Greene County Mental Health Center

905 GREENE COUNTY OFFICE BUILDING
CAIRO, NY 12413

2022 Annual Report

Prepared by: Jason Fredenberg, Psy.D.,
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.

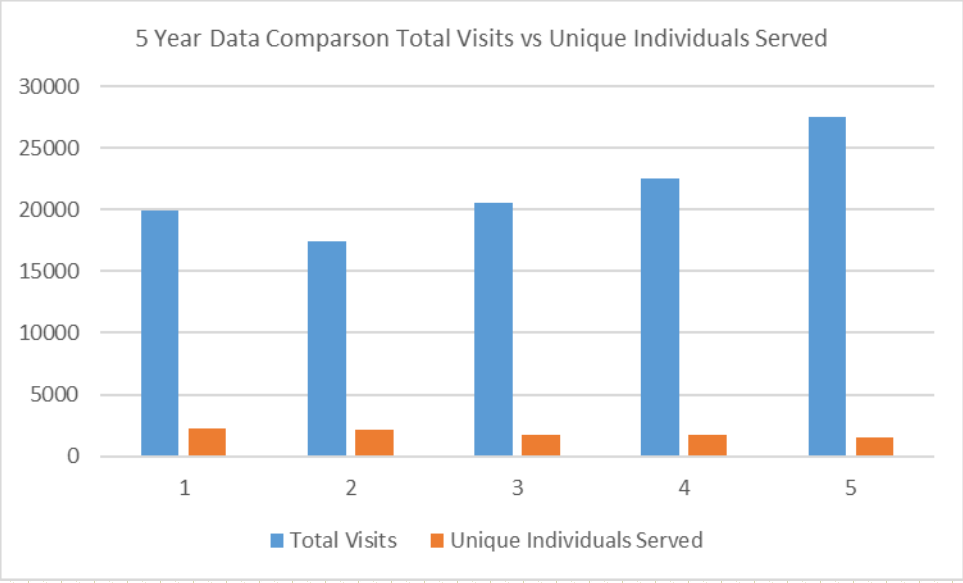
CENSUS INFORMATION

Over the course of 2022, Greene County Mental Health Center (GCMHC) served a total of 1,536 unique individual clients; 1,146 Adults and 390 Children & Adolescents. We provided 27,481 billable direct service contacts to 879 Females, 655 Males and 3 identifying as Other.

5 Year Census Data Comparison

2018	2019	2020	2021	2022
Total Visits – 19,878	Total Visits- 17,443	Total Visits- 20,579	Total Visits- 22,547	Total Visits- 27,481
Adults – 14,292	Adults – 12,107	Adults – 13,655	Adults-16,548	Adults-19,745
Children – 5,586	Children – 5,336	Children – 6,924	Children-5,999	Children-7,736
Total Unique Individuals Served 2,222	Total Unique Individuals Served 2,115	Total Unique Individuals Served 1,679	Total Unique Individuals Served 1,720	Total Unique Individuals Served 1,536
Male 46.17%	Male 46.44%	Male 44.18%	Male 42.85%	Male 42.62%
Female 53.83%	Female 53.56%	Female 55.82%	Female 57.15%	Female 57.19%
Unrecorded	Unrecorded	Unrecorded	Unrecorded	Other 0.20%
Adults 71.24%	Adults 69.4%	Adults 75.5%	Adults 71%	Adults 74.61%
Children 30.6%	Children 28.76%	Children 24.5%	Children 29%	Children 25.39%

5 Year Data Comparison Total Visits Vs Unique Individuals Served



EVALUTION OF 2022 GOALS

Adapt to the new world of service provision after the height of the COVID-19 pandemic

It is well known that the COVID-19 pandemic transformed healthcare in countless ways. One of the changes that most impacted Greene County Mental Health has been the new ability to provide remote services via telephone or video-based telehealth. Telehealth services allow for either the client and/or the healthcare provider to be at locations other than the clinic itself. This has provided numerous advantages over the past few years.

Historically, transportation limitations throughout the county have been a significant barrier for residents to access care. Likewise, severe winter weather has also been a barrier. Having the ability to provide telehealth services, which is now permanently part of our operating license, has helped to transcend these barriers.

At the close of 2022, roughly two-thirds of our services were still being provided remotely. However, at that time, we were beginning to see a gradual decrease in those remote services, thus suggesting that our clients are moving in the direction of preferring in-person services instead. Having never been in this situation before, we have no way of knowing for certain what the future will hold with regards to the demand for telehealth services, but we do expect it to be here to some degree well into the future.

Continue to address the Opiate Epidemic

Greene County continues to be one of the hardest hit counties in New York State with regards to the Opiate Epidemic and overdose deaths from opiates. Over the past few years, Greene County Mental Health has spearheaded various initiatives while hosting the Healing Communities Study, which is a large scale federal study through Columbia University. Some of those initiatives included expanding Medication Assisted Treatment (MAT) in the county, establishing an Opioid Court, expanding the use of Certified Peer Recovery Advocates (CRPA's), and other initiatives and collaborations between agencies. Throughout 2022, these efforts have continued and work was done to help sustain them to continue addressing this ongoing concern. As the Opiate Epidemic continues to rage and impact Greene County, we will continue these and other efforts to continue to address this ongoing issue.

Staff Retention and Development

Like many other industries, the mental health field has struggled with staff retention and development since the pandemic. The industry as a whole has had difficulty finding worthy applicants for vacant positions and many clinics, hospitals, and services across the state have struggled to find adequate staffing.
Over the past few years, Greene County Mental Health has also struggled with staffing but by the close of 2022, we were almost fully staffed. We entered 2023 with only one clinical vacancy and one support staff vacancy.

We believe one thing that has helped us retain and rebuild our staff has been our flexible schedule and the hybrid nature of some of our work. Our hope is that this will continue into the future and we will be able to attract and retain a motivated and highly skilled workforce to provide our valuable services.

Expansion of Peer to Peer Mental Health Services for Veterans

The Dwyer Program provides non-clinical support by Veterans to other Veterans. The support by these Veteran peers helps provide resources and connections to community organizations as well as assists those in need of reintegration support. The program will help engage not only veterans but also their spouses and families. Greene County received its first DWYER Fund award of $100,000 in the 2022-2023 NYS Fiscal Year. Greene County Mental Health and Greene County Veteran's Agency worked diligently throughout early to mid-2022 to get The Dwyer Program off the ground and contracted to Hudson Valley National Center for Veteran Reintegration (HVNCVR), hosting a grand opening ceremony to the public On September 27th. From September 1, 2022 thru December 31, 2022, the HVNCVR staff attended 10 community events and 5 inter-agencies trainings.

