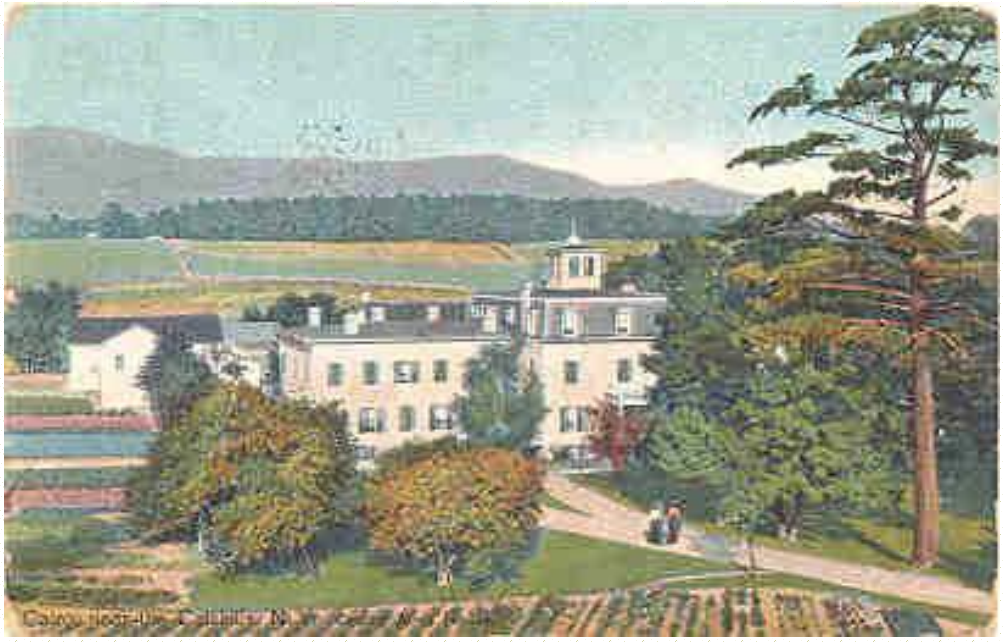
Greene County Mental Health Center

905 GREENE COUNTY OFFICE BUILDING
CAIRO, NY 12413



2020 Annual Report

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Director of Community Services
& Mental Health Center Staff

INTRODUCTION

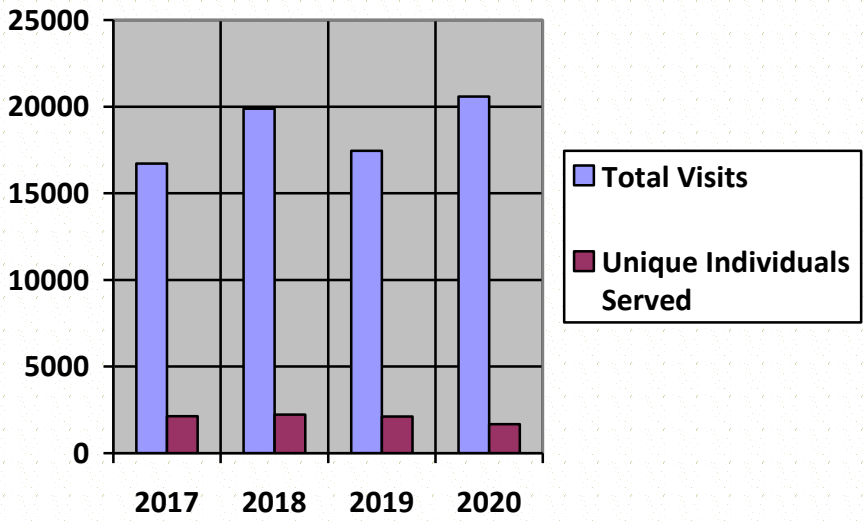
The Greene County Mental Health Center is an Article 31 community mental health clinic licensed by the NYS Office of Mental Health. It employs a full contingent of professional staff, including Psychiatrists, Nurse Practitioners, Psychologists, Social Workers, and Mental Health Nurses. Our staff is dedicated 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 2020, Greene County Mental Health Center (GCMHC) served a total of 1,684 unique individual clients; 1,272 Adults and 412 Children & Adolescents. We provided 20,579 billable direct service contacts to 940 Females and 744 Males.

4 Year Data Comparison

2017	2018	2019	2020
Total Visits - 16,713	Total Visits – 19,878	Total Visits- 17,443	Total Visits- 20,579
Adults – 11,580	Adults – 14,292	Adults – 12,107	Adults – 13,655
Children – 5,133	Children – 5,586	Children – 5,336	Children – 6,924
Total Unique Individuals Served 2,141	Total Unique Individuals Served 2,222	Total Unique Individuals Served 2,115	Total Unique Individuals Served 1,679
Male 41.8%	Male 46.17%	Male 46.44%	Male 44.18%
Female 58.2%	Female 53.83%	Female 53.56%	Female 55.82%
Adults 75.4%	Adults 71.24%	Adults 69.4%	Adults 75.5%
Children 24.6%	Children 28.76%	Children 30.6%	Children 24.5%



EVALUATION OF 2020 GOALS

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

By early March 2020, the COVID-19 pandemic reached Greene County and on March 17th, Greene County Mental Health transitioned to providing almost all services remotely via telephone and video. The only services that were continued in-person were the provision of injections to those patients who received injectable medications. Otherwise, all staff began working remotely from their homes and provided all services by telephone and/or video.

This transition was difficult for support, clinical and administrative staff as it required IT accommodations and expansions, as well as changes to workflow, documentation, and many other procedures. The staff, however, rose to meet this challenge and made the transition almost seamlessly with minimal disruption to our services and to our clients. Having purchased a new Electronic Medical Record (EMR) in 2019 (one of our annual goals for that year), we were better prepared to make the transition to remote services. The new cloud-based EMR provided a HIPPA-compliant secure platform for video services and allowed for other conveniences and streamlined workflows as the staff adapted to working remotely.

Since that time, most of our services have remained remote. Attempts were made in late summer to bring staff and clients back onsite, but when there was another spike in COVID numbers in the county, the staff had to pivot again to providing fully remote services.

Throughout this difficult time, Greene County Mental Health continued to work collaboratively with other agencies and County departments to provide the comprehensive mental health services that are needed in the community. In fact, some services were even expanded, most notably, those related to addressing the opiate epidemic as noted below.

