Greene County Mental Health Center

905 GREENE COUNTY OFFICE BUILDING
CAIRO, NY 12413

2017 Annual Report

Prepared by: Margaret Graham, APRN BC
Director of Community Services
& Mental Health Center Staff

MISSION STATEMENT

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

Total Visits – 16,713

Adults – 11,580

Children – 5,133

Total Unique Individuals Served

(Estimated Percentages)

Male – 41.8%

Female – 58.2%

Adults – 75.4%

Children – 24.6%

EVALUATION of 2017 Goals

1. **Improve IT security issues within the clinic. Establish encrypted email and improve other security issues (fax servers, user boxes for compliance) addressed with IT in 2016.**

   Email encryption is available and being used. GCMHC continues to work with IT and county on security related issues. This goal will continue into 2018.

2. **Implement new cloud based Electronic Medical Record (EMR). Anticipated start date of August 2017.**

   Greene County Mental Health made a significant transition with the EMR system in that we transitioned to a cloud-based (internet based) EMR. This means GCMH no longer has to rely on the physical computer servers. This allows for more reliable connectivity and data protection.

3. **Migration to new Practice Management provided by QuicDoc, our EMR vendor. Anticipated start date of May 2017.**

   In May 2017, Greene County Mental Health transferred to a new cloud based practice management software that allows the clinic to track appointments and billed services in a timelier manner. The software provides us the ability to have real-time reports regarding patient eligibility. It provides us with a timelier response to denied claims and an automated payment processing. In addition we are also able to run reports for productivity analysis which give us a more accurate snapshot of clinic services provided.

4. **Continue to develop connection with Regional Health Information Organization (RHIO) which permits data sharing.**

   Greene County Mental Health is currently contracted with our local Regional Health Information Organization (RHIO) known as HIXNY, to provide single consolidated health record for patients in treatment that include records and data sources statewide. Currently GCMHC is operating in the testing environment to ensure that all sources of information we will be sharing will properly report at the RHIO level. GCMHC is expected to go live with real time data exchanges by June 2018. This goal continues into 2018.

5. **Assessing internal clinic data on hospitalization of clients currently in our system as well as those new to us and timeliness of follow-up visits. What % of psychiatric hospitalizations had a clinic follow-up visit within 7 days of discharge. Doing outreach to those who no show for appt. A more targeted and coordinated approach to engaging those who are a post hospital visit. Using our EMR to generate a monthly report that can guide management.**

63% of all hospital discharges were seen within 7 days of hospital discharge. (Data is based from June 2017 to December 2017). During this time the clinic has outreached 100% of discharged clients through automated reminder calls for post hospital follow ups. In addition any missed appointment has received outreach phone calls and follow up letter as well as immediate collaboration with discharging hospital and Mobile Crisis assessment Team (when appropriate).

In our ongoing efforts to improve the quality of care, GCMH conducted a 3-session training with our staff in best practices to manage high-risk clients. This focused on engagement and retention of clients, as well as how to assess and manage high risk clients.

6. Overhaul Corporate Compliance structure, revise manual, and train staff.

2017 marks another consecutive year in which advancements were made to the Corporate Compliance Program to both monitor and enhance the quality of care and accuracy of billing for the clinic. In 2017, we began to focus on, monitor, and track the 7 key areas of compliance risk. The staff has been trained in this and new procedures to tracking and monitoring have been put in place. Manual still needs to be revised. This goal will be carried over into 2018

GOALS FOR 2018

1. **Revise Corporate Compliance Manual.**

2. **Revise GCMHC Policy & Procedure Manual.**

3. **Complete the RHIO connectivity which permits data sharing.**

4. **Optimize the use of our current EMR software to track quality measures as it relates to patient centered care.**

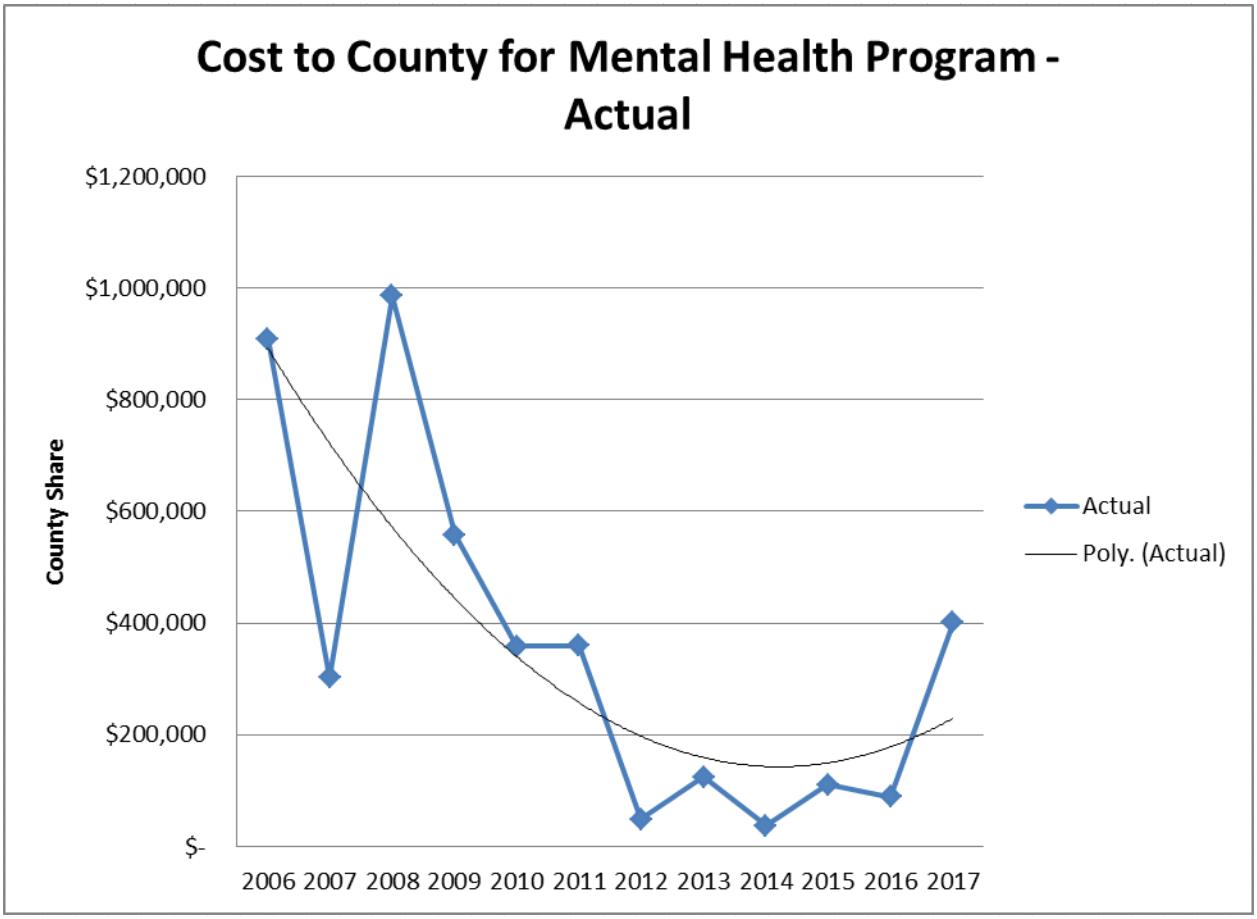
5. **Building improvements: Installation of handicapped accessible bathroom for clients and upgrade the waiting room area.**