Despite being a brand new program with, peer to peer contacts in the three month period have exceeded 107 contacts and 2 additional Individual services were provided to family and collateral contacts in the form of emotional support and education/information. The HVNCVR Vet-2-Vet Program Operates from the Cairo, NY office location which is centrally located in rural Greene County and co-located in a county owned office building. Their team is constructed of one full-time Program Manager who is also a peer specialist along with two part-time peer specialists. In addition to providing the peer-to-peer services at the office site the staff also travels to Veterans residing in the three assisting living homes in Catskill as well.

2023 GOALS

Continue to adapt the provision of mental health services to the changing needs of our community

The impact of the COVID-19 pandemic on the provision of mental health services was significant in that it broke the mold of typical treatment. This is mostly related to the provision of telehealth services, which has proven to be very effective and productive over the past few years. Currently, we are seeing fluctuations with regards to the needs and demand of our clients regarding in-person versus telehealth options. It is likely that these changing needs will require us to continue to be nimble and adaptive in our provision of services. By doing so, this brings on other needs in the way of Information Technology for our building and the services we provide. We will continue to monitor and revise these services as indicated to meet these needs.

Ongoing Focus on Workforce Retention and Development

Because the workforce shortage has had such a profound impact on the provision of mental health services across the state, this will continue to be a priority focus for us. We will strive to maintain our current professional staff and to find ways to retain them while also fostering their development and warding off any burnout. This is an ongoing challenge that is of utmost importance since, without a skilled and effective staff, we cannot provide the services we are responsible for. So this will remain a priority focus for us well into the future.

Continue to address the Opioid Epidemic

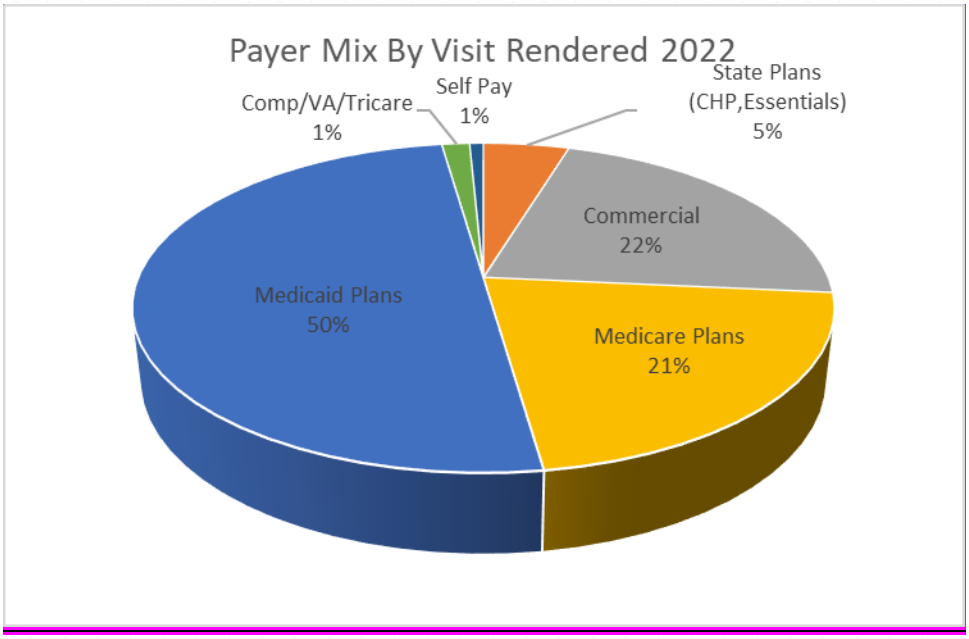
The Opioid Epidemic has had a devastating impact on our community and, despite our best efforts and new initiatives, it continues to remain a significant public health hazard. Greene County Mental Health, along with Greene County Public Health, have led the charge with this in the County. Greene County Mental Health has expanded some of its services and has also worked with other agencies in the community in efforts to establish a reliable network of services to help address this issue. This will remain a goal and at the forefront of our work into the future.

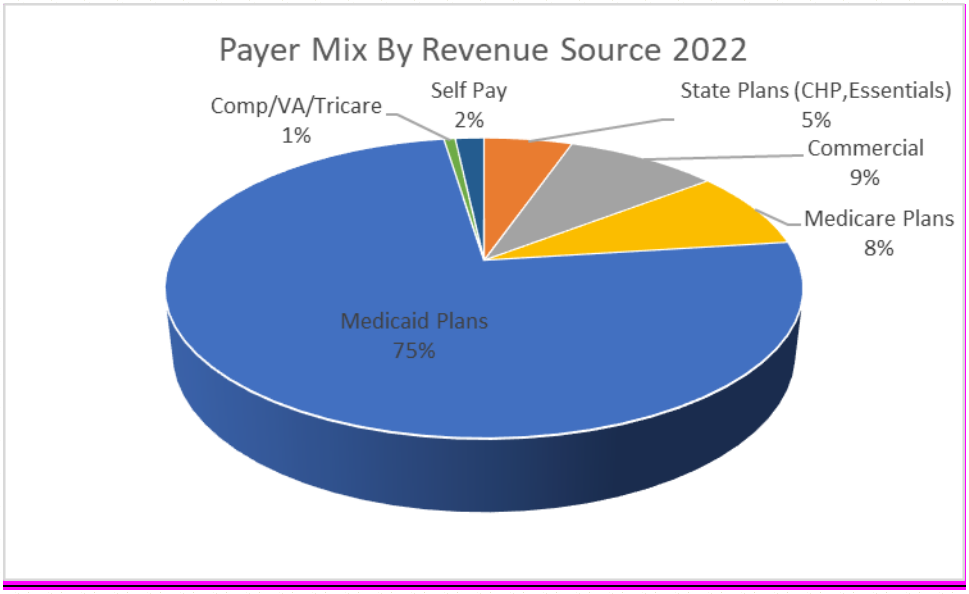
Fiscal Developments

The Mental Health Department is still continuing to evolve in many ways since the end of DSRIP and throughout the Public Health Emergency brought on by COVID-19 as well as the Opioid Epidemic 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. All staff have remained diligent in their efforts to remain efficient and productive during these trying times. In 2022, the overall department's estimated cost to the county was $234,605 approximately $646,091 below our anticipated budgeted cost. Many factors attributed to the department falling under budget which included, an increase in Medicaid Rates for clinic based services rendered, increase in productivity, and a decrease in CPL730 Commitments expense.