County residents and officials alike should be proud of their Mental Health Department's ability to weather such transitions while continuing to provide such necessary services through a time of great need in our community. The efforts and accomplishments of the Department's staff is nothing less than impressive under these challenging circumstances.

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.

Despite the impact of COVID-19 on Greene County Mental Health's work environment and their provision of services, the Department made great strides in its ability to address the opiate epidemic in the community.

Greene County Mental Health expanded services on two fronts to help address the needs of the opiate epidemic. First, by the end of 2020, the clinic began offering Medication Assisted Treatment (MAT) for opiate use disorders. Specific staff were trained to provide that service and other staff were identified to work closely with that population of clients and to act as a liaison to Greene County Public Health who also offers MAT and with whom much collaboration was needed.

Secondly, as part of an initiative of the NYS Office of Mental Health, Greene County Mental Health also became certified under the NYS Department of Health as an Opioid Overdose Prevention Program (OOPP), which allows us to train people on the use of Naloxone, a life-saving medication to reverse opiate overdoses, and to supply such trainers with Naloxone.

The Healing Communities Study through Columbia University has also brought much needed resources, expertise and action to the county regarding the opiate epidemic. Greene County is one of 16 counties in New York chosen to participate in the Healing Communities Study which is a national study aimed at reducing opiate related deaths by 40% over five years. Greene County Mental Health is responsible for managing the administration of the study for the county and this has led to significant impact on services and collaboration within the county. In addition to strengthening and expanding an existing network of local stakeholders, community groups and resources, the study has also resulted in bringing a great deal of grant money into the county to help address the opiate epidemic. In fact, it was this grant funding that helped fund the expanded MAT services that Greene County Mental Health began offering in 2020. Additional grant monies were used to fund other agencies' services and initiatives to have significant impact on the community.

In addition to these expanded services and additional funding within the county, Greene County Mental Health also began offering additional training to its staff regarding substance abuse treatment and the opiate epidemic. This was done with the aim of broadening the scope of the clinic's services to begin more directly working with the substance abuse population in the county.

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

Greene County Mental Health has strengthened and expanded its collaborative relationship with Greene County Public Health. Historically, both agencies have seen many patients who could benefit from engaging in services at the other agency. This is especially true with many of Public Health's patients who were receiving Medication Assisted Treatment (MAT) for opiate use disorders. Based on this, Greene County Mental Health strengthened its collaborative relationship with Public Health and formalized a mutual referral process between the two agencies. Further, as Greene County Mental Health began offering MAT, the two agencies also collaborate closely around this. A new therapist at Mental Health has been formally assigned as the liaison for Public Health and in 2021 will be co-located at Public Health for at least one day per week. All of these efforts between the two agencies have been extremely beneficial to their shared clientele and the community as a whole.

Greene County Mental Health also continues to work closely with other local agencies including the Mental Health Association of Columbia-Greene Counties, Twin County Recovery Services, the Columbia-Greene Healthcare Consortium, and others. Again, as mentioned above, the Healing Communities Study has strengthened the collaborative relationship among all of these agencies, which benefits the community in immeasurable ways.

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

Greene County Mental Health has made some progress on this over the year and this will continue to be a high priority into the next year.

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

Likewise, the Corporate Compliance Plan is one that has seen some updates and will continue to be a priority in 2021.

GOALS FOR 2021

1. Continue to meet the needs of the community with regards to the COVID-19 Pandemic

As the COVID-19 pandemic rolls on, Greene County continues to be affected, and Greene County Mental Health continues to forge ahead in adapting in whatever way necessary to meet the Mental Health needs of the community. Towards the end of 2020, Greene County Mental Health was forced to abandon its attempts to return to on-site services and was forced to go back to providing services remotely. Our staff, however, was able to make this transition with much more ease than the first time. It is our hope that the pandemic will see improvement in 2021 and likewise, our clinic will return to providing services as it had prior to the pandemic. A return to in-person services at the clinic will likely require a phased-in approach where different groups of staff will return to on-site services in stages. Such a return may also require IT upgrades in order to accommodate the increased number of video and phone sessions as well as virtual meetings that will likely continue into the future. Early in the pandemic in 2020, Greene County Mental Health successfully applied to NYS Office of Mental Health and added telehealth services to our license and operating certificate, which will allow for us to continue to provide these services indefinitely after the pandemic has ended. With transportation historically being one of the biggest obstacles to access services for residents in our rural community, it is our hope that this will open new opportunities for us to reach clients who haven't been able to be seen previously.

Additionally, as a result of the COVID-19 pandemic, many frontline workers including our own are experiencing COVID Fatigue. One goal for 2021 will be to put more focus on both our internal staff, as well as offering remedies to our fellow county departments and agencies in efforts to assist them in practicing self-care and healing their struggles from providing service throughout the pandemic. Such remedies might include providing staff with support and training to help manage the day-to-day stress associated with being frontline workers, as well as techniques when working directly with clients impacted by the pandemic.

2. Continue to address the Opiate Epidemic and other issues with substance abuse within the County.

Despite the rise in services and attention over the last year, the opiate epidemic continues in the county. It is the goal of Greene County Mental Health to continue to provide the newly started and expanded services that directly address this concern within the county. MAT (Medication Assisted Treatment) will likely expand and the work of our OOPP will continue to become more active. The ongoing work of the Healing Communities Study is scheduled to continue for another 2 years and it is our hope that we will continue to see a positive impact from that in the community.

3. Complete revisions to the Policy and Procedure Manual and the Corporate Compliance Plan

As staffing has changed at Greene County Mental Health, there is now the position of Quality Assurance Coordinator and Agency Compliance Officer. The person in this role will be charged with the responsibility (among other things) to update both of these documents so they are current and live, functional documents that continue to evolve with the needs of the agency.