6. **Completion of client satisfaction survey.**

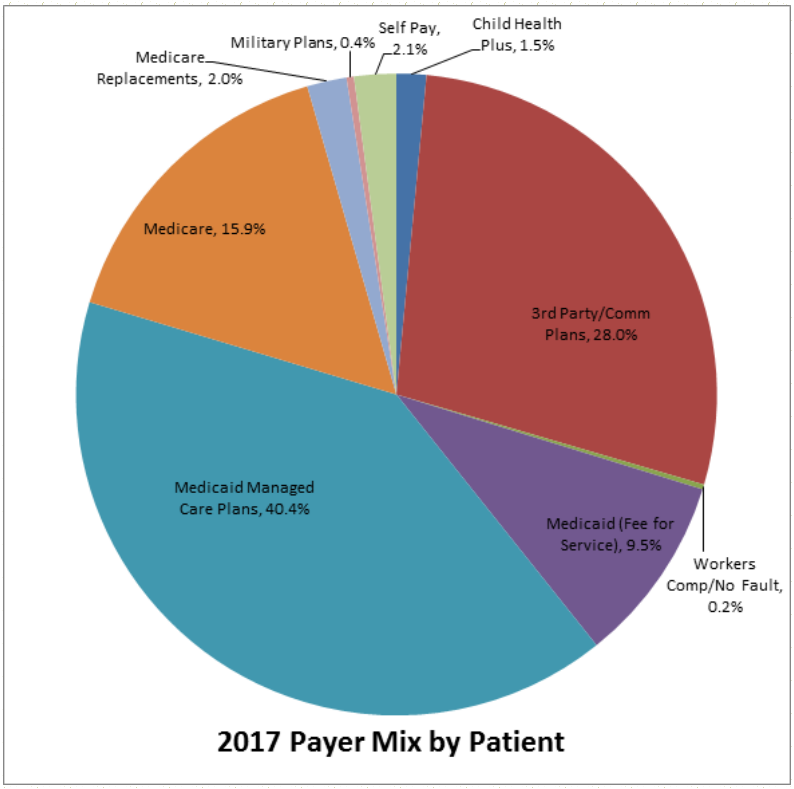
Fiscal Developments

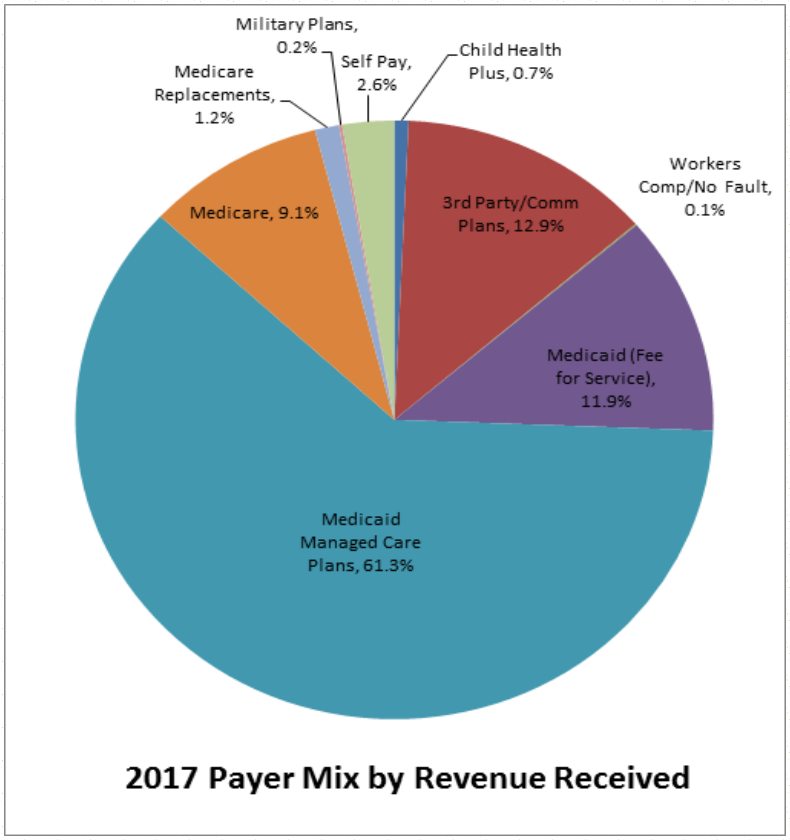
In May 2017, Greene County Mental Health transferred to a new cloud based practice management software that allows the clinic to track appointments and billed services in timelier manner. The software provides us the ability to have real-time reports regarding patient eligibility. With real time eligibility we are able to correct issues with patient insurances at the time of visit versus after the service has been rendered and billed. It provides us with a timelier response to denied claims and automated payment processing. In addition we are able to run reports for productivity analysis which gives a more accurate overview of the clinic service rendered.