While we didn't see an increase in unique individuals served, likely due to the months where we were at critical staffing shortage levels and had to hold back on new admissions, we did maintain our current caseloads and also furnished nearly 5,000 more services to our clients then we did in 2021. 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. With the permanent implementation of telehealth in our OMH license we will have the ability to maintain this flexibility in the future and by doing so we can continue to engage well with our clients and meet the needs of our community where ever they may need to be served either in-person at one of our multiple locations or in their homes via telehealth.

Payer Mix by Patient vs. Revenue Received





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.

In April 2021 the initiative was again rolled out to clinics with an emphasis first on expanding telehealth capacity and securing permanent administrative approval from the NYS Office of Mental health for telehealth which Greene County Mental Health had preemptively done in July of 2020.

The Opiate Use Disorder Clinical Quality Initiative aligns with and prepares Greene County Mental Health to enhance services to those with mental health and substance use disorder as the NYS Office of Mental Health and the NYS Offices of Addiction Services and Supports move toward an integrated care model to treat the most vulnerable high risk population in Greene County.

As of December 2022, the Greene County Mental Health Clinic had met all of the requirements set forth for the initiative, however continues to participate in meeting with The Office of Mental Health to ensure best practices continue.

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, however these have greatly reduced with the addition of increased monthly Quality Assurance reviews and a dedicated QA staff member.

Returned funds have been mainly due to time sensitive required documentation and 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.

As in 2021, in 2022 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.

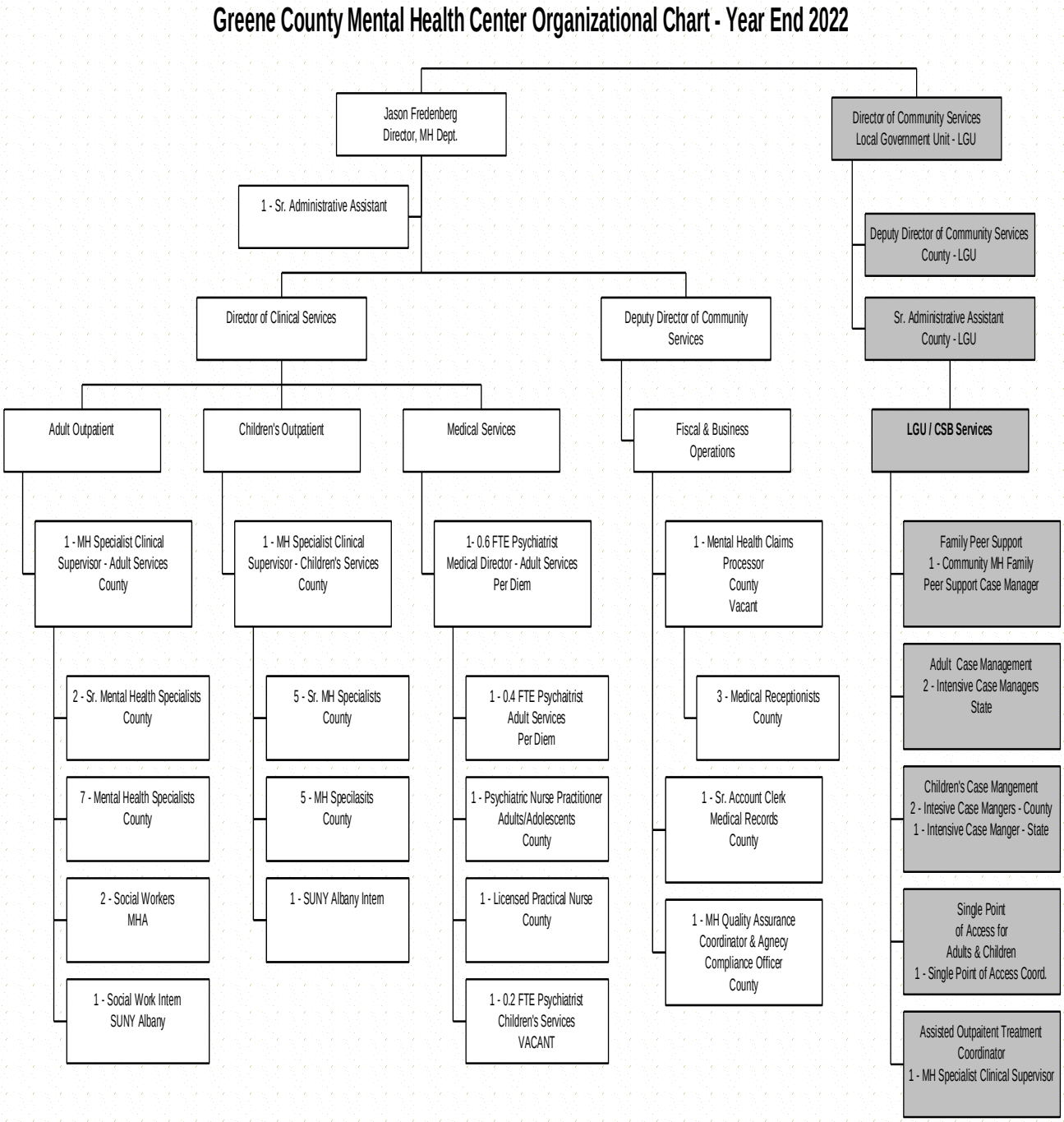
Staffing News

Greene County Mental Health Center experienced several staffing changes during 2022. In February we welcomed the addition of a Psychiatric Nurse Practitioner who prescribes for adults as well as adolescents. On the social work side we saw 2 Mental Health Specialists drop from full time to per diem status and the full resignation of a social worker sub-contracted through MHA. Between August and September we hired 3 new Mental Health Specialists, 2 of who were our former interns from SUNY Albany who recently obtained their licenses. A vacant Medical Receptionist position was filled in February, and in October we saw the resignation of our Mental Health Claims Processor.

Our 3 SUNY Albany interns completed their clinical experience in May and in September we welcomed 2 new student interns from the Masters in Social Work Program. They will be with us until May 2023. GCMHC also hosted several students from Columbia Greene Community College's Nursing program for their rotation through mental health services and one from intern the Human Services program.

A staffing challenge GCMHC continues to experience 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. We also have seen many social workers leave to start their own private practices in the community.

Staff Organizational Chart



Staff Trainings

During the course of 2022 employees took part in in-house staff development trainings, mandated County trainings, outside educational opportunities. Opportunities for in person trainings remained limited due to COVID restrictions and the new found ease of web-based trainings.

In House Staff Development & In-Services included the following topics: Recognizing Racial Stigma and Opportunities to Change, Corporate Compliance, FEMA – Intro to Incident Management, and Transforming Trauma the Roots of Addiction.

County Mandated/Offered Trainings included: Workplace Violence, Workplace Bullying & Violence Prevention, NYS Discrimination and Harassment, Sexual Harassment, Lockdown/Active Shooter with a Simulation, and Stop the Bleed Training.