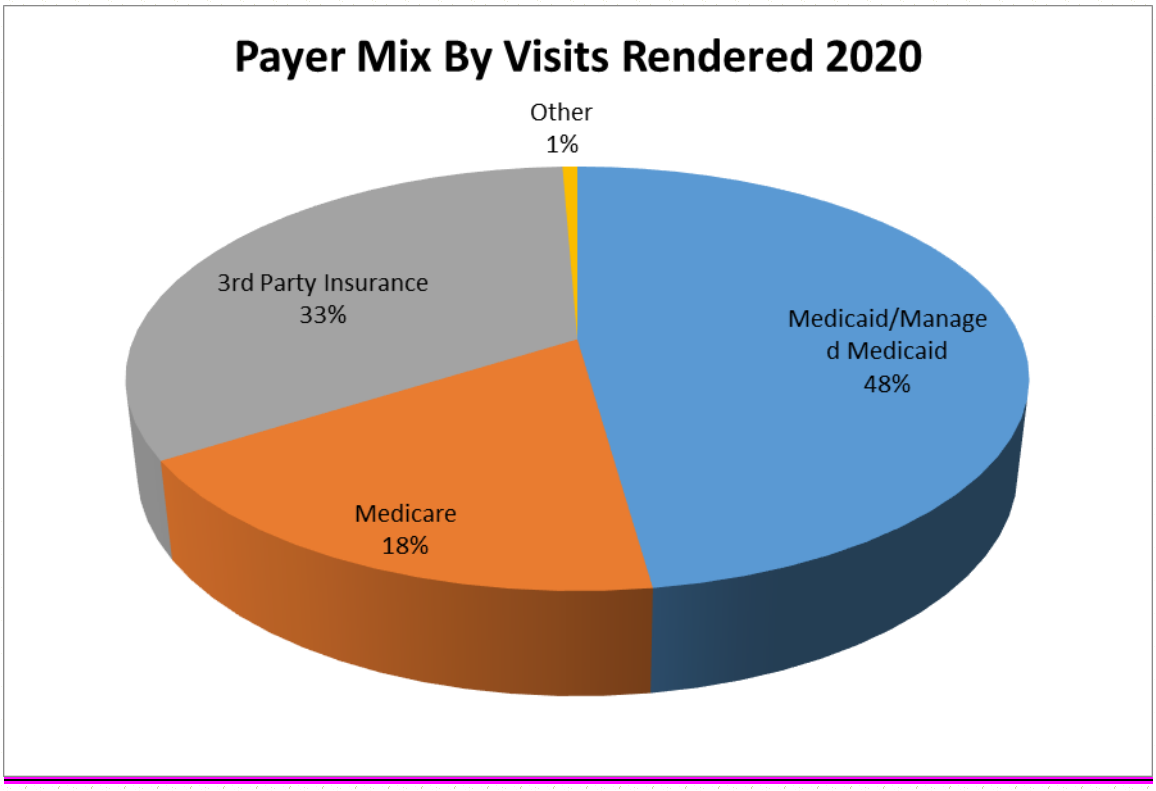
Fiscal Developments

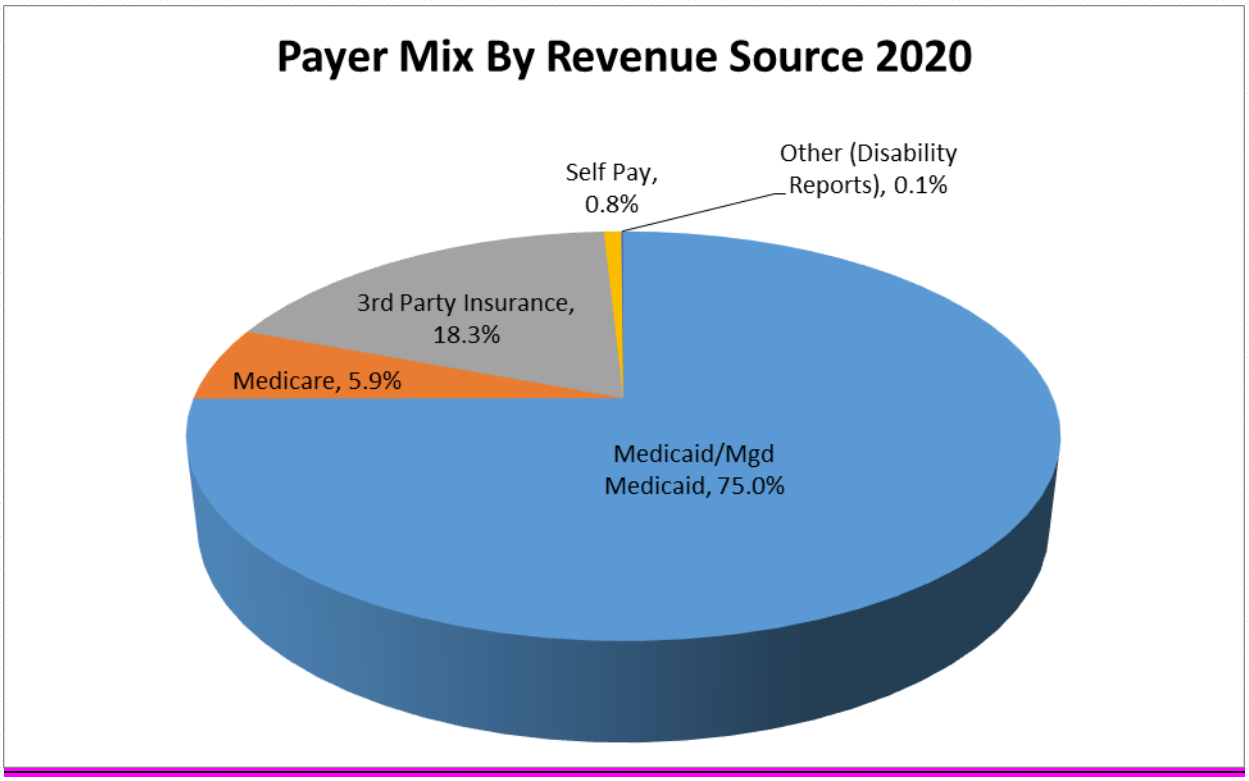
The Mental Health Department has changed in many ways over the past year but yet still continues to balance the provision of evidence based, clinically relevant service while being mindful of the tax burden on Greene County tax payers. Clinical, fiscal and support staff have remained diligent in their efforts to keep costs low despite the increased needs for improved technology, increased cleaning and an increased demand for PPE. In 2020, the department's cost to the county was $921,920 approximately $604,667 above our anticipated budgeted cost. While we were within approximately $4,473 for billable service revenue we were not able to address the additional expenses that we incurred in 2020 that were not previously budgeted for.

