Greene County Mental Health Center

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Director's Report

January – December 2014

INTRODUCTION

Over the course of 2014, Greene County Mental Health Center (GCMHC) served a total of 1,866 separate individual clients: 1452 adult and 414 children; 813 male and 1,053 female. We provided 21,498 direct service contacts. Throughout the year we performed 1051 intakes: 794 adult and 257 children; 482 male and 569 female. A total of 921 clients were discharged: 730 adult and 191 children.

During 2014, GCMHC typically had a waiting list of 30-40 non-emergent clients. The average wait time from first contact with GCMHC to the time of an intake was 14.4 days in 2014. We assign emergent clients within a week and strive to not keep anyone on the waiting list for more than 30 days unless they make special requests for a specific therapist or need to meet some criteria before they can be assigned. The average wait time for non-emergent clients from the time of intake to being assigned a clinician was 20.9 days in 2014.

Evaluation of 2014 Goals

1. **Extend access and use of the Electronic Medical Record (EMR) system to the clinicians performing On-Call Emergency duties and those providing services in Greene County Jail.**

Great progress has been made in expanding the use of the EMR by on-call clinicians and those providing services in the jail. Use of the EMR remains problematic in Primary Care Offices (PCP) and periodically at the school districts where a clinician is located.

2. **Evaluating the content of clinical documentation using revised clinic standards of care that became effective May 2013 from NYS Office of Mental Health. The clinic will be audited again in the summer of 2015 using these standards.**

Ongoing, continue into 2015 as the Clinic prepares for the Office of Mental Health audit and re-certification in Summer 2015.

3. **Utilize Healthcare Navigators to facilitate enrollment of those clients who are uninsured/underinsured in the open marketplace. As of October 31st, 2013 there were 1,000 children ages 0-18 and 5,100 ages 19 and upwards in Greene County who were uninsured.**

Utilizing Healthcare Navigators and having them located at the clinic has assisted many of our clients in evaluating their insurance options and/or making changes to their current plan. Our uninsured rate dropped to 10.1% in 2014 from 15% in 2013. The use of Healthcare Navigators will continue in 2015.

2015 Goals

1. **Evaluating, diagnosing and addressing EMR issues in the satellite locations will continue in 2015. The Director of Clinical Services is in the process of scheduling a meeting that will include County IT, Columbia Memorial Hospital(CMH) IT, (majority of PCP offices are affiliates of CMH), clinicians in the satellites and Clinic Director. Addressing EMR issues and connectivity remain at the forefront so that a streamlined, efficient and fiscally prudent workflow is maintained.**

2. **Quarterly audits of clinical records to meet Corporate Compliance guidelines will undergo changes in the way the audit is conducted in 2015. These changes will incorporate utilization review criteria and quality assurance.**

3. **Develop Policy and Procedure in addressing the high "no show" appt rate at the clinic. It will include notifying clients but also charging those clients who no show.**

Corporate Compliance, Quality Assurance, and Utilization Review

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

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

In 2015, Greene County Mental Health is poised to make changes to the way in which the audits are conducted. Those changes will likely involve incorporating utilization review and/or quality assurance reviews as part of those audits. These changes are likely to be implemented in early 2015.

Collaboration with Outside Agencies

Functioning as a county clinic, Greene County Mental Health has a great deal of interaction with other agencies and providers in the county. Just some of the agencies we have the most frequent contact with are the Greene County Sherriff's Department, Greene County DSS, Greene County Probation, Mental Health Association of Columbia-Greene Counties, N.Y. State Police, Greene County District Attorney's Office and Public Defender Office, Twin County Recovery Services, and Columbia Memorial Hospital. Efforts have been made to maintain positive working relationships with all of these agencies. Many times, the clinic might be involved in any given time with multiple agencies regarding a single client.

Because many of our clients have also experienced psychiatric hospitalization at our local hospital, Columbia Memorial Hospital, it is extremely important that there are clear lines of communication and collaboration between our two agencies. The Clinical Director for Greene County Mental Health has a regular, weekly telephone appointment with the Director for Psychiatry at Columbia Memorial (CMH). It is in the weekly call that information about shared clients of our two agencies is shared to help coordinate treatment and facilitate the smooth and appropriate referrals and transitions between our two agencies. This is a development in our collaborative relationship with CMH that has been extremely beneficial to both our clients and staff.