Outside Educational Training Opportunities that were taken advantage of included: Animal-Assisted Interventions and the Range of Therapeutic Benefits, Changing Landscape of Treatment Courts, Social Anxiety & Perfectionism, Trauma Informed Compassionate Classrooms and Strategies for Schools and Other Settings, Threat Assessment and Management Basics, DBT Certification Training, Cognitive Processing Therapy, and Gaming Disorder Training.

ADULT SERVICES

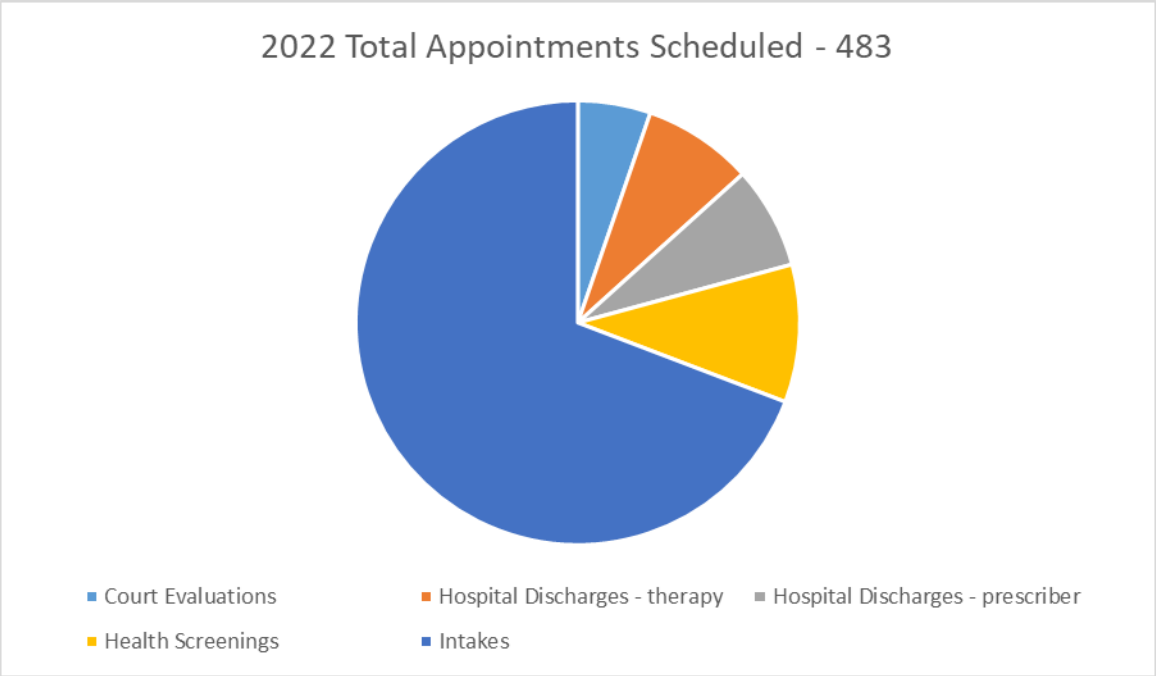
Adult Intakes

When the clinic closed to in-person clients in March 2020, the intake process had to transition quickly to a more set schedule of telehealth appointments as opposed to walk-in hours held in the previous years. 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 intake process. Some client were given 4-6 appointments 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 clinic staff every few weeks to make sure they were stable and still interested in services.

As the regulations changed and need progressed, the intake process was changed once more. Beginning in June 2021 and throughout the rest of the year there became options for both in-person and telehealth appointments. Instead of staying within the confining hours and days of prior years, each adult therapist gave at least one slot across the week in which an intake could be scheduled and indicated whether they would be in person at the clinic or remote. These clients were tracked through their intake appointment, an appointment to complete a treatment plan and then placed on the waitlist to be assigned to a permanent therapist. This allowed clients to still be assessed in a timely manner and much more flexibility.

The clinic continued to experience a staffing shortage and a continued influx of need. In the summer of 2022, the clinic stopped scheduling the usual amount of intake appointments for both adults and children. During this time, new clients would call the intake line, leave a message with their information and would be placed in a queue for a call back to schedule as appointments and availability opened up. The intake line was checked daily and calls were screened for acuity, need and were given outside referral information when appropriate. Hospital follow-ups, discharges from jails and prison, high-risk cases, and court evaluations were all still scheduled in a timely manner. This change shortened the wait time between a client's first intake appointment and their assignment to a permanent therapist. Intake appointments were then booked week by week which exponentially helped the attendance of appointments as well as long-term engagement.

Total scheduled appointments for the intake process in 2022 included: 483 first time new intake appointments, 37 court evaluations, 56 new hospital discharges scheduled with a therapist, 52 new client hospital discharges were scheduled to meet with a prescriber and 70 Health Screenings were performed. This equates to a total of 698 appointments scheduled through the intake program. Out of these 698 total appointments, 123 were marked as "no show" and 251 were marked as "canceled," and 97 were "rescheduled," leaving 227 appointments attended. Unfortunately, there is no way in 2022 to differentiate between which type these "no-show," "rescheduled," and "canceled" appointments fall under.



Health Screening occur 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. This service is billable, bringing additional revenue to the clinic. 70 Health Screenings were able to be performed in 2022 compared to 101 in 2021.

In 2023, it is the clinic's goal to be able to schedule the regular number of intake appointments and have clients assigned to their permanent therapist directly upon completion of the intake process with little to no wait times. The clinic continues to work on staff retention, client engagement and appointment attendance.

Insight-Oriented Psychotherapy/Supportive Counseling

Adult therapists assess and treat individuals who are age 18+. Our first client contacts typically begin with an intake assessment and a follow-up appointment to complete a treatment plan. 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 build on the treatment plan established from the intake process. This treatment plan is updated and reviewed as needed/desired. The 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. 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-based trauma treatment. In 2020 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 clinical issues that arise. 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.

Due to the pandemic, our therapists and psychiatry staff became rapidly acquainted with using telehealth services as a means to provide services for our clients. 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 clinic continues to offer telehealth clinic services but we are presently and steadily increasing our in-person visits. Whenever possible, our intakes are conducted in-person at the clinic.

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

With COVID-19 restrictions being lifted, we have more groups that are either starting or in progress at the clinic:

Smoking Cessation Group - A co-ed adult psychoeducational group that focuses on assisting individuals with support in their efforts to quit using tobacco products. The curriculum includes information about nicotine dependence, options to assist in clients' efforts to quit, and promote support from others who are also trying to quit their use of tobacco products. This group is appropriate for 6-10 participants. It is held weekly for 8 weeks and new members can join at any point in the curriculum. This group is facilitated by a nurse.