In 2020, the state forensics contract expense to the county doubled as of April 2020, when NYS OMH stopped contributing their 50% share which lead to Greene County absorbing 100% of the expense. This amounted to additional costs of $249,746 for 2020. With the CSEA bargaining agreement contract being signed in early spring of 2020 this added $263,465 to our cost of doing business in addition to COVID related expenses that weren't budgeted for such as cost for additional web cameras, video visit licenses and a pre-check consents module with our electronic medical record vendor Medent.

However, through the strong emphasis for staff to meet individual productivity goals, reduction in onsite expenses as a result of remote services being rendered, revenue received from the Federal Provider Relief Fund, and participation in DSRIP we were able to obtain additional revenue to help offset these added costs associate with COVID.

Payer Mix by Patient vs. Revenue Received





COVID Response to Programs & Fiscal Impact

As you've read in the previous sections the COVID-19 Pandemic has changed much of the way the Mental Health Department conducted operations in 2020. We had to purchase additional technology to meet the demand of providing services remotely. Some of these expenditures include Medent subscriptions for video visit capability, web cameras for each staff member's desktop computers, and costs associated with our new electronic pre-check function for consents and necessary intake documents.

Additional costs associated with our COVID response have also included installation of Plexiglas barriers in therapist's offices, protective equipment for the staff and the building (masks, gloves, social distancing signs, thermometers, etc.), more cleaning products for each common area and therapists office, and expanded contracts with our cleaning service provider to maintain the minimum cleaning requirements per OMH regulations regarding the operation of an outpatient healthcare facility.

Our staff also had to make accommodations, switching to working remotely in a matter of 24 hours. Much preparation was done to accommodate our new work flow and to ensure a seamless transition. As we made preparations to connect and engage remotely with our clients we soon realized that many of our clients have limited capabilities to connect via video. With limited access to computers, reliable internet and cell service across our rural county, our clinicians and prescribers had to become even more flexible on how they connected with their clients. After hours sessions, weekends, and lunch hour sessions were just some of the ways they connected with their clients. One other option available to us was the temporary expansion of our telemental health services to include audio only, this helped us reach clients who had limited access to alternative methods. We made every effort possible to meet the needs of our clients and continued to provide required injections on a weekly basis in-person. The COVID screening calls performed by support staff for those receiving in person visits were also done regularly and have added to our work load but are certainly necessary to ensure we are doing everything within our powers to keep the public and staff safe from transmission.

While we didn't see as many referrals as we usually would due to the COVID-19 pandemic, and our overall unique individuals served has slightly dipped in 2020, our visits rendered had actually increased. We believe this is thanks to our staff's ongoing engagement with clients and the ability to have flexibility when scheduling appointments both on the part of the provider and the client. Our hope is that this pattern continues into the future so we can continue to engage well with our clients and meet the needs of our community.

Delivery System Reform Incentive Payment (DSRIP)

Greene County Mental Health continued to actively participate in the DSRIP (Delivery Systems Reform Incentive Payments) Program in 2020. 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.

Data was pulled not only from the clinic's Electronic Medical Record, but also from the OMH PSYCKES database and submitted monthly to DSRIP by the MH Quality Assurance Coordinator/Agency Compliance Officer and the Deputy Director of Community Services. Metrics were paid on a pay for performance scale through June of 2020 and due to the COVID 19 pandemic were temporarily suspended through the fall when the contracts were changed to pay for submission.

Greene County Mental Health received a total of $46,408 in 2020 from DSRIP funds, with a residual balance paid in 2021 for the January 2021 submission. Participation in this program continued to helps us provide better quality of care to our clients and prepare us for value-based contracts in the future.
DSRIP programming ended in December of 2020 with final submission in January 2021, however Greene County Mental Health continues to participate in collaborative group meetings focused on reduction of hospitalizations, high utilization of Medicaid dollars, and best outcomes for clients served.

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 programs.

In February 2020 the clinic opted into the OUD (Opiate Use Disorder) Initiative as it tied into other programs and initiatives the clinic was focusing on surrounding opiate overdoses and opiate use disorders. Due to the COVID-19 pandemic, all initiatives were suspended and planned to resume in April 2021.

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 2020 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.

Staffing News

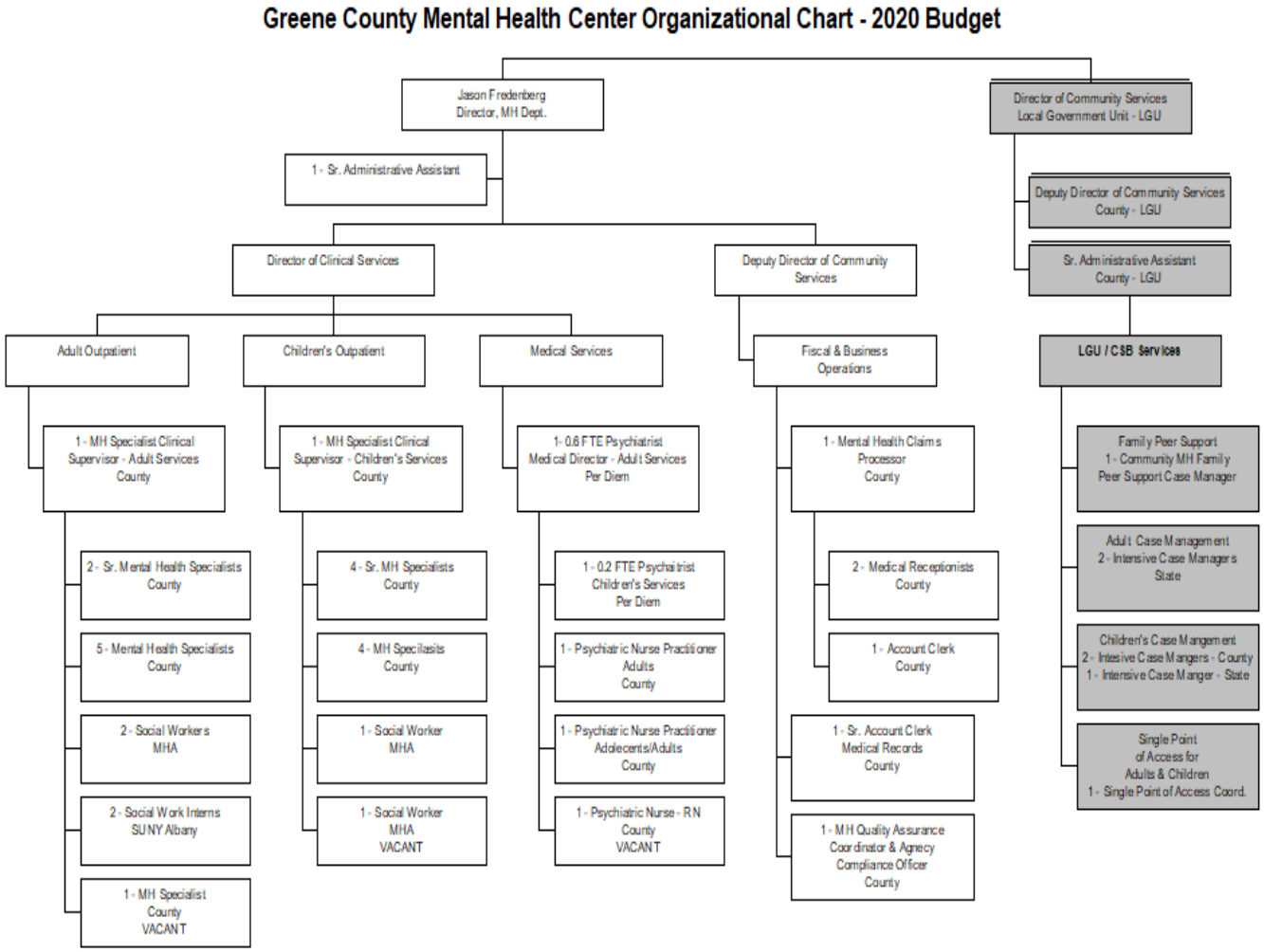
Greene County Mental Health Center experienced several staffing changes during 2020.