Missed Clinic Appointments

The ability to gather better data using the new Electronic Medical Record has allowed the clinic to analyze trends and make more informed decisions regarding clinic policies and procedures. One startling finding in 2014 was the discovery that the clinic experiences missed appointments, otherwise referred to as "no shows," at the disturbing rate of anywhere from 20-30% of overall scheduled appointments per month. This is even after the clinic has instituted an automated call reminder system that calls each client for every appointment 48 hours prior to that appointment. The clinic receptionist also makes a phone call the day before to all new clients coming to clinic for an initial appointment and/or evaluation by the psychiatrist. This was a painful and disturbing discovery as there is little that can be done to productively fill or compensate for those lost hours and the associated loss of revenue.

In attempts to analyze this further, the clinic administration decided to conduct a survey of clients regarding their history and experience with No Shows. Over the course of three weeks, all clients entering the clinic were given a survey to complete anonymously. The results were collected and tabulated. The results indicated that overwhelmingly, the two most common reasons for No Shows were Transportation Problems and Illness. The results also indicated that contrary to what one might suspect of clients who No Show, the vast majority of clients indicated that they were very invested in their treatment and find it very helpful. Thus, the survey seemed to suggest that clients are invested in and benefiting from their treatment, but transportation issues and illness are contributing to the no show problem.

The administration has been considering and using these results in their attempts to combat the problem of the high No Show rate. Various ideas have been suggested, including charging for No Shows, and limiting access for clients who have many No Shows. But many of these situations are complicated and there is rarely a clear-cut response that is applicable to all situations. The administration continues to contemplate this and is poised to implement some changes in early 2015.

Fiscal Developments

The current fiscal viability of any mental health clinic across New York State is uncertain and trying due to lower rates of return for services, growing employee costs, the number of uninsured or underinsured clients and a demand for increased services. Greene County's Mental Health Center is not immune to these issues. The goal is to provide clinically relevant, fiscally prudent service, with the least amount of expense put on the tax payers.

The Greene County Mental Health fiscal department has experienced some challenges in 2014 with regards to additional decreases in reimbursement amounts from Medicaid for Ambulatory Patient Group (APG) billing, which began in early 2013 with the transition to new CPT codes per the American Medical Association (AMA) guidelines.

An ongoing concern for GCMHC is the process of enrollment of clients in the NYS Healthcare System. Despite Affordable Care Act (ACA) regulations requiring all citizens to enroll in a qualified insurance plan, many cannot afford the plans and would rather pay the fine, while others have selected plans that are out of network for many Greene County providers therefore having little utility unless the client goes to the hospital. Many others who have obtained health insurance through The Marketplace have experienced high deductibles and copayments which they are unable to afford, resulting in non-payment of the co-insurance/co-payment to the clinic.

Despite these challenges the clinic has achieved some major accomplishments in 2014 such as, continuing to engage in an open dialogue with clients who are uninsured or underinsured, and assisting them to obtain insurance coverage whether public or private. Our uninsured rate in 2013 was 15% and in 2014 has dropped to 10.1%.

Goals for 2015 will be to continue to work on getting new and existing clients insured as well as work on a more aggressive collection policy for those who are not meeting their financial obligations with the clinic. In addition, the financial department will be implementing additional billed services audit controls to ensure the timeliness of billing, proper coding and documentation supports each service rendered and billed.

Technology Developments

In 2013, Greene County Mental Health made the transition from paper medical records to Electronic Medical Records (EMR). This required a long, slow transition that is still progressing to this day. While all of our active clients now have an electronic record, all clients who were active prior to March 2013 still require their old paper records to be scanned into their new EMR. Our Medical Records Clerk has made significant progress with this, in addition to her other many responsibilities, but this process continues.

The transition to EMR has had multiple benefits to the clinic and its clients. First and foremost, it provides a more thorough medical document that allows for ease of collaboration and communication between treatment providers. This will certainly result in better and more comprehensive care for our clients while also allowing the clinicians to work much more efficiently. Further, the electronic record also allows the clinic administrators to collect and track data that we have never had the means to do in the past. This data has already informed new policies and procedures and helped the administration make more informed decisions regarding the provision of clinic services.