The clinic continues to balance the provision of evidence based, clinically relevant service while being mindful of the tax burden on Greene County tax payers. Clinical, fiscal and support staff have remained diligent in their efforts to keep costs low. In 2016 the department's cost to the county was $89,096, approximately $279,452 below our anticipated budgeted cost. In 2017, our cost to the county is estimated at $400,903 coming in $234,479 under budget. The increase in the cost to the county is a result of the clinic's commitment responsibilities to those who are currently being served in the state psychiatric forensic unit.



Payer Mix by Patient vs. Revenue Received





Technology Developments

Greene County Mental Health continues to use the Electronic Medical Record (EMR) system it implemented in 2013. All clients, whether they're seen at the clinic or at a satellite, have records within the EMR system.

In 2017, GCMH saw the completion of the 4-year process of scanning and storing all hard copies of medical records. At this point in time, all records for all existing clients are now part of our electronic medical record.

Greene County Mental Health also made a significant transition with the EMR system in that we transitioned to a cloud-based (internet based) EMR. This means GCMH no longer has to rely on the physical computer servers. This allows for more reliable connectivity and data protection.

Along with the transition to the cloud-based servers, the Billing Department also transitioned to using the EMR's Practice Management software as referenced in the Fiscal Developments.

Corporate Compliance, Quality Assurance, and Utilization Review

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

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

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

2017 marks another consecutive year in which advancements were made to the Corporate Compliance Program to both monitor and enhance the quality of care and accuracy of billing for the clinic. In 2017, we began to focus on, monitor, and track the 7 key areas of compliance risk (billing, payment, medical necessity and quality of care, governance, mandatory reports, credentialing and other risk areas. The staff has been trained in this, new procedures for tracking and monitoring have been put in place.

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

Open Access Clinic

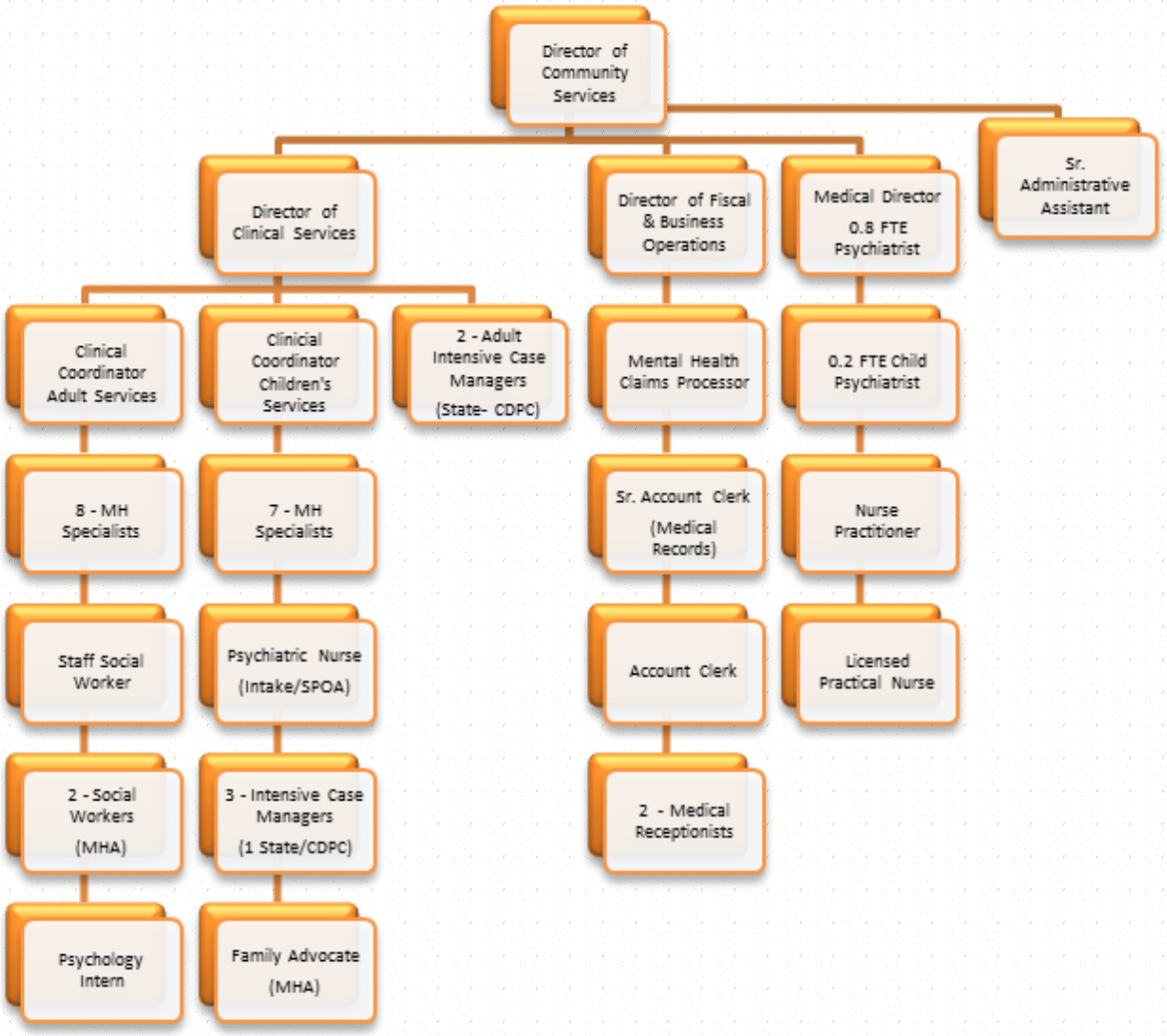
In September 2015 Greene County Mental Health overhauled the way adult clients enter the clinic. The purpose of the change was multi-faceted; we wanted to reduce the amount of time it takes for a client to be seen after first contact with the clinic. We wanted to reduce the number of missed appointments for intakes. We wanted to maximize the chance for engaging clients that might otherwise be hesitant to engage or drop out of treatment prematurely. This led to the creation of the Open Access Clinic.