In early 2020 the Director of Fiscal and Business Operation's title was changed to Deputy Director of Community Services. There were several changes in medication management providers with the hire and departure of contracted physicians and psychiatric nurse practitioners. In 2020 we saw the resignation of two Mental Health Specialists, and a contracted social worker. A psychiatric nursing position remained unfilled throughout most of the year, into 2021.

In early 2020 we hosted a nurse practitioner intern from Russell Sage College. In fall of 2020 we welcomed 2 student interns from SUNY Albany's Master in Social Work program who were with us until May 2021. GCMHC also hosted 4 students from Columbia Greene Community College's Nursing program for their rotation through mental health services.

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 2020 employees took part in in-house staff development trainings, mandated County trainings, outside educational opportunities. Opportunities were limited during 2020 due to COVID restrictions.

- **In House Staff Development & In-Services**

Substance Abuse Resources Training in the Community, Mental Health Association Residential Services, Opiate Use Disorder and Screening, and Medication Assisted Treatment.

- **County Mandated Training**

Know Be4 IT Safety, Workplace Violence, Workplace Bullying & Violence Prevention

- **Outside Educational Training Opportunities**

Treatment Courts 2020 Vision: Improving Health, Justice and Communities, Eye Movement Desensitization and Reprocessing, Screening, Acceptance & Commitment Therapy, Trauma and Attachment, Brief Intervention, and Referral to Treatment (SBIRT)

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 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 the beginning of 2020 from January until March 16th, The Open Access Clinic (OAC) was running as usual by having drop-in hours for all new adult patients desiring services from GCMH. Clients would walk into the clinic any time between 9:00am-11:00am on Monday, Wednesday and Thursday. No appointment was necessary. The exception to this was clients who were referred from the hospital who are new to us; they received follow-up appointments to attend. Our quality assurance staff also made efforts to engage these new clients to ensure they presented for their follow-up appointments. They were then evaluated and the proper level of service was determined by a small treatment team of clinicians who staff the Open Access Clinic.

When the clinic closed to in-person clients in March 2020, The OAC had to transition quickly to a more set schedule of telehealth appointments as opposed to walk-in hours. Those referred by the hospital were still given a scheduled telehealth appointment within 5 days of discharge. New adult clients seeking services would call the clinic, give their information and be given an appointment during the same days and hours as before. The clinic experienced an influx of new and returning clients, which meant that not everyone was seen the same week as they called. Having such a high volume of clients with the amount of staff at the clinic created a lengthy waitlist for clients to be assigned a therapist after completing the open access process. Some client were given 4-6 appointments in open access before being assigned a permanent therapist. Some preferred to wait on the waitlist but were told they could call the clinic at any time in between for an appointment if they felt it was needed. These clients were still checked-in on by the open access staff every few weeks to make sure they were stable and still interested in services.

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 would meet with the clinic nurse who obtained a medical history, list of current health providers, performed a tobacco screening and willingness to quit question set, obtained 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. Only 90 Health Screenings were able to be performed in 2020 due to the in-person OAC being open from January-March 16th, 2020.

Since its implementation, the OAC continues to meet the needs of our clients and the clinic itself. In 2021 it is the clinic's goal to re-establish OAC as it was before the pandemic. The goal is to once again have clients able to access services without an appointment and to have the clinic no longer experiencing no-shows for intake appointments.

Further, for there to no longer be an extensive waiting list for services. Even with the challenges 2020 presented, the OAC continued to be a great success for the clients, clinic and community.

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 provide treatment recommendations. The Adult Treatment 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. This year we also implemented a Medication Assisted Treatment (MAT) program in collaboration with Public Health to address unique issues associated with clients who struggle with Opioid Use Disorders (OUD). The Adult Treatment 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.

In 2020 our therapists and psychiatry staff became rapidly acquainted with using telehealth services as a means to provide services for our clients. Due to COVID-19 restrictions, the majority of our clinic services were conducted remotely this year. Our clinical staff utilized video and telephonic means to connect with clients for telehealth services. Attempts at a telehealth video group centered on tapping were made as a response to the stress of COVID-19/isolation, but attendance was sporadic/minimal and ultimately the group disbanded.

The Adult Treatment 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 Treatment 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. This group has been placed on hiatus until we can resume in-person group facilitation.

Men's Group- The men's group terminated this year following the departure of the therapist who facilitated it. Plans to resume the group are in place for when we can resume in-person group facilitation.

Coping Skills Group (DB) - Plans are in place to begin a Coping Skills group centered on Dialectical Behavior Therapy Skills Training.