The benefits of these technology developments and the transition to an EMR extend beyond the walls of the clinic. In 2014, Greene County Mental Health has also transitioned our clinicians and prescribers who provide services to Greene County Jail to transition to an EMR. This also has numerous benefits to the clients and the staff. Most importantly, it helps to ensure clear communication and continuity of care for clients who pass through both Greene County Jail and Greene County Mental Health.

Greene County Mental Health's After Hours On-Call emergency services were also poised to see the benefits from technology. By the end of 2014, all GCMH clinicians who provide On-Call services were about to transition to having remote computer access to the clinic's EMR system and to be able to perform other necessary functions from the field. This transition was set to take place in the very first month of 2015. This development is sure to benefit GCMH's clients, staff, and other agencies the On-Call staff regularly interact with, such as hospitals, police, DSS, etc.

Building & Safety

Throughout 2014 there were 2 Sheriff's Deputies in the building at all times. Use of a magnetometer and screening of those entering for Mental Health Services became operational in January 2014. This has run smoothly with many clients expressing satisfaction that safety in the building is being addressed. A new phone system was installed which allows for intercom capability, more strategic placement of cameras allows for improved visibility outside and inside the building. The Greene County Sheriff's Department met with staff at the Cairo Office Building and reviewed lockdown procedures in preparation for a lockdown drill that will take place in the spring of 2015.

Staffing News

A full time Nurse Practitioner position vacated in August 2013 was filled in September 2014. Greene County Mental Health Center experienced several other staffing changes during 2014 as a result of staff retirement. Clinical staff retirements result in the loss of experienced clinicians, thus hiring of new clinicians recently graduated from a Social Work program with limited clinical experience, who require weekly clinical supervision and support as they transition to their new role. It can also effect assignments and revenue generation as Medicare and other commercial insurance companies will not reimburse for services provided by Licensed Master's Level Social Worker. This takes coordination and oversight at the front door in the assignment of clients.

ADULT SERVICES

Community Health Integration Program

In 2014 the Community Health Integration Program (CHIP) maintained six satellite offices in rural Greene County despite intermittent periods of where staffing was not available. For instance, in early January 2014 one clinician was out on medical leave, and later another clinician retired. However, screening continued at all locations where face-to-face services were not available, with supportive and educational assistance through the coordinator.

CHIP clinicians provide mental health assessment and treatment services directly to clients at the satellite locations as well as in-home, when determined necessary. One clinician was added to the team in 2014.

For the past eight years, the Rural Health Network has provided support of this program, including grants and outreach, which includes supporting the salary for the coordinator and a budget for supplies, and has in the past included advertisement via radio and tv, as well as educational pamphlets and materials that are distributed to the satellite locations. In addition, a reward program was established by RHN in late 2013 through 2014 to provide incentives to the satellites to increase screenings. At least one office took advantage of this, and earned a luncheon provided by RHN. Additional site visits by the coordinator were also completed to increase screenings in 2014.

The coordinator presented during a graduate class at SUNY Albany in March 2014 on the success and status of the program in the community. The coordinator was invited to attend a presentation by Office of Mental Health (OMH) on the continued promotion of programs of this type to students and professionals at the Veterans Administration in Albany, NY in 2014. The coordinator was contacted to provide programmatic information via conference call hosted by OMH to inform other prospective programs on the history, structure, and current operations of the program.

Revisions to the data collection method were made. Now productivity reports are generated by a manager and provided to the coordinator, resulting in a decrease in human error. The coordinator continues to compile reportable data from clinicians and the manager, as well as site-specific needs, which are now presented in quarterly reports (CHIP 1st, 2nd, 3rd, 4th Quarter Reports, etc). One laptop was replaced with a tablet this year; one wireless stick was replaced by a wireless hotspot.

The Mental Wellness Screen was updated to include a yes/no response for perspective clients to indicate whether follow up was welcomed. Revisions were made to the posters promoting CHIP in 2014.