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

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

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

Staff Organizational Chart



Staffing News

Greene County Mental Health Center experienced several staffing changes during 2017 due to employee retirement, pursuit of private practice, career advancement and/or salary increase. This resulted in the loss of experienced clinicians. We have recruited new clinicians who have been former student interns and have recently graduated from a Social Work program. Being new to the field, their clinical experience is limited and they 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 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

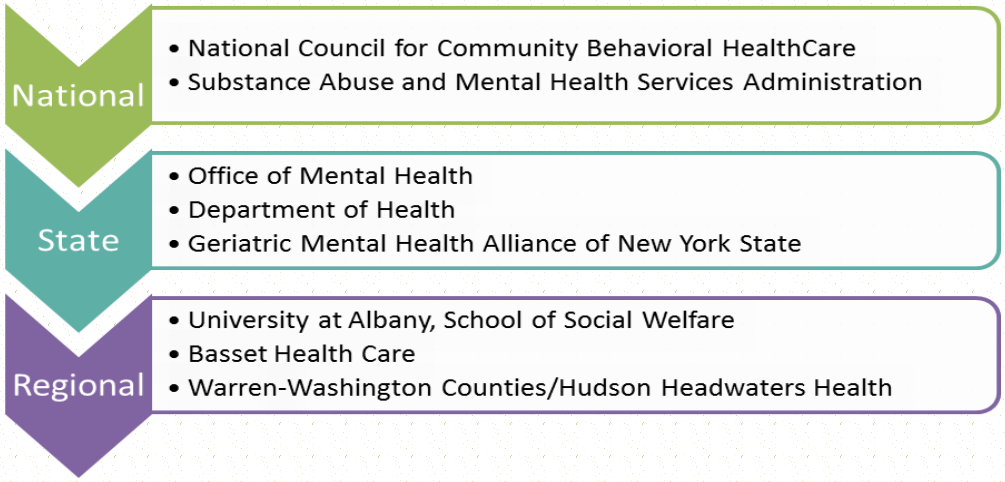
With its roots in prevention and crisis management, Community Health Integration Program continues to operate throughout Greene County and provide vital outreach services to residents.

In 2017 CHIP maintained three satellite offices in Greene County. CHIP clinicians provide mental health assessment and treatment services directly to clients at the satellite locations, as well as linkage and referral to other programs and services.

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

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

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

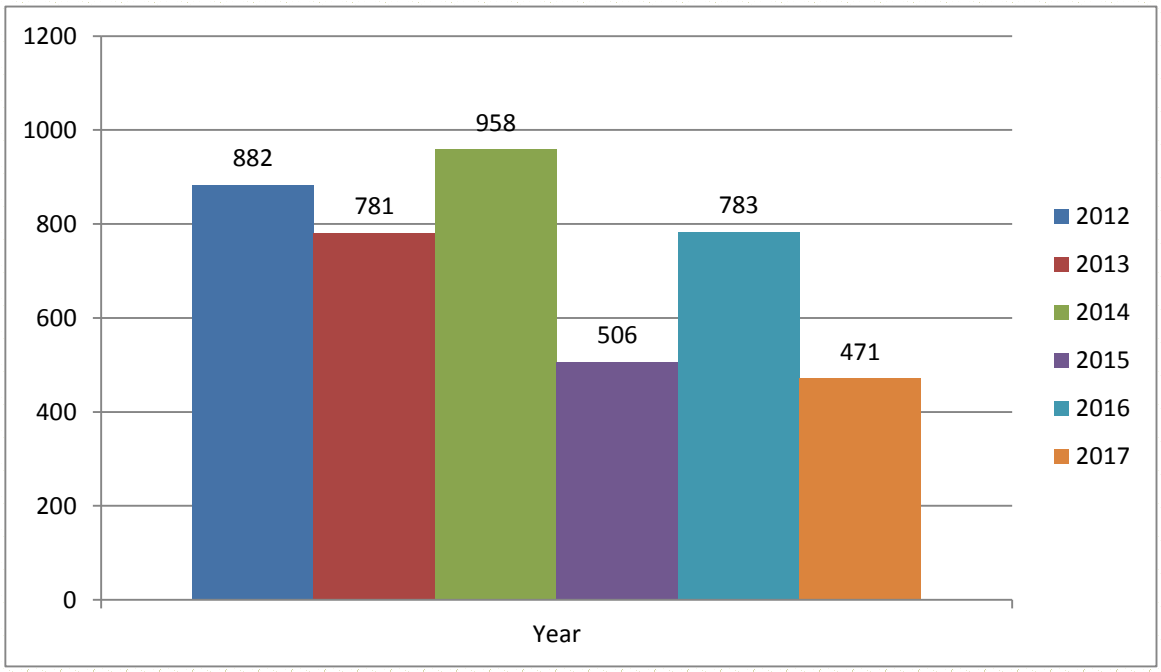


Presentations and other materials on CHIP are posted on the State Office of Mental Health website. CHIP was featured in a National webinar (available online) by the Office of Mental Health and SAMHSA in 2013. Presentations to local Graduate social welfare students occurred in 2013 - 2016.