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 2020 GCMHC had 3 licensed satellite offices in Greene County; Jefferson Heights Family Care in Catskill, Windham Medical Care in Hensonville, and Coxsackie Medical Care in West Coxsackie. Due to COVID in March 2020 we were unable to continue to provide services from the primary care offices, but we were able to serve the clients being seen at those offices via telemedicine. The Coxsackie Medical Care office remains unstaffed at this time.

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 2020, there were no Greene County residents released from prison on an AOT status. In 2020, two 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, however when a bed opened at the Community Residence the individuals were transferred to our Community Residence. Individuals under AOT receive priority access to case management, outpatient services and residential housing options.

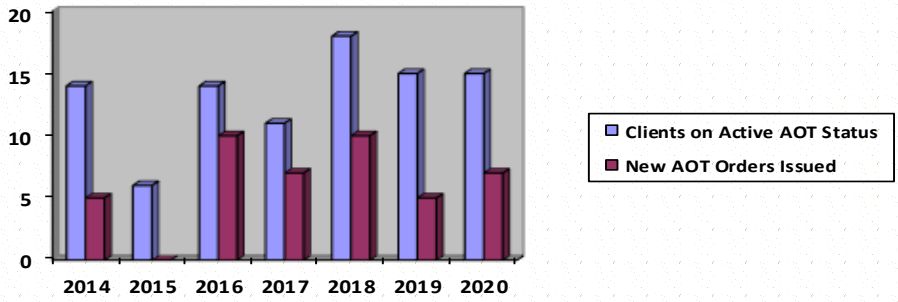
Enhanced AOT or Enhanced Service Program is a less restrictive program. It is used prior to getting an AOT order or used in stepping a client down from an AOT order. This program does not involve court orders but is helpful when a client is at high risk in the community and noncompliant with treatment. 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 2020, 12 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. Six (6) 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 2020, seven (7) new AOT orders were issued. Nine (9) 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**	**2020**
New AOT Orders Issued	5	0	10	7	10	5	7
Moved to Enhanced Status	1	2	0	1	2	1	0
Discharged from Enhanced	1	6	1	1	1	1	0
Active AOT Status	14	6	14	11	18	15	15
Active Enhanced Status	3	3	2	2	1	0	0
Pick Up Order Issued due to Non-Compliance	12	15	10	10	14	12	9



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.

By the end of 2020, one inmate continued to remain at Central New York Psychiatric Center (admitted 2016). This individual 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 2020, 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. In 2020, however, the State shifted the cost to the counties to then pay 100% cost to house and treat them. This announcement was made in early 2020 and took effect in April. Therefore, the counties had to absorb this cost even though it had not been budgeted for.

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.

In 2020, the majority of court appearances were held virtually over Microsoft Teams.

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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, Capital District Psychiatric Center or WillCare agencies. In 2020 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. Due to COVID-19 and the lack of movement in housing due to funding and a scarcity of affordable apartments, 2020 saw a decrease in housing referrals. This was not because there is a lack of people needing supportive housing but due to people needing more immediate housing options than SPOA was able to provide. The amount of referrals to DSS emergency housing increased dramatically. Interviews to determine the eligibility of the client and tours of facilities also became challenging due to the restrictions and safety measures put in place due to COVID-19. Organizational and tracking measures continued, including that each client's file is scanned and available electronically for committee members; client is added to an updated roster and progress is tracked; case summaries continued to be completed in 2020.

Residential Services

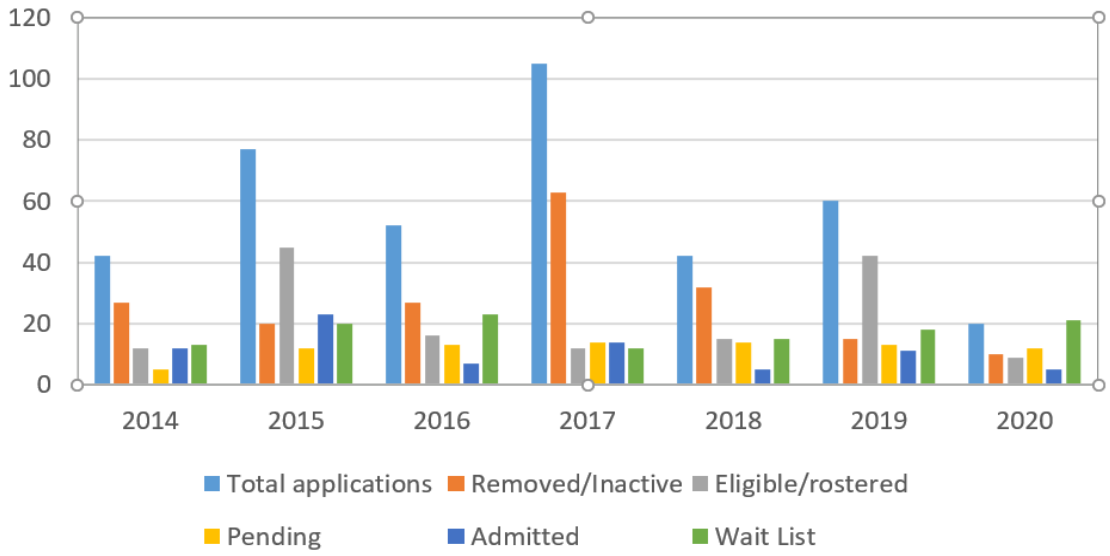
The Mental Health Association (MHA) of Columbia and Greene County provides housing for Greene County adult residents who have a psychiatric disability. There are three distinct levels of housing that are reflective of the distinct levels of residential need.

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.