Annual Data Summary:

2010

Service Description	Total
Seen (face to face contacts: brief assessment, crisis intervention, referral, etc)	976
Screened (Mental Wellness Screen *basic* or *enhanced*)	693
Verbal Therapy sessions (billable services, ongoing psychotherapy)	664
Home Visits	24

**Figures for the months of January and February 2010 have been estimated based on a monthly average*
Table 1

2011

Service Description	Total
Total Scheduled Appointments	1015
Kept Appointments (face to face contacts: brief assessment, crisis intervention, referral, etc)	594
Screened (Mental Wellness Screen *basic* or *enhanced*)	940
Assessed/Intake Evaluation (billable services)	86
Home Visits	28

Table 2

2012

Service Description	Total
Total Scheduled Appointments	1130
Kept Appointments (face to face contacts: brief assessment, crisis intervention, referral, etc)	882
Screened (Mental Wellness Screen *basic* or *enhanced*)	418
Assessed/Intake Evaluation (billable services)	88
Home Visits	2

Table 3

2013

Service Description	Total
Total Scheduled Appointments	996
Kept Appointments (face to face contacts: brief assessment, crisis intervention, referral, etc)	781
Screened (Mental Wellness Screen *basic* or *enhanced*)	1004
Assessed/Intake Evaluation (billable services)	59
Home Visits	1

Table 4

2014

Service Description	Total
Total Scheduled Appointments	1252
Kept Appointments (face to face contacts: brief assessment, crisis intervention, referral, etc)	958
Screened (Mental Wellness Screen *basic* or *enhanced*)	2032
Assessed/Intake Evaluation (billable services)	44
Home Visits	0

Table 5

Data in table 1 was estimated for two months in 2010. Categories of service were added in table 2 in 2011, and remain for all future reports.

Two offices were unstaffed during the last quarter of 2014, table 5.

Results of increased efforts to improve screenings can be seen in table 5 where figures have more than doubled since 2013, see highlighted text.

Assisted Outpatient Treatment Program (AOT)

This state-wide initiative has been developed to assist non-compliant treatment clients with obtaining the mental health treatment they need. To date, Seventy (70) Greene County residents have been referred to the AOT program. In 2014, five (5) new AOT orders were issued for Greene County residents; one client moved to enhanced status and one client was discharged from enhanced status. Currently there are fourteen (14) clients on active AOT status and three (3) clients on enhanced status. During 2014, twelve (12) pick-up orders were issued to AOT clients due to non-compliance with treatment or an increase in symptoms. Five (5) of the pick-up orders resulted in inpatient psychiatric hospitalization.

Greene County Jail Services

Services provided by Greene County Mental Health Center in the Greene County Jail continue to reflect the trend of increasing need and utilization of psychiatric treatment in the jail setting.

A total of 452 interviews were conducted by the Forensic Mental Health worker; which included suicide risk assessments, supportive counseling requests, and evaluations for medication. Suicide Risk assessments (537) were completed at booking and reviewed daily on all new admissions. The Clinic's Medical Director provided an additional 69 medication related contacts. The Medical Director's involvement and collaboration with the jail has resulted in a more efficient use of the jail's medication formulary with an overall reduction in cost.

Several inmates were transferred directly from Columbia Memorial Hospital or Albany Medical Centers psychiatric floor to the Jail; requiring follow up psychiatric care.

There were 3 suicide attempts last year. None required outside medical attention. Two had upcoming Court appearance and were sent to CMH for further evaluation upon release by the Court. One was evaluated and released; the other admitted. The third was successfully managed at the jail until he was transferred to NYSDOC.

Unfortunately, many times when inmates meet criteria for hospitalization, there are no beds available at Central New York Psychiatric Center (CNYPC). Typically, we are able to stabilize these inmates with medication before a bed becomes available at CNYPC.

Court Ordered Mental Health Evaluations continue to be conducted at the jail by the Forensic Worker. The clinic also provides 730 competency exams for the Courts on as needed basis.

Clinic on-call services are available as needed after hours, Holidays and weekends.

Comments:

The Greene County Jail has seen a trend of inmates presenting with more significant psychiatric needs. Greene County Mental Health has responded to this need by improving suicide screening and prevention; providing a Licensed Clinical Social Worker daily to provide services to inmates; providing 3 hours per week of psychiatric medication therapy by a Psychiatrist; providing on-call services through the clinic on-call service for weekend and Holiday needs; providing follow-up services for inmates upon release; providing case management services during incarceration; and providing the staff for Court Ordered Evaluations. These services are provided with the intention of lowering the risks of psychiatric and behavioral emergencies, increasing the safety of inmates and staff; as well as facilitating ongoing care for inmates needing Mental Health follow-up services.