Annual figures of scheduled, kept, intakes and home visits from this program were reported manually from 2012 – 2016. **Reports after this date are now available through the fiscal officer, and are not reflected here.** Mental

Wellness Screens, previously reported here, are now collected through GCMHC's electronic medical records, **and are not reflected here.**

Annual Data Summary Graph



Annual Data Summary

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

Assisted Outpatient Treatment Program (AOT)

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

There are clear and precise AOT eligibility requirements. One of the seven eligibility requirements are clients having two or more hospitalizations due to non-compliance within the last 36 months or clients having one or more acts of violence toward self or others within the last 48 months. These clients can be high risk in the community because of danger to oneself or others secondary to non-compliance with treatment. In 2016 and 2017, two Greene County residents were released from prison on an AOT status. Both clients required a Community Residence level of support and oversight, not available at the time of release in Greene County. We worked with State Operations to have the clients housed in other counties until this level of care was available in Greene County. In 2017, two Greene County AOT clients had to be transferred to other counties for the same reason; Greene County could not provide the level of residential housing that the client required. Individuals under AOT receive priority access to case management, outpatient services and residential housing options.

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

Significant Event reports are reports filed with OMH when a client is on an AOT order and is noncompliant with treatment, or demonstrates other high risk behaviors in the community such as criminal activity, whether it is being accused, committing a criminal act, or being a victim of crime; danger to self or others; non-compliance with mandated treatment; homelessness; psychiatric inpatient hospitalization or emergency services used; psychiatric decompensation; death; substance abuse; risk of non-delivery of mandated services; and if an AOT client is missing. In 2017, 13 significant event reports were filed with OMH. Half of the significant events filed were due to noncompliance with treatment. Three (3) were related to substance use, one (1) was a missing client, one (1) was related to the client being a danger to others, and one (1) was the death of a client. This death was a result of noncompliance with treatment and substance use.

Many of these AOT clients have co-occurring diagnoses, severe mental illness and substance use disorder. Seven (7) 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 trend noted for the upper Hudson Valley Region is the shortage of appropriate housing for AOT clients. This may be related to the acuity of the client, the need for licensed housing support, or the lack of affordable low income housing in an area.

To date eighty nine (89), Greene County residents have been referred to the AOT program. In 2017, seven (7) new AOT orders were issued. Ten (10) pick-up orders were issued to AOT clients due to non-compliance with treatment and/or an increase in symptoms. Three (3) of the pick-up orders resulted in inpatient psychiatric hospitalization. Currently there are fourteen (11) clients on active AOT status.

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

Greene County Jail Services

Services provided by Greene County Mental Health Center (GCMHC) in the Greene County jail continue to reflect need and utilization of psychiatric treatment in the jail setting.

A total of 235 interviews were conducted by the Forensic Mental Health worker; which included 58 suicide risk assessments and 168 supportive counseling and medication requests. Suicide screens that are completed at the time of booking are reviewed daily by Forensic Mental Health worker on those newly incarcerated. The Clinic's Psychiatrist/Medical Director provided an additional 42 medication related contacts.

Service Type	2014	2015	2016	2017
Interviews by Forensic Mental Health Clinician	452	516	574	235
Review of Suicide Screening completed at booking	537	550	421	440
Psychiatric Services	69	49	99	42

There was one admission to Central Hudson Psychiatric Center (State Operated Forensic Inpatient Unit) as part of a 730 Court Ordered Commitment. One inmate remains in Central New York Psychiatric Center (admitted 2016).

Psychotic symptoms, suicidal thinking and behavior, refusal to accept medication treatment are frequently part of the determining factors that result in the request for admission to Central New York Psychiatric Center (CNYPC). There were 7 inmates that met criteria for hospitalization. Our local Article 28 hospital - Columbia Memorial Health - will not accept inmates for psychiatric care due to concern about safety as well as confidentiality issues on the unit. We have seen a marked decrease in bed availability at CNYPC; typically we have been able to stabilize inmates on medication and supportive therapy before a bed becomes available.

Of the 7 inmates meeting criteria for hospitalization upon admission, 3 were stabilized and referred to GCMHC for follow up upon release; 4 were maintained at the jail facility and transferred to CMH for evaluation/hospitalization following release.

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.

The Greene County Jail has seen a trend of inmates presenting with increasingly significant psychiatric needs. Greene County Mental Health has responded to this need by improving suicide screening and prevention, providing a Licensed Clinical Social Worker 5 days a week to provide evaluations and counseling services to inmates; providing 2-3 hours per week of psychiatric medication therapy by a Psychiatrist; after hour services through the GCMH clinic on-call service for weekend and holiday needs; providing follow-up services for inmates upon release; providing case management services during incarceration; providing discharge planning when

indicated and providing the staff to complete Court Ordered Evaluations and 730 Competency Exams. These services are provided with the intention of lowering the risks of psychiatric and behavioral emergencies, to increase the safety of inmates and staff as well as facilitate ongoing care for inmates needing Mental Health follow-up services.

Last year, the GCMH's Forensic Worker, with GC Jail's Training Officer, attended a Train-the Trainer program 'Suicide Prevention in County Jails and Police Lockups'. The training will be presented to Correction Officer Recruits jointly by The Mental Health Worker and the Corrections Training Officer, in an effort to prevent suicide in the jail.

The increasing Substance Abuse problem in the County also impacts services at the jail. There has been a sharp increase in inmates being admitted with active substance use/dependence. This includes those displaying psychotic symptoms, which resolve over time, indicating a sharp increase in Substance Induced Psychotic Disorder; more frequently presenting with sleep disorders and anxiety as a result of withdrawal; and an increase in Benzodiazepine abuse/dependence. When indicated, inmates 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.

The sharp decline in services rendered is a result of half the jail being closed and an increase in inmates being boarded at Columbia County Jail.

Family Court Services

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

Drug Court

Greene County Mental Health has collaborated with Greene County Drug Treatment Court since the inception of the alternatives to incarceration program. Since the retirement in October 2017 of our longtime representative for the team, GCMH's Clinical Director has fulfilled the roll. The roll entails weekly attendance and participation in the Drug Court Team meeting followed by the weekly appearance in Drug Court. The entire weekly commitment is expected to last from 9:00am - 12:00pm.