Women's Group- A psychotherapy group for adult women 18 + years. The group is designed to support women in their efforts to cope with daily stressors and build healthy relationships. It is offered weekly and remains open for those who wish to join while the group is in progress. It is facilitated by a social worker and a nurse.

Heathy Relationships Group- A Co-ed group focusing on communication, copings skills, and improving relationships. This group will be facilitated by a social worker and is currently pending approval to start.

Medication Management- Psychiatry Services

In 2022, the clinic continued to serve adults and teens in need of medication management and was able to maintain these services both in person and via telehealth. Psychiatric prescriber services for children ages 5-14 continued to see an increase in demand while recruitment of this specialty remains severely understaff throughout the state. The clinic was able to partner and build community relationships with private providers in the region to ensure access to medication management for this population.

The clinic employs one full time Psychiatric Nurse Practitioner (35 hours per week) and two part time contracted Psychiatrists (up to 40 hours per week combined). In total, they provide medication management services to approximately 500 clinic clients.

There continues to be a large demand for medication evaluation and medication management across all age groups 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 clinic'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. Prescribers also continue to offer consultation services to area Primary Care offices.

MOUD – Medication for Opiate Use Disorder

As part of the PSYCKES Clinical Quality Improvement Initiative and in conjunction with the Columbia University "Healing Community Studies" grant, in an effort to reduce opiate overdose deaths, the clinic continued into 2022 working closely with Greene County Family Planning to treat those struggling with the disease of addiction by provide MOUD services in conjunction with psychotherapy to this highly vulnerable population. This process continues to be a well-coordinated and efficient effort with regular collaboration by both departments.

The clinic also was able to strengthen collaboration and interagency referrals community substance abuse treatment providers in the community, while reducing duplication of services in an effort to engage those individuals in treatment with both agencies and reduce the risk of disengagement from treatment by eliminating barriers to treatment with multiple providers.

In 2022, the clinic provided MOUD services to 11 unique individuals, with a slight decrease noted from 2021 due to a staffing change in Psychiatric Nurse Practitioners.

The clinic also operates a New York State Department of Health Opiate Overdose Prevention Program which provides Narcan kits and Fentanyl test strips to clients, families, and community members.

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 2022 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 we remain 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.

It is uncertain if these Columbia Memorial Health run offices will be willing to have the GCMHC CHIP program staffed in the future or if the satellites will need to be officially closed through OMH.

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. This year, the law was updated to include a statute that if a client is re-hospitalized within 6 months after being discharged from AOT status, they can be placed back on an AOT. In 2022, there was one Greene County resident released from prison on an AOT status. 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.

Many of these AOT clients have co-occurring diagnoses, severe mental illness and substance use disorder. Eight (8) of the eleven (11) 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 continuing/worsening 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 eighteen (118), Greene County residents have been referred to the AOT program. In 2022, twelve (12) new/renewed AOT orders were issued. Currently there are eleven (11) clients on active AOT status.

Assisted Outpatient Treatment Statistics	2017	2018	2019	2020	2021	2022
New AOT Orders Issued	7	10	5	7	7	12
Moved to Enhanced Status	1	2	1	0	1	2
Discharged from Enhanced	1	1	1	0	0	1
Active AOT Status	11	18	15	15	14	12
Active Enhanced Status	2	1	0	0	2	3
Pick Up Order Issued due to Non-Compliance	10	14	12	9	16	12

Forensic and Family Court Services

GCMH continues to provide follow-up services for inmates upon release from the Greene County Jail and New York State Department of Corrections. In 2021, in response to a growing need for increased collaboration between agencies and in attempt to reduce the risk of released individuals becoming lost in transition, Greene County Mental Health dedicated a staff member to coordinate these follow up services.

We also continue to provide Court Ordered Mental Health Evaluations for individuals incarcerated in the Greene County Jail as ordered by the courts.

Greene County Mental Health continues to provide succinct mental health evaluations to Greene County Family and Criminal Courts 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 and criminal court proceedings.

In 2022 a total of 19 Criminal and Family Court Mental Health Evaluations were completed at the request of the courts.

Additionally we continued to provide 730 Criminal Procedure Law (C.P.L) competency examinations as ordered by the courts in criminal procedures. In 2022 nine individuals were seen by psychiatry staff for this specific exam. This is an increase from three 730 CPL examinations in 2021

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 GCMHC, 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 2022, the Greene County Drug Treatment Court expanded to include an Opioid Intervention Court. Effectively treating opioid use disorder (OUD) and preventing overdose requires a collaborative approach across systems. Opioid Courts have become an opportunity to address this public health crisis and prevent overdose deaths by rapidly linking participants to evidence-based treatment including Medication for Addiction Treatment (MAT) and other recovery support services. In Intervention Court, mental health services are offered, but not required as part of this program.

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 2022 no additional representative supports were requested from other community agencies or entities other than those listed above.

With 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 and Community Action of Greene County continued to increase dramatically as there continues to be little to no movement among the SPOA housing programs.

2022 saw a decrease in housing referrals due to the severe lack of openings in all of the housing programs. The majority of referrals still came from the Columbia Memorial Hospital Psychiatric Inpatient Unit. Interviews by the SPOA Housing Committee 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. Almost all interviews in 2020 took place virtually and there were only a few tours were given. In 2021 and 2022, most of the interviews were done in person again when location and restrictions allowed. Organizational and tracking measures continued for both years, 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 2022.