An increasing number of psychiatrically impaired individuals are finding their way into the legal system. Many of these individuals have a history of psychiatric treatment and discontinuation of their treatment leading to decompensation. Several may have co-occurring addiction and physical health issues. Several may have been better served within a psychiatric facility rather than incarcerated. Their psychiatric symptoms probably a contributing factor in the crimes committed. While incarcerated, they lose their housing, leaving them homeless upon release. Homelessness can be a big factor in this population discontinuing their treatment, and putting them at risk for re-incarceration.

The ability to provide these services within GCJ has enabled inmates with psychiatric impairments to be identified, treated, and offered follow-up care; in some cases, preventing re-incarceration. Very good collaboration continues with Jail staff, the Sheriff's Department, and local law enforcement in an effort to identify and engage in treatment those individuals that are clearly exhibiting behavioral health symptoms.

The substance abuse problem in the County can impact services at the jail. Upon incarceration those with substance abuse histories may look to Mental Health services to provide an alternative to what they were using on the street. Persons without previous Mental Health histories are evaluated and seen in an attempt to discern need for psychotropic medication vs. withdrawal and need for substance abuse treatment.

Last fall Superintendent of the jail provided a secure computer to be used by Mental Health Staff at the jail. This has assisted facilitating needed mental health services by having clinic records readily available. Conversely, records generated at the jail by Mental Health Staff are readily available to clinic staff upon an inmate's release. Having access to clinic records has streamlined Mental Health care of inmates both upon incarceration and upon release.

Family Court Services

In 2012, Greene County Mental Health initiated significant changes to the services we provided to Greene County Family Court. Historically, GCMH provided extensive Child Custody Evaluations for the Court. These evaluations were extremely time consuming for which we received very little revenue. As it coincided with a loss of qualified personnel, it was decided in 2012 that the clinic could no longer sustain that service and it must be cut. In 2013 the clinic only provided a re-evaluation (a follow-up) to an evaluation that was performed in previous years.

In place of the extensive, time consuming evaluations the clinic used to provide, Greene County Mental Health has collaborated with the Family Court Judges and now provides them with a succinct mental health evaluation that is billable to insurance while also serving some of the needs of the court. It has been reported by the judges that they find these evaluations very helpful in their deliberations in Family Court.

Sex Offender Treatment Program

The Sex Offender Treatment Program is coordinated by Greene County Mental Health Center's Associate Psychologist and a Senior Probation Officer from Greene County Probation. 2014 saw some changes in the program, as the 2 independent groups were consolidated into 1 group that operates Wednesdays from 4:30 pm until 6:00 pm, located in the Probation Department. This occurred in May of 2014. The year began with 12 offenders in 2 groups, however during the year several offenders successfully completed their probation sentences. One member was incarcerated and violated on his probation for non-sexual offenses, and 6 other members successfully completed their probations. Also, 4 new offenders have joined the group in 2014. Currently, there are 9 members attending the Wednesday afternoon group. Of these members, 5 are registered at Level 1, one is registered at level 2, and one is registered at level 3. There are 2 members who are not on the Sex Offender Registry but are mandated to attend Sex Offender Treatment. During 2014 there has been no known sexual re-offending from existing program members.

Currently attending members are all supervised in the community by the Senior Probation Officer. The group runs for 90 minutes weekly. The Senior Probation Officer attends and completes probation monitoring functions for the first 30 minutes, and the remaining 60 minutes are utilized for Sex Offender Treatment.

The Sex Offender Treatment Program serves 3 primary functions. The Program provides ongoing community supervision of members, groups provide a support network for members, and all members are expected to take responsibility for their individual offenses and openly discuss the changes they need to make in their lives in order to prevent further offenses. Victim Impact, trust, honesty, and sobriety issues are often at the forefront of the focus in the groups.

The overall goal of the program is to improve community safety through preventing re-offending behaviors.

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 Mental Health, as well as members of community supports and services, such as the Greene County Department for Social Services, Greene County Adult Protective Services, and the Mental Health Association of Columbia and Greene Counties. When appropriate or necessary, additional community stakeholders are invited to participate, such as the ARC or WillCare agencies.