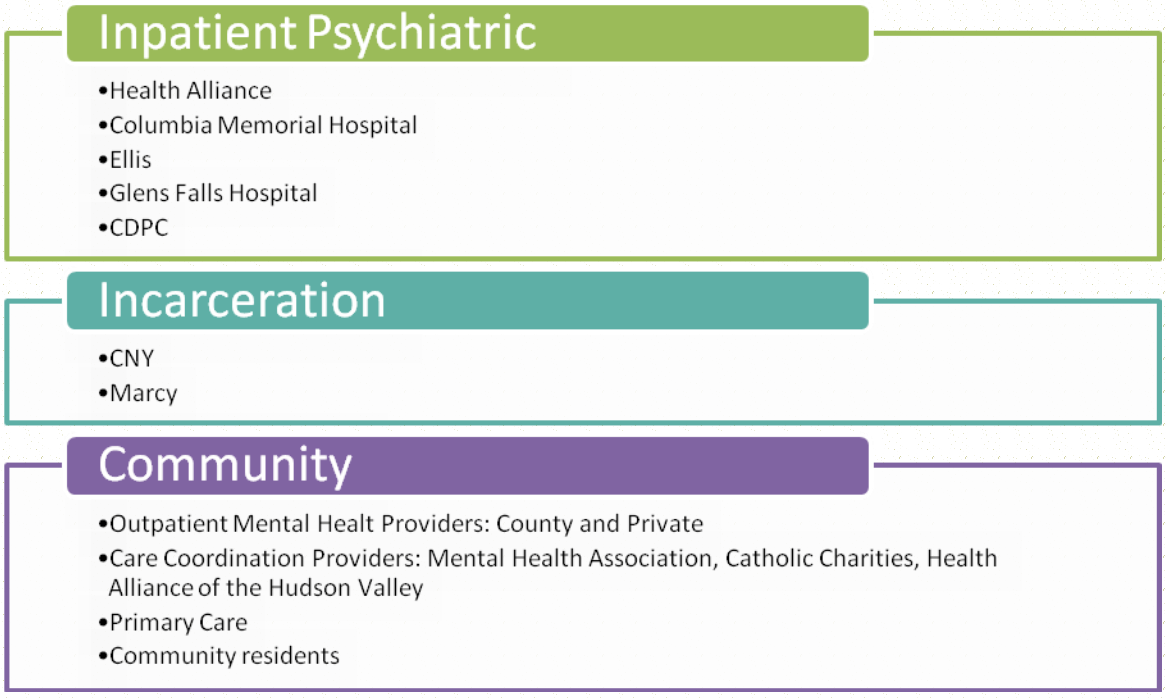
Residential Housing Applications



Residential Applications	2014	2015	2016	2017	2018	2019	2020
Total applications	42	77	52	105	42	60	20
Removed/Inactive	27	20	27	63	32	15	10
Eligible/rostered	12	45	16	12	15	42	9
Pending	5	12	13	14	14	13	12
Admitted	12	23	7	14	5	11	5
Wait List	13	20	23	12	15	18	21

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 2019 were placed in housing in 2020; 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.

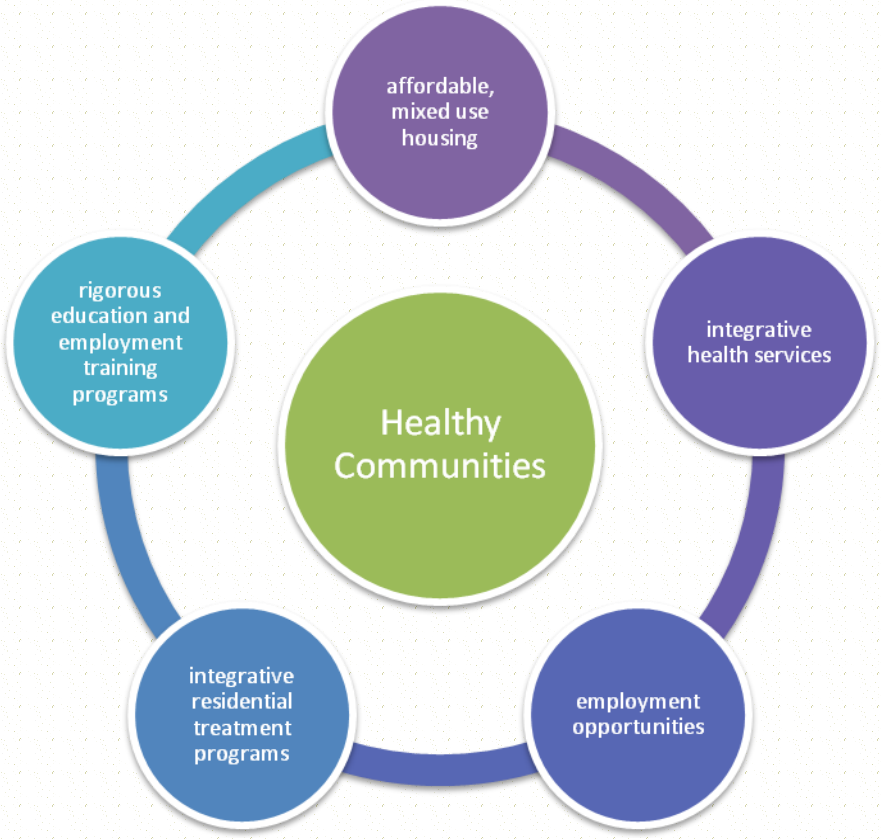
Many recently released inmates, psychiatrically impaired or not, have limited, if any, family or social supports. Upon incarceration, many individuals lose their housing, as well as their belongings, and find it necessary to start over upon release.

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.

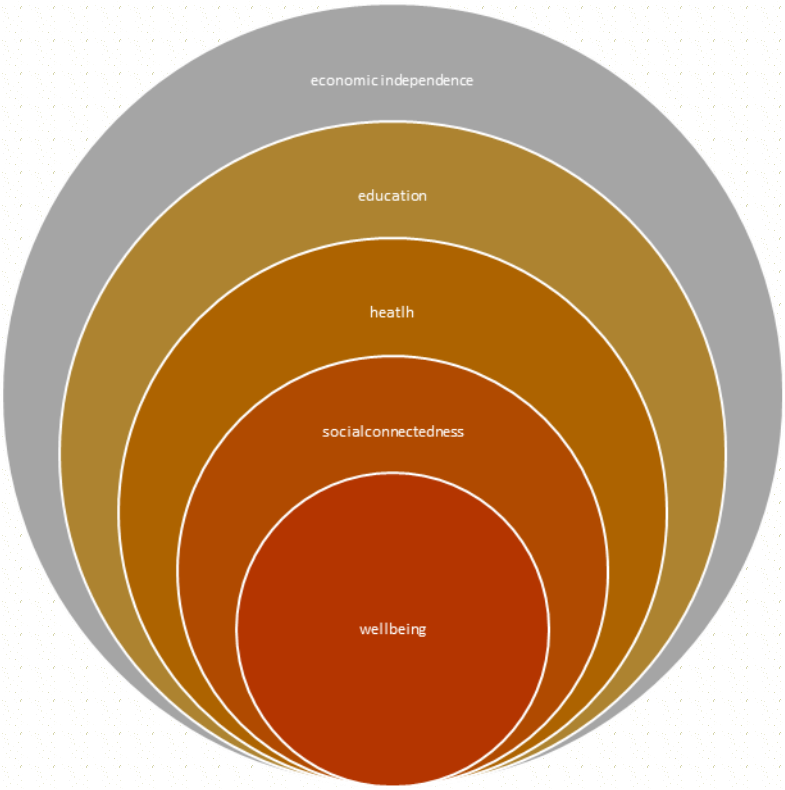
There remains a growing need for **permanent supervised housing** that transitions to permanent independent housing for individuals age 18 – 24 years old transitioning from residential or foster placements, or are no longer able to reside with family. This subset of clients requires permanent safe housing 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.