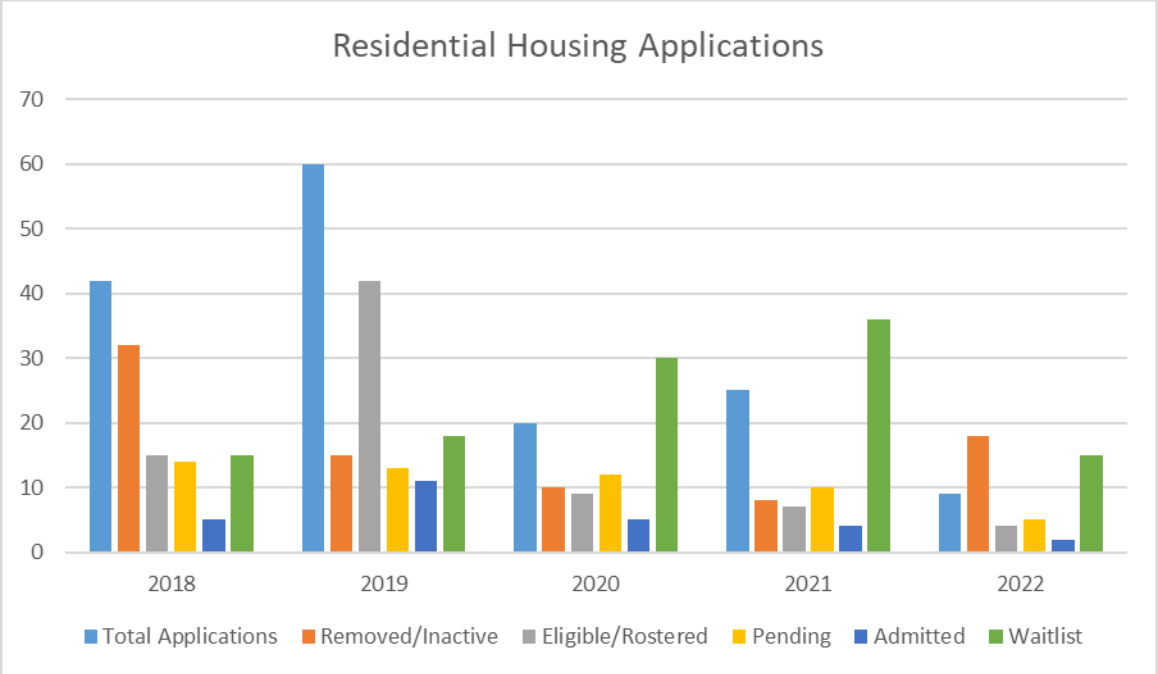
Residential Services

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.

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. SHUD has forty-five (45) beds with nine (9) of them dedicated to people coming out of a hospital or prison. Due to the increase of rent prices in Greene County in 2021, some of the apartments are so expensive that they take up the funding for two (2) spaces. All recipients of a SHUD grant must also demonstrate eligibility with a psychiatric disability.

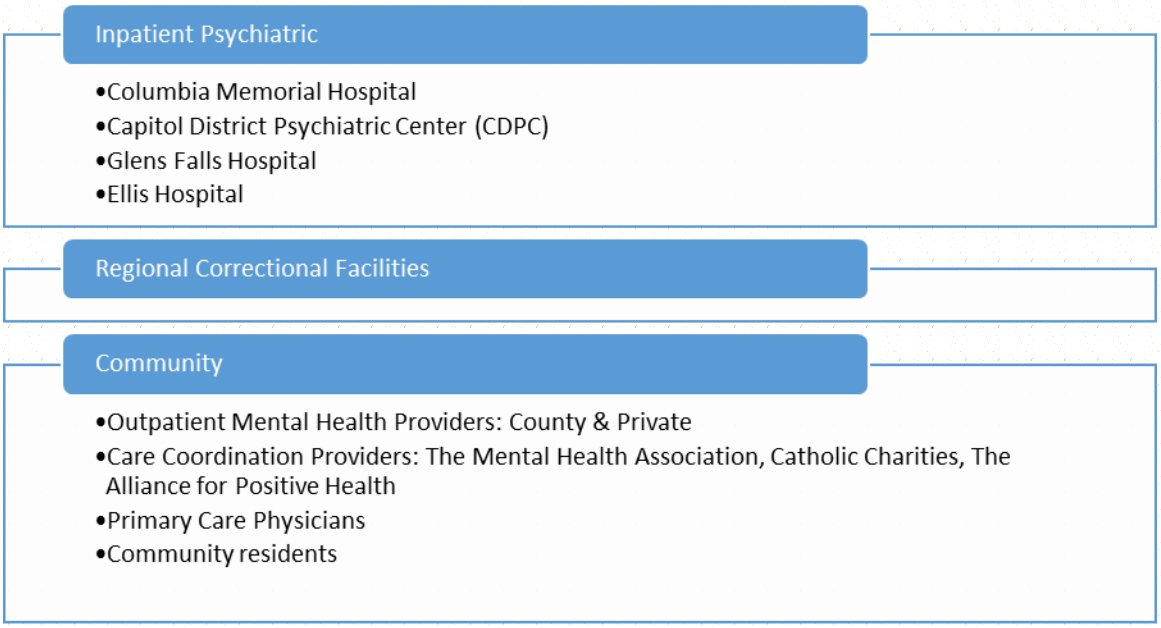


Residential Applications	**2018**	**2019**	**2020**	**2021**	**2022**
Total applications	42	60	20	25	9
Removed/Inactive	32	15	10	8	18
Eligible/rostered	15	42	9	7	4
Pending	14	13	12	10	5
Admitted	5	11	5	4	2
Wait List	15	18	30	36	15

There may appear to be a discrepancy between number of applications eligible, the number admitted and the number remaining rostered to the waitlist. This is due to (1) while an individual may be deemed eligible for the service, while awaiting an available placement the life circumstances and residential needs may have changed. Clients were removed from the Wait List as a result of moving out of the county, incarceration, moving in with a significant other or other family member, death; (2) some individuals on the wait list from 2021 were placed in housing in 2022; (3) individuals are carried over from other years; (4) internal moves occur within each residential program that are not tracked here.

In 2022, the removed/inactive referrals increased quite a bit due to the amount of referrals made for individuals who, when contacted, were not interested in the housing programs.

Applications are received primarily, but not limited to, 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, illicit drug use 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.

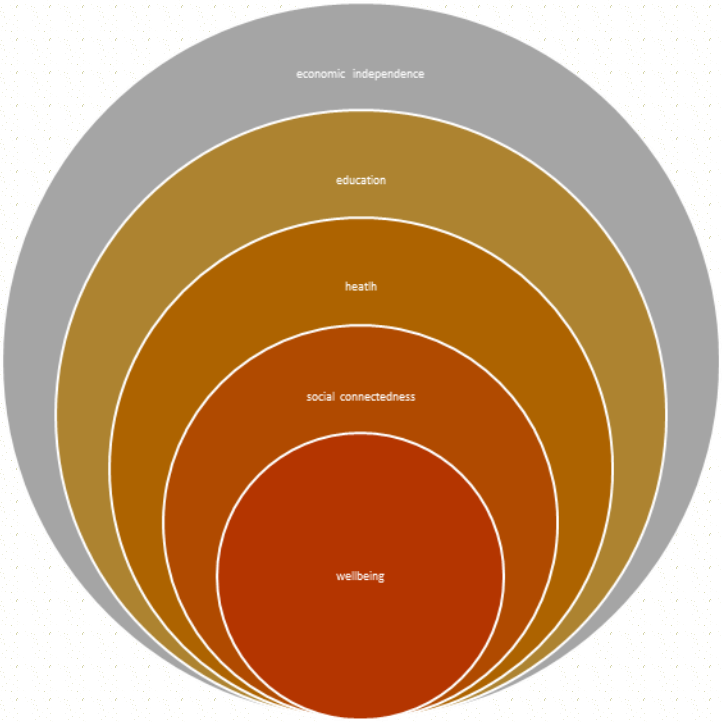
There remains a growing need for **permanent supervised housing** that transitions to permanent independent housing for individuals age 18 – 24 years old transitioning from residential or foster placements, or are no longer able to reside with family. This subset of clients requires permanent safe housing 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. High utilizers of services can be eligible for the Health Home Plus services, which allows for a care coordinator to have billable increased contact with a client to provide the higher level of needed services.