In 2014 work on the unified application continued, and a new referral form and process was developed. The prior applications involved applicants submitting a full, 18 page application with additional attachments before coming before the committee for review. The new process eliminates this step, in effect allowing applicants to be directed earlier in the process to the appropriate service by reducing the referral to a 3 page document. Related supporting documents are requested as needed, and on a case-by-case basis. Implementation of this change occurred late in 2014, and no data is presently available on the effectiveness of this change.

Residential Services

The Mental Health Association (MHA) of Colombia 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 (30) SHUD apartments. Five (5) of these beds are designated specifically for homeless families / individuals. All recipients of a SHUD grant must also demonstrate eligibility with a psychiatric disability.

The following reflects applicants in 2014:

2014 Residential	
Submitted applications	42
Removed/Inactive	27
Determined eligible/rostered	12
Pending	5
Admitted	12
Wait List	13

There may appear to be a discrepancy between number of applications eligible, the number admitted and the number remaining on the Wait List. 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) individuals on the wait list from 2013 were placed in housing in 2014; individuals are carried over from other years.

Applications 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.

There are an increasing number of psychiatrically impaired individuals that are 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.

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. With limited funds, this becomes difficult, many resorting to whatever services they may be able to acquire through DSS. These individuals have a difficult time finding safe, permanent, affordable housing after release from jail.

There has been an increasing number of referrals from jail and prison systems this service year. Typically these systems do not recognize the limitations of the settings available in Greene County, and applicants are often ineligible due to a lack of structured settings. Referrals from the justice system are usually directed elsewhere.

Likewise, local psychiatric inpatient providers forward referrals to Greene County for applicants that are waitlisted in other counties that also may be inappropriate for the level of care available within the County. As such, many of these referrals are redirected to more appropriate service settings.

There are an increasing number of AOT (Assisted Outpatient Treatment) than ever before, placing a strain on already strained resources in the community. AOT clients are typically placed at the top of the housing list. Many of the clients on the list have been consistently bumped in favor of an AOT client, leaving them waiting for housing for two or more years.

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

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

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

Adult Care 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 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. The Adult SCM visits clients bi-weekly (2x) mo. In the newly formed Hudson River Health Home, Care Managers provide

linkage between the individual and health care providers. Greene County now has both Case Managers and Care Managers, 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 resolves 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.

The Greene County Department of Community Services is the umbrella for Adult Case Management services in Greene County. The Mental Health Association of Colombia/Greene Counties employs three 3) Adult Care Coordinator (formerly Supportive Case Managers (SCM)) and one (1) Adult Intensive Case Managers (ICM), both of which are now providing services through the newly implemented Hudson River Health Home. Capital District Psychiatric Center employs two (2) Adult ICM's for Greene County and they operate and bill Medicaid and Medicare in the traditional model. In this new role as Care Managers, both are providing traditional services through the use of legacy slots while also enrolling new applicants in the Health Home Services, a lower intensity service, for Medicaid recipients. Caseloads have expanded to approximately 30 to 40 individuals per care manager.

The following reflects applicants in 2014:

2014 Care Management (trad. ICM and SCM srvs.)	
Submitted applications	5
Removed/Inactive	0
Determined eligible/referred	8
Pending	0
Admitted	8
Wait List	0

Care Coordination

In 2014 there was increase in the use of Care Coordination Services, a less intensive form of Care Management. For this service, individuals need to have a mental health or medical diagnosis and higher-than-average contacts with service systems, such as the ER, psychiatric inpatient and outpatient, and primary care. The Mental Health Association employs four (4) Care Coordinators, two full time and two part time workers, with full time case loads averaging 30 clients each.

Over the course of this service year, applications for this less-intensive program were forwarded directly to MHA, by-passing the SPOA in many instances. 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.

With the introduction of this new service, every applicant requesting Care Coordination was served. Wait time was eliminated as caseloads were expanded this year. Applicants found to be eligible for a higher level of care were deferred to ICM (5 total, with 3 additional applications), a service that did not have a waitlist this year. Applications referred for this higher level of care are typically individuals who are admitted under a court order (AOT).

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. It is at the time of intake for that program that some applicants are found to have relocated or refuse the service, or ineligible due to primary payer, however this data is not available to the SPOA, and for purposes of this report are considered to have been eligible and referred to the service.