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

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

The Greene County Single Point of Access for Adult Services is a Committee comprised of a coordinator from Greene County 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 directors of residential services and community program management from Mental Health Association of Columbia and Greene Counties. When appropriate or necessary, additional community stakeholders are invited to participate, such as The Arc of Ulster/Greene, Catholic Charities, or WillCare agencies. In 2017 no additional representative supports were requested from other community agencies or entities other than those listed above.

2017 saw an increase in the use of the unified referral form as well as an increase in the number of referrals reviewed by the committee. Organizational and tracking measures continued, including that each client's file is now scanned and available electronically for committee members; each file is assigned a date of receipt (for tracking); case summaries were also introduced in 2017.

For approximately half of the 2017 calendar year, an additional support staff was added. The Adult SPOA Assistant position was occupied by a part time staff person. Duties assigned to this role included scanning clinical records, creating electronic charts, meeting minutes, distributing minutes and agenda schedules. Duties from this position were absorbed by the coordinator due to a vacancy in the position in late 2017.

Residential Services

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

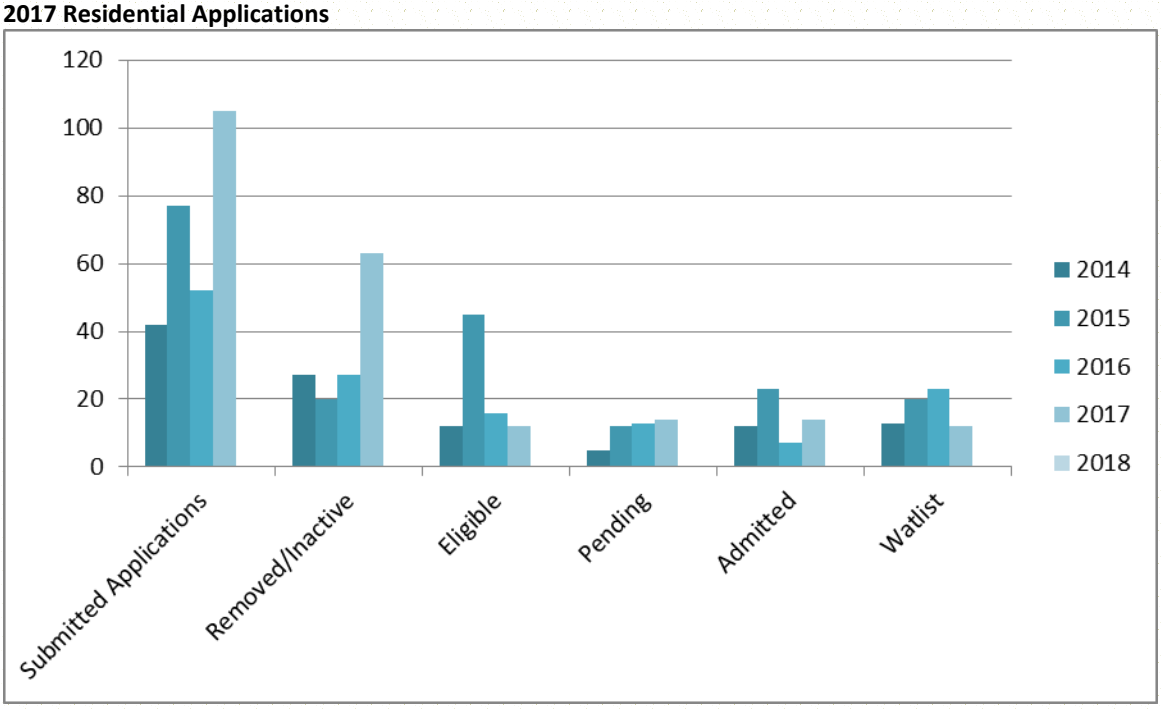
High Cliff Terrace, a ten (10) bed, twenty-four hour supervised community residence, provides housing to individuals with a higher level of need for monitoring and who require a supervised setting as a first step toward learning skills for a step up to more independent living arrangements. High Cliff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

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

The Supportive Housing (SHUD) Apartment Program is the most independent residential setting wherein an individual receives a housing stipend similar to a Section 8 entitlement. They are assigned a case manager from MHA who is required to provide a single monthly contact in direct conjunction with housing issues: collection of rent, monitoring ongoing condition of the apartment and negotiations with landlord re: repairs, tenant concerns,

etc. There are a total of thirty (38) SHUD apartments. Five (5) of these beds are designated specifically for homeless families / individuals. 3 additional beds were added in 2016. All recipients of a SHUD grant must also demonstrate eligibility with a psychiatric disability.