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 aka Foothold and all data/charts were migrated to Relevant aka Foothold. A total of 29 Active Enrolled clients (7 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 2022, The Mental Health Association of Columbia-Greene Counties employed a team of 14, which included their Director, Assistant Director, one Enrollment Care Coordinator, and eleven Care Coordinators. The average caseloads for Care Coordinators are 30-40 people depending on need. The Director, Assistant Director and Enrollment Care Coordinator carry 10-12 clients as well. In 2022, the total amount of Greene County clients served was 327 with 25 being Health Homes Plus and/or AOT and 6 Non-Medicaid clients. The Mental Health Association reports a decline in census due to a pause in enrollments from a staffing shortage and high turnover rate. They experienced 8 staff members leaving in 2022.

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 care coordination referrals received in 2022 compared to the ones in 2021. As time continues, more and more hospitals and inpatient facilities have begun referring directly through MHA and bypassing the SPOA process. This has led to the numbers in the chart decreasing, but the numbers in the prior paragraphs to be more accurately representative of the care coordination program.

Care Coordination Referrals 2021 vs. 2022

	2021				2022		
Month	**# of referrals**	**Enrolled**	**Inactive**		**# of referrals**	**Enrolled**	**Inactive**
Jan	3	3					
Feb	2	2			2	2	
March					4	3	1
April	2	1	1				
May	2	1	1				
June					3	3	
July	4	3	1				
Aug					1	1	
Sept	2	2			2	2	
Oct	3	2	1				
Nov	1	1					
Dec	1	1					
Total:	20	16	4		12	11	1

CHILDREN'S SERVICES

Child and Family Services

This past year, the Children's Team at GCMH has continued to provide responsive and comprehensive treatment to the children and families of Greene County. Our team of experienced children's therapists, case managers, 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, via telehealth, in the home, and in school satellite offices.

In 2022, providers continued to address the ongoing impact of the COVID-19 pandemic, with an increased demand for mental health services at all levels. This high need was paired with widespread staffing shortages in the field. Despite limited resources, the children's team continued to provide service to high risk clients and those returning from a higher level of care throughout the year. A temporary pause on incoming intakes in the spring/summer of 2022 allowed the team to manage established caseloads, and reorganize for upcoming staffing changes. This period of time was also helpful in maintaining staff morale and quality of care. School base staff continued to accept referrals during this time, and clinic based staff were able to resume scheduling intakes by the fall of 2022.

The clinic has maintained a hybrid model of service delivery which has allowed for continued remote services through video and phone to accommodate the needs of clients. While many children and families have opted to return to clinic based therapy, others have responded well to the option for virtual sessions. In a rural county with limited transportation and economic struggle, the clinic has found that flexibility in this area has improved engagement and productivity. Our school based workers have remained in the school setting throughout the year, including summer months, also improving access to a much needed service for many Greene County students.

Initiating Children's Clinical Services at GCMH

Parents may start the intake process by calling the clinic, completing required intake paperwork, and then completing a triage with the intake coordinator. This is consistent with both clinic based, and school based services. The coordinator will then schedule an in initial assessment with a therapist depending on acuity, school district, and staff availability. Children's intake assessments are scheduled in advance and a legal guardian is required to participate and provide active consent for services. 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 emergency services including the Mobile Crisis Assessment Team (MCAT) or the ER.

Our children's therapists complete a thorough bio-psychosocial assessment including clinical diagnosis and treatment recommendations. This past year, the children's team has moved towards a 2 appointment intake assessment. This allows more time to engage a family and to gather necessary information to determine treatment needs. Our clinic does it's best to minimize wait times for intake and assignment. Average wait time for an intake appointment with a children's therapist is a month or less, with a wait for assignment 1-3 weeks depending on acuity. This is well below industry standard.

Referral sources may include:

- Parents
- ER/Inpatient Programs

- Primary Care Offices
- School Staff
- Pre-PINS or Probation
- Department of Social Services
- MCAT

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

Referral reasons: in 2022 the majority of new referrals concerned the following issues:

- Anxiety
- Depression
- Behavioral Difficulties
- Attention Issues
- Adjustment/Family Disruption
- School avoidance

Many high risk referrals indicated concerns about self-harm/cutting, suicidal thoughts, 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.

While the COVID-19 pandemic has improved, many children and families are still struggling to adjust back to routine. Many clients have exhibited anxiety and other behaviors related to a period of isolation, remote schooling, and lack of access to normal outlets and social supports. Our children's therapists continue to be mindful of the challenges of the last few years. They engage in regular clinical discussions about changing needs and creative ways to both engage and support children through this difficult time. While remote sessions are challenging with certain age groups and clinical presentations, therapists have been meeting clients where they are at, prioritizing in person appointments for those who need them, and linking families with additional resources.

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 trauma informed, 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
- Child Protective Services

- Prevention/PINS Diversion
- Pre-PINS/Youth Bureau
- In-Patient/Partial Hospital Programs
- Probation
- Respite Services
- Family Support Worker

At any given time, the children's team serves anywhere from **350-400** active clients. Several children's team therapists also see adult clients, primarily transitional age youth. This blend is reflected in the number above. Full time children's therapists carry a caseload of **45-50** clients depending on acuity.

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 2020-2021 school year include:

- Windham/Ashland/Jewett school district 2 days per week
- Cairo/Durham Middle/High School 4 days per week
- Cairo Elementary 3 days per week
- Hunter Tannersville Central Schools 3 days per week
- Coxsackie Athens High School (grades 9-12) 4 days per week
- Coxsackie Athens Middle School (grades 5-8th) 4 days per week
- Coxsackie Elementary School (grades K-4) 3 days per week

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.

Child and Adolescent Medication Management

In 2022, the Children's Team was happy to welcome a new Psychiatric Nurse Practitioner with experience in treating children 5 and up. This prescriber now oversees medication management for many of the higher need youth seen at the clinic. 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

Greene County Mental Health employs 2 full time Health Home Care Managers. The county contracts with CHHUNY (Children's Health Home of Upstate New York) for documentation and billing of these services. 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. She tends to serve non-Medicaid referrals when possible.

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.