2014 Care Coordination	
Submitted applications	30
Removed/Inactive/deferred to ICM	5
Determined eligible/referred	23
Pending	0
Admitted	23
Wait List	0

CHILDREN'S SERVICES

Clinic Based Mental Health Services

The clinic has 4 clinic based children's therapists on staff. There are also 3 therapists who have blended caseloads and provide counseling to a number of youth and families. The clinic has a children's RN who triages initial calls for services and assigns intake appointments as well as triages crisis calls from schools and parents throughout the week. Children's therapists provide both individual and family therapy to a case load of children and transitional age youth (18-21.) They coordinate with collateral agencies including schools, case managers, medical professionals, law guardians, hospitals, and probation to best meet the often complex needs of high risk youth in the community. Children's therapists also provide individual parenting support and training to adult clients upon request. Several therapists have provided in-service training and support in the community upon request as well as providing crisis intervention and support in and outside of the clinic.

The Children's Psychiatrist on staff is in the clinic 5 days per month for assessment, consultation, and ongoing medication management. The children's therapists also work hard to collaborate and consult with primary care physicians in the community who provide medication management for their clients.

School-Based Mental Health Services

GCMHC continues to have school-based satellite programs in several school districts. These include Windham/Ashland/Jewett school district three days per week, and both Cairo/Durham Middle/High School and Catskill Elementary staffed four days per week. School districts support these collaborations with approximately 25% funding (adjusted based on the number of days the clinician is at the school). As we do every year, the Director of Community Services meets with school superintendents each spring to discuss satellite programs and has received positive feedback about this service. School based services are overseen by the Clinical Supervisor 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 & Family Single Point of Access (SPOA)

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

The 6 Home and Community Based Waiver (HCBW) slots for severely emotionally disturbed children continue to be utilized to full capacity. There is a small waiting list for these services which is reviewed upon openings to prioritize families with the highest need. The New York State Office of Mental Health continues to fund these slots which are contracted through Parson's Child and Family Center. The goal of this intensive program is to provide children, at the highest risk of placement and/or hospitalization, and their families, an enriched service plan while remaining at home in their communities.

SPOA continues to be the conduit for all case management referrals. Greene County currently has approximately 62 slots for case management services: There are 20 Supportive Case Management Slots and 18 Intensive Case Management slots through Greene County Mental Health (including 3 for transitional age clients) and 24 Supportive Case Management slots through the Mental Health Association.

SPOA has also served as a referral mechanism for other services and support programs including Pre-PINS, Respite, IAPP (Intensive Aftercare Prevention Program), mediation, kinship care support, Twin Counties Substance Abuse services, Peer/Parent support, Autism Connection, and the Reach Center. SPOA is the referral source for two resources in case children need to be placed out of their homes: Community Residences and Residential Treatment Facilities, both administered by the Office of Mental Health.

In 2014 the committee received 64 new SPOA referrals and 23 SPOA reviews to follow-up on previous SPOA meetings. These referrals came from many different sources including Mental Health, schools, Greene County Youth Bureau, and Psychiatric Hospitals. Case management continues to be the most utilized resource in the county for children and families. There were 64 new referrals made to case management services (combined ICM, SCM and MHA). Other top referrals include Greene County Mental Health (20), and the OMH Waiver program (8) for the most intense cases.

Early Recognition and Screening Program

The Greene County Early Recognition and Screening Program (ERS) concluded year two with 573 completed screens in the County. Last year not all school superintendents agreed to allow screens to be sent to their school populations. Of the 573 responses 185 youth scored High Risk. Of the 185 High Risk screens, 99 youth actually entered services at the clinic.
The ERS has exhibited at; National Night Out sponsored by REACH at Dutchman's Landing, Parents, Partners and Pancakes at Catskill CSD, Greene County Youth Fair, Dare Day at Angelo Canna Park, American Foundation for Suicide Prevention "Out of the Darkness Walk" at the Hudson Waterfront, the Rural Health Network Health and Screening Fair at the Medical Arts Building in Jefferson Heights in Catskill, the Community Forum at the Athens Legion Hall, and the Recovery Art Show at the Bridge St. Theater in Catskill. The ERS presents brochures and information on mental health and support services at these events for public perusal and use. This is an important part of the outreach of the ERS Program that highlights the service provided for screening for school age children and the services provided by Greene County Mental Health.