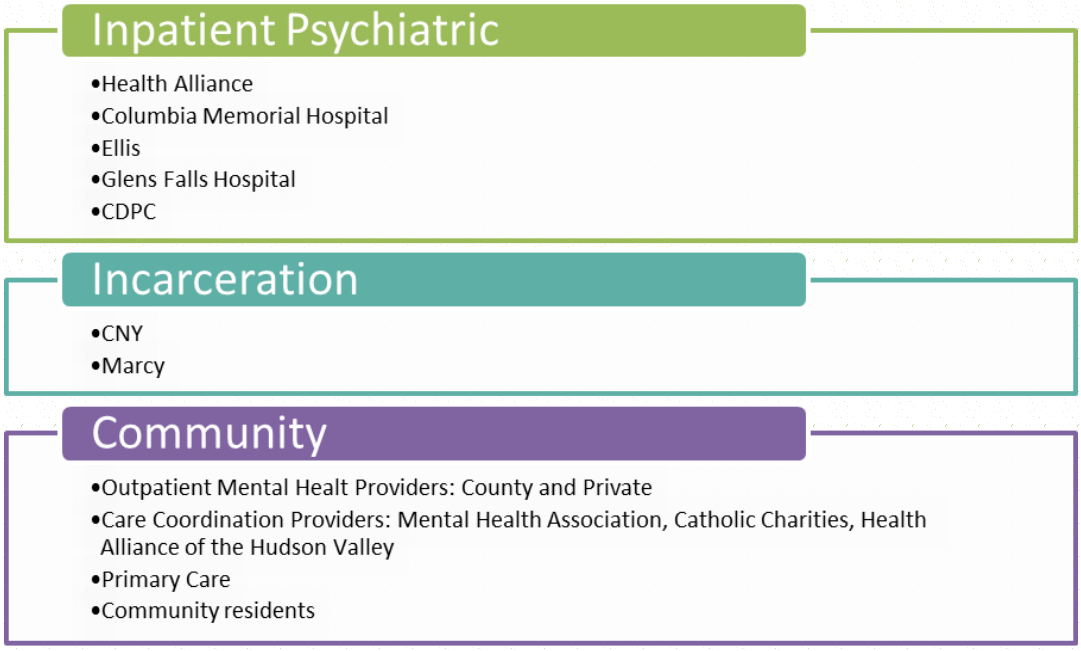
2017 Residential Applications



Residential Applications	2014	2015	2016	2017
Submitted applications	42	77	52	105
Removed/Inactive	27	20	27	63
Determined eligible/rostered	12	45	16	12
Pending	5	12	13	14
Admitted	12	23	7	14
Wait List	13	20	23	12

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 2016 were placed in housing in 2017; individuals are carried over from other years; (3) internal moves occur within each residential program that are not tracked here.

Applications are received primarily through the following sources:



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

The Future of Residential Services

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

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

Many recently released inmates, psychiatrically impaired or not, have limited, if any, family or social supports. Upon incarceration, many individuals lose their housing, as well as their belongings, and find it necessary to start over upon release.
Post-release incarcerated and AOT clients are typically placed at the top of the housing list. Clients on the list have been bumped in favor of an AOT client, leaving them waiting for housing for two or more years.

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

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

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

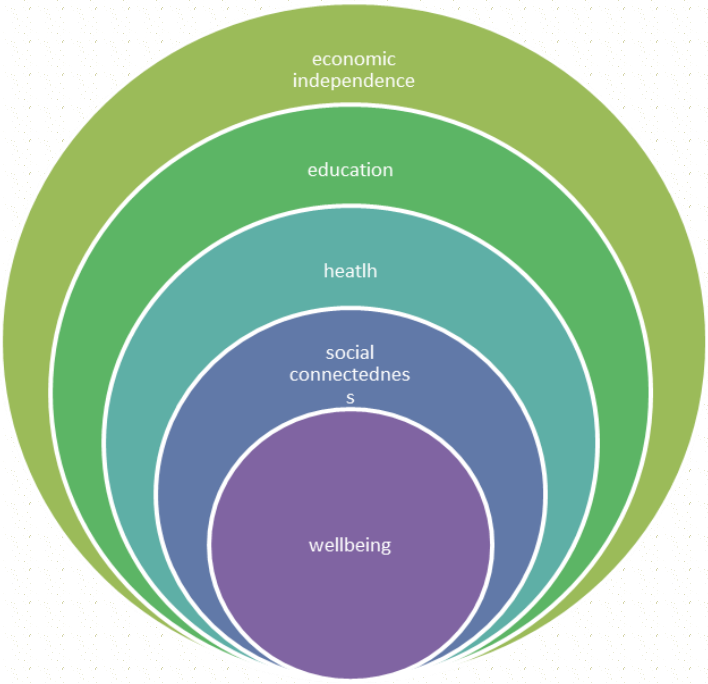
There remains a growing need for **permanent supervised housing** that transitions to permanent independent housing for individuals age 18 – 24 years old transitioning from residential or foster placements, or are no longer able to reside with family. This subset of clients requires permanent safe housing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

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

Adult 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 focus on:



CM staff assists 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, Care 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(State employees who are embedded within clinic), 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.

In 2016, a procedure was developed to link the referral process from Care Coordination to Care Management. Specifically, this process is enacted for when an individual requires a higher level of care. In 2017, multiple reviews were requested by clinical teams representing individuals in the community who were at risk for hospitalization; the procedure was utilized, and appropriate care was provided.

In 2017, data management for Care Coordination was fully transitioned to the service provider, who is also reporting to the State of New York; figures are not included here. Asking Jess to get from MHA

Care Coordination

In 2016 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 between four and six Care Coordinators with full time caseloads averaging 60 clients each.

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

With the introduction of this new service, every applicant requesting Care Coordination was referred; individuals requesting Care Management that did not meet that eligibility criteria were also referred to CC. Wait time was eliminated as caseloads were expanded this year. There were no waitlists for Care Management or Coordination. 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. 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.

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.

For approximately half of the 2017 calendar year, an additional support staff was added. The Adult SPOA Assistant position was occupied by a part time staff person. Duties assigned to this role included scanning clinical records, creating electronic charts, meeting minutes, distributing minutes and agenda schedules. Duties from this position were absorbed by the coordinator due to a vacancy in the position in late 2017.

CHILDREN'S SERVICES

At GCMHC we pride ourselves on providing responsive and comprehensive treatment to the children and families of Greene County. Our team of experienced children's therapists, case managers, prescribers, and family support worker offer families a collaborative network of services and support.

Initiating children's services at GCMH:

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

Referral sources include:

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

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

Referral reasons: in 2017 the majority of new referrals concerning:

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

Many high risk referrals indicated concerns about:

- self-harm/cutting
- suicidal thoughts/behavior
- aggression/threats

Younger children have been referred to address issues with significant family loss/change including witnessing violence, family disruption, and parental separation. The opioid epidemic has contributed to an increase in referrals related to foster care placement, parenting/safety concerns, and adjustment to parent death by overdose.

Verbal Therapy/Supportive Counseling

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

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

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

At any given time, the children's team serves anywhere from **220-280** active clients.

Full time children's therapists carry a caseload of **45-50** clients.

Medication Management

The Children's Psychiatrist on staff is in the clinic 5 days per month for assessment, consultation, and ongoing medication management. Two nurse practitioners at the clinic provide medication management to a small number of adolescents.