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 Sunriver Health (formerly known as Hudson River Health), the Health Home who is also responsible for reporting to the State of New York. In August 2020, the documentation platform transitioned from GSI to Relevant and all data/charts were migrated to Relevant. A total of 22 Active Enrolled clients (13 are AOT) are in the Relevant system for Greene County CMA.

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. In 2020, The Mental Health Association of Columbia-Greene Counties employed a team of 16, which included their Director, Assistance Director, two enrollment care coordinators and 12 care coordinators. The average case load of care coordinators is 32-42 depending on the level of need the clients have. The enrollment coordinators carry a caseload of 10-12 clients also depending on the level of need. In 2020, approximately 449 Greene County clients were served in these programs with 404 enrolled in Health Homes and 45 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 2020

Month	# of Referrals	Enrolled	Inactive
January	2	2	
February	1		1
March	2	1	1
April	1		1
May	2	2	
June	2	2	
July	2	1	1
August	1	1	
September	2	2	
October	3	3	
November	1	1	
December	2	2	
Total:	**21**	**17**	**4**

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.

This past year, the clinic has provided primarily remote services due to the COVID-19 pandemic. This has met the safety needs of both clients and providers, and will continue to be offered as needed and when appropriate into 2021.

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 2020 the majority of new referrals concerned the following issues:

- 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.

This past year has been especially challenging for local children and families. We have received numerous referrals to address symptoms/stressors related to the COVID-19 pandemic. Children have struggled with isolation, remote schooling, and lack of access to normal outlets and social supports. Our children's therapists have attempted to creatively engage these clients remotely and support them through this difficult time.

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 2020, the Children's Team had some turnover in child psychiatry services. Medication management and consultation services were available part time for much of the year, while some clients were referred out to area prescribers. 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 continue to 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 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 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 4 clinic based therapists and 6 school based therapists. 2020 saw some changes to satellite staffing due to the pandemic.

- In 2020 the clinic had a Child Psychiatrist who worked 5 days per month providing consultation and medication management services for part of the year. The clinic then employed another Child Psychiatrist 3 days per week for the second part of the year. There is currently no child psychiatrist on staff, though the clinic is actively seeking a local prescriber.

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

- The clinic has 1 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 clinical support for 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 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 in 2020 (currently 3 days per week)
- 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 3 days per week until March of 2020

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.

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 over time. 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.

These services are currently available remotely.

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. On March 17th, 2020, the clinic was instructed by county administration to begin working remotely due to the COVID-19 pandemic. Guidance from the NYS Office of Mental Health ended all face-to-face meetings for the time being including respite outings, SPOA meetings, and in person meetings with case managers and Family Peer Advocates. The SPOA committee continued host meetings virtually the first Thursday of every month dedicated to a census update and utilization review. The working committee continued to include representatives from the 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 continued 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.

In the Beginning of 2019, Home and Community Based Waiver joined the Health Home arena. This continued throughout 2020. The 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).

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 2020, 48 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. Respite services looked a little different in 2020 due to not being able to safely take children out of the homes and restrictions on face-to-face meetings. Respite workers became very creative during that time, using different virtual platforms to check-in with the children, play games, and still provide a source of social interaction.

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 2020, we used 93 of them to serve 10 different children. We

believe that 100% of them would have been used, as they were in 2019, if COVID-19 had not affected the number of available homes and people's comfortability with opening their homes during a pandemic.

In 2019 Greene County Mental Health through MHA 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 2020, the Family Peer Advocate had a caseload of 30. In the beginning of 2020, Greene County Mental Health through MHA was able to employ a second full-time Family Peer Advocate. At the end of November 2020, the second Family Peer advocate had a caseload of 9. She then transferred to another position beginning December 2020.

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 2020, 2 referrals were made to Community Residences and 1 was made to a residential treatment facility.

In 2020, the SPOA committee met in person for the beginning months of January, February, and March and continued to meet virtually on the first Thursday of the months following. The committee did not continue meeting on the third Thursday of the month as they had in previous years. This decision was made partly due to the COVID-19 restrictions and partially because it was deemed more effective to have family meetings as necessary on an open schedule instead of confining them to a certain day of the month. This provided flexibility during a time where in-person meetings were not allowed, schools continued to open and close, and much communication was happening over the phone or through video. In 2020, 3 family meetings were held in person and 9 happened virtually, focusing on current issues the child was facing, treatment plan reviews, and discharge planning from community residences. The SPOA committee held 3 in person and 9 virtual census and utilization review meetings for a total of 6 in person meetings and 18 virtual meetings.

Referrals for case management and family peer support came from many different sources including Mental Health Clinics, local school districts, Greene County Youth Bureau, Greene County Department of Social Services and Psychiatric Hospitals. Case management continues to be the most utilized resource in the county for children and families. There were 57 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 (30), and Mental Health Association Respite (18) (which currently has a wait list of 16 children.

	2016	**2017**	**2018**	**2019**	**2020**
Initial SPOA meetings	58	75	60	54	12
SPOA Reviews	13	8	3	7	0
Referrals to Case Management	49	61	60	54	57
Referrals to Waiver	12	6	3	N/A	N/A
Referrals to Family Peer Advocate	40	41	29	39	30
Referrals to Respite	10	19	21	26	18

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 2019 was completed by the Director of Community Services and CSB Co-Chair in collaboration with the Community Services Board and submitted in June 2019 for the plan year 2020.

While the subcommittees and CSB continued to meet in 2020, no formal local services plan was required for counties due to the ongoing COVID-19 pandemic. Priority focus was on meeting the needs of those populations served while navigating benefits and challenges of telehealth services and ensuring access to care.