The ERS continues to lead a youth support group called "Future's Promise" on the last Tuesday of the month in conjunction with a parent support group called "Parent's Promise" facilitated by our SPOA Family Peer Partner. Both of these organizations are a chapter of the New York State Families Together Organization. Both groups attended the Families Together Legislative Day in March and spoke with Senator Amedore's staff regarding the need for supported housing for adults living with mental illness in Greene County. The youth also spoke with Aileen Guenther regarding housing and services for young adults with mental illness.

The ERS has continued to participate in the PAS It On Committee, (Problems, Alternatives, Solutions), the Columbia Greene Suicide Prevention Task Force, the American Foundation for Suicide Prevention "Out of the Darkness Walk"

Committee, the Mental Health, Office of Alcohol and Substance Abuse Services, (OASAS) and the Office of People with Developmental Disabilities (OPWDD) Sub Committees. Networking at these meetings helps to keep the Early Recognition and Screening Program a part of the culture of services in Greene County.

This spring the ERS will collaborate with the Early Childhood Learning Center and Head Start. Reading to students and providing follow up activities provides the ERS an opportunity to work with young children, parents and staff at these venues to offer resources and screening as the young children become kindergarten eligible. The ERS is also piloting a program called “Mind UP” with one Head Start Class. This program promotes techniques and skills to help young children become mindful learners and teaches children how to use deep breathing and controlled breathing as a mechanism to focus during learning and to relax in times of stress. It is a brain based program that the children have been very successful with.

The ERS works closely with Greene County Mental Health Youth Case Managers to provide information for parents and children in need of a variety of services and resources throughout the County.

COMMUNITY SERVICES BOARD & NAMI

Greene County Community Service Board

The Greene County Community Service Board (CSB) and its Sub-committees 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). This year has been a year of challenges with all of the changes in healthcare, services, and organizational structure of many NYS governing and service organizations. Areas of focus include the transition to managed Medicaid; Delivery System Reform Incentive Payment Program (DSRIP)part of Medicaid Redesign that focuses on the avoidable use of the ER and avoidable hospitalizations over the next 5 years; transition of Children's Case Management into the Health Home and enrollment of children into the Health Home; roll out of NY START which is Systemic, Therapeutic, Assessment, Resources and Treatment a crisis based response program through the Office of People with Developmental Disabilities.

As in the past, the Subcommittees reviewed all 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 local service plans that are maintained by the OASAS Bureau of Information Technology. Local services plans are central to State long-range planning and budgeting. The Local Services Plan for 2015 completed by the Director of Community Services following collaboration with the Community Services Board included focus on housing availability and stability; transportation; integration of physical and behavioral healthcare; advancing systems of care approach in the delivery of care to children and families; a Columbia/Greene cross systems approach to Suicide Prevention, Education and Awareness; enhancing the coordination and integration of local OPWDD Services within Greene Co and community education that highlights addiction as a chronic illness that can respond to treatment.

During 2014, The Director of Community Services had an opportunity to put in proposals to OMH for additional State Aid (investment dollars available from the closure of article 28⁄31beds) to support needed services in the county. In Dec 2014, Greene County was notified that state aid (annualized $330,000) would support the development of Mobile Crisis Team(it will be a team that will serve both Columbia and Greene County operating scheduled hours on a daily basis, 365 days/yr), 5 additional Supported Housing slots, 10 additional day respite slots for children and adolescents, 100 nights of crisis and planned respite for children and adolescents using therapeutic foster homes in the county and the ability to convert the current Situational Crisis bed at our Community Residence to hospital diversion bed with funding to support additional staffing.

Greene County NAMI (National Alliance of the Mentally Ill)

Greene County NAMI celebrated its twelfth anniversary with its annual dinner celebration and fundraiser at the Quarry Steakhouse in October 2014. The NAMI president continues to attend regional and NAMI NYS meetings and provides important program information to the Greene County Community Services Board. NAMI continues to be an active leader in supporting mental health services and initiatives in Greene County, participating in various health fairs and conferences throughout the county. Two members were trained to teach the Family to Family class, one member trained to teach the Family Basics class. NAMI Greene continues to offer high caliber educational programs and family support groups in Cairo and Windham.