This past year, SPOA has received a steady flow of children's case management referrals and clinic case managers have had full caseloads much of the year, often referring overflow to outside agencies. Case managers have reported a continued high incidence of family crisis, lack of resources, referral to higher level of care (hospitalization, placement, etc.), and need for specialized evaluation (psychological, Autism Spectrum, etc.) Case Managers continue to work hard to fill gaps in access to programming, services, basic needs for the families they support.

Family Support

GCMHC 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

Our family support worker continues to bill Medicaid for services under CFTSS (Child and Family Treatment and Support Services) as part of the Children's Medicaid redesign. She also carries a small caseload of non-Medicaid clients. This year, our family support worker has continue to engage the community by offering trainings and outreach as needed to schools, at events, and collateral agencies.

School Avoidance Task Force/At Risk Youth Task Force

In 2022 the clinic resumed facilitation of the At Risk Youth Task Force, a multidisciplinary team which started in 2017 to address school avoidance in Greene County as well as other presenting issues. This task force has shifted over time to address a broader range of at risk youth and community concerns. This meeting is attended by representatives from Greene County School districts and community providers. It is a forum to discuss a range of topics 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. This year the Task Force has met every other month and focused on new and changing community resources.

Children's Team Staffing

- In 2022, the clinic currently employed 2 clinic-based therapists and 7 school-based therapists. While the clinic struggled with staffing in the first half of 2022, the children's team was pleased to fill 2 school based positions (one vacated, one new) over the summer, meeting the need of children seeking services at the start of the school year.

- In 2022 the children's team was excited to welcome a new Psychiatric NP experienced in treating children ages 5+. This is an ongoing need the clinic is seeking to meet in the community.

- The clinic employs 2 full time Health Home Care Managers and has 1 part time State employed Health Home Case Manager shared with Schoharie County.

- 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 a majority of the children's therapists, the children's Care Managers, and clinical supervision for the 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.

- In 2022 the children's team has hosted SUNY Albany MSW interns across two academic years.

In-services/Trainings

Representatives from the Greene County Children's team have offered formal and informal supports to the community in a variety of settings. 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 as well as in person.

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 children, 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 maintained a strong 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. As the state and county continued to monitor the pandemic throughout 2021, respite outings and family sessions with case managers and Family Peer Advocates were able to begin in person again with the proper safety precautions. Throughout 2022, all of the services SPOA provides were able to work in a hybrid model in order to serve the families properly around these challenges and begin to get back to pre-pandemic ways.

The SPOA committee continues to host most meetings virtually the first Thursday of every month dedicated to a census update and utilization review. At the end of 2022, one in person meeting was held and going forward, the committee plans to meet in person every other month. 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.

SPOA is encouraged to be the conduit for all care management referrals. Since 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 2021, 36 out of 45 case management referrals qualified for Health Home Case management. In 2022, 31 out of 41 case management referrals qualified.

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 and 2021 due to not always 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. All of the respite outings for 2022 were able to be held safely outside comparatively to very few face to face ones in 2020.

Overnight respite is provided through Northeast Parent and Child Society, coordinating with local therapeutic foster homes. In 2019, all of the 100 allotted nights were used. The ongoing pandemic over these past two years made it increasingly harder to find foster homes willing to take in these children. In 2022, 27 out of the allotted 100 nights were used to provide overnight respite to 7 different children. During this year, children and their families desperately needed this service but without homes to take them in, these kids stayed on the referral/waitlist for months with no movement.

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 2021, the Family Peer Advocate had a caseload of 30. Comparatively in 2022, the caseload remained around that number, as referrals were steady and ready to replace any closed cases. 20 Family Peer Advocate Referrals were received in 2022 and 15 were opened and engaged in the program.

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 CRs) and Residential Treatment Facilities (RTFs), both administered by the Office of Mental Health. In 2021, 2 referrals were made to Community Residences and 3 were made to Residential Treatment Facilities. Due to the long waitlists and lack of residences available to Greene County, concurrent referrals for the 2 children were made to 3 separate Community Residences. Comparatively in 2022, we had multiple children “step-down” from an RTF level of care to a CR. 1 new referral was made to a Community Residence and none to Residential Treatment Facilities.

In 2022, the SPOA Coordinator also began participating in regular treatment team meetings for individuals from Greene County who were placed in CRs or an RTF. In the past, SPOA was mostly included in these meetings once the facility was looking to discharge in individual back to the community. These meetings were held virtually throughout the year and gave SPOA a better idea of how to support these individuals upon discharge.

A Greene County SPOA representative continued to participate monthly in virtual statewide Children and Families Committee Meetings, quarterly in the Hudson River Children's SPOA collaboration with representatives from the Office of Mental Health, and attend periodic Systems of Care webinars.

In 2022, 5 family meetings were held virtually that included in attendance members from the Children's SPOA Committee, parents/guardians of the child, service providers from the child's school, representatives from the Department of Social Services, members of the Intensive Aftercare Prevention Program through Northern Rivers, and discharge planners from several Community Residences. The SPOA committee met virtually for 11 census and utilization review meetings, and met in person for 1, for a total of 17 meetings throughout the year.

Referrals for case management and family peer support came from many different sources including Mental Health Clinics, parents self-referring, 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 41 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 (17), and Mental Health Association Respite (8). Respite had a waitlist of 9 at the end of 2022.
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	2018	**2019**	**2020**	**2021**	**2022**
Initial SPOA meetings	60	54	12	12	12
SPOA Reviews	3	7	0	0	0
Referrals to Case Management	60	54	57	45	41
Referrals to Waiver	3	N/A	N/A	N/A	20
Referrals to Family Peer Advocate	29	39	30	17	8
Referrals to Respite	21	26	18	21	12

GREENE COUNTY 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 Addiction Services and Supports (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 2022 Local Services plan outlined three goals for the board for 2022- 2023. Most specifically these goals were:

- Advocate at the local, state, and federal level for a better understanding of the housing crisis, as it negatively impacts not only the workforce on all levels, but specifically our healthcare system and the individuals we represent in the LGU. Understanding the issues that we face, how it impacts our residents and economy and advocate for resources directly related to housing.

- Work with local government and transportation agencies to improve and expand access to transportation across the county that will allow for individuals and families to access services within the county.

- Work with local governmental, non-profit, and for profit agencies to create flexibility, hybrid work options when appropriate, and continue to advocate for high wages across all systems to attract and retain qualified staff.

The Greene County Community Services Board in 2022 formed a Nominating Committee to recruit and attract a diverse board population as membership had declined in recent years and is comprised mainly of service providers.

Priority focus continued to be on meeting the needs of those populations served while navigating benefits and challenges of telehealth services and ensuring access to care.