA Reviews	13	8	3	7
Referrals to Case Management	49	61	60	54
Referrals to Waiver	12	6	3	N/A
Referrals to Family Peer Advocate	40	41	29	39
Referrals to Respite	10	19	21	26

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.

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 2020 was completed by the Director of Community Services and CSB Co-Chair in collaboration with the Community Services Board and submitted in June 2019. The following priority goals were identified as a continuation of the 2019 priority goals:

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.

In December of 2019 the priority goals were reviewed by the subcommittees and the CSB in January 2020.

- Priority goal 1 with regard to housing was determined to have remained unchanged with regard to need and remains a priority and unmet need in the community.
- Priority goal 2 with regard to transportation was determined to have improved significantly and the identified goal met.
- Priority goal 3 with regard for crisis services, targeted messaging, and education was determined to be accomplished and met.
- Priority goal 4 with regard to Substance Use Disorder treatment availability education and accessibility was determined to be accomplished and met.
- Priority goal 5 with regard to increasing mental health services, supports, and resources available to children and families in Greene County was determined to have improved significantly and the goal met.
- Priority goal 6 with regard to meeting the needs of the intellectually and developmentally disabled in the community was determined to be unchanged and continues to be a priority unmet need in the community.

The CSB in collaboration with the Director of Community Services continues to work toward meeting the needs of the community.