There continues to be a large demand for medication evaluation and medication management in our region with limited prescriber availability. The clinic often refers out to primary care offices and specialists if a client is less complex or unable to wait for assessment. The clinic child psychiatrist prioritizes the most severe and complicated cases, with the goal of transferring care to one's primary care provider once stabilized.

Children's Health Home Care Management

Greene County Mental Health community services board is a care management agency within GCMHC. We employ 2 full time Health Home Care Managers. The clinic also has a half time state item care manager shared between Greene and Schoharie County who carries a smaller caseload of Greene County youth.

Health Homes: Starting in December of 2016, the New York State care management model changed from targeted case management, to Health Homes Serving Children. Health Home services are now available to any Medicaid eligible children who meet certain criteria including a significant mental health diagnosis, two qualifying health conditions, HIV, or Complex Trauma. Once deemed eligible, the care manager determines a child's acuity by completing regular assessments, which drive the number of contacts per month as well as the problems and goals

in the plan of care. Most referrals for care management come from SPOA, but can also be expedited after a hospitalization, parent referral, or other outside source. Care Management including assessment of needs and progress towards goals, ongoing service coordination, individual and family support, and referrals/linkage to community resources.

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

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

Family Support

The clinic 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 partnership and promote the practice of family-driven and youth-guided approaches.

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

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

Children's Team Staffing

- The clinic currently employs 3 clinic based therapists and 4 school based therapists.
- An RN acts as the children's team intake/crisis coordinator, and SPOA coordinator.
- The clinic has a children's psychiatrist who works 5 days per month providing consultation and medication management services.
- The clinic employs 2 full time Health Home care managers and one half time state item care manager.
- The clinic has a full time family support worker who provides family support, advocacy, skill building, and community outreach.

- The Clinical Coordinator for Children's Services supervises most of the children's therapists, the children's care managers, and family support worker. She acts as a liaison with other child serving agencies in the county and sits on various committees related to children's services. She acts as team leader and carries a personal caseload of children and transitional age youth.

Our Children's team is responsive to the needs of the community

School-Based Mental Health Services

GCMHC continues to have school-based satellite programs in several school districts. School based services increase access to services many families would not be able to easily utilize. Participating districts include

- Windham/Ashland/Jewett school district 3 days per week,
- Cairo/Durham Middle/High School 4 days per week,
- Cairo Elementary 3 days per week, and
- Hunter Tannersville Central Schools 3 days per week.

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 positive feedback about this service. School based services are overseen by the Clinical Coordinator of Children's Services. The clinic continues to collaborate with school staff in districts not participating in the school-based program to accommodate referrals, manage crisis, communicate about high risk students, and provide trainings when requested.

School Avoidance Task Force

This past year the clinic has hosted and helped facilitate the School Avoidance Task Force. This meeting attended by representatives from Greene County School districts and community providers, addresses the pervasive issue of chronic and severe attendance issues. Members have discussed factors contributing to poor attendance including

- mental health issues including anxiety and depression
- parenting deficits/lack of engagement with schools
- behavioral challenges/refusal
- bullying/social issues
- chronic academic struggle

The task force has been meeting monthly to collaborate and problem solve, starting in the spring of 2017. Currently, members are working to develop a unified attendance policy for all Greene County school districts that align with appropriate interventions including voluntary services (counseling, family support) and involuntary services (probation involvement, child protective services.) Providers are developing materials for schools to better engage and inform parents of what to expect when accessing supports offered. This task force plans to continue its mission into the 2018-2019 schoolyear.

In-services/Trainings

Representatives from the Greene County children's team have offered formal and informal supports to the community in a variety of ways in 2017. 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 clinic based and school based team has offered support to school districts in response to crisis on several occasions. This has taken the form of safety assessments, in house counseling for staff after a tragedy, and consultation with staff around high risk students.

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

High Risk Clients/Crisis Response

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

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

The children's team maintains a watch list of high risk clients, reviewed regularly in supervision and in children's team meetings. There is ongoing discussion of how to best safety plan and meet the needs of these children and family systems to help prevent future hospitalization and placement.

The children's team maintains positive working relationships with the Mobile Crisis team, area hospitals, and all child serving agencies so that response and collaboration is smooth in the event of a crisis.

Groups

The children's team has continued to run 2 groups in 2017.

- **Youth Power**: is a support and advocacy group open to clinic and non-client adolescents who have been labeled in a child serving system. The group provides a safe space for youth to connect, learn about themselves and their rights, and to improve self-care/independence. Youth Power is a state-wide, peer run program promoting youth involvement in the services they receive.

- **Girl's Group**: is a monthly group for adolescent females receiving case management in Greene County. This group uses hands on expressive arts and psycho-education to help members develop self- esteem, coping skills, and age appropriate social skills.

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 to prevent higher levels of care. We have developed a reputation amongst our clients and collateral agencies as a knowledgeable, reliable, and responsive team of mental health professionals who care about those we serve.

Child & Family Single Point of Access

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

The 9 Home and Community Based Waiver (HCBW) slots for severely emotionally disturbed children continue to be utilized to full capacity. Currently there are 6 children on the wait 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 is encouraged to be the conduit for all care management referrals. Starting in December of 2016, the New York State care management model changed from targeted case management, to Health Homes Serving Children. Health Home services are now available to any Medicaid eligible children who meet certain criteria including a significant mental health diagnosis, two qualifying health conditions, HIV, or Complex Trauma. This service may include ongoing assessment, care planning, care coordination and health monitoring, linkage and referrals, and family support. For the year 2017, 38 out of 61 case management referrals qualified for Health Home Case management.

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

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

In 2017 the committee completed 75 SPOA initial meetings with families and collateral agencies as well as 9 SPOA reviews to follow-up on previous SPOA meetings for a total of 84 meetings. These referrals came from many different sources including Mental Health, local school districts, Greene County Youth Bureau, Greene County Department of Social Service and Psychiatric Hospitals. Case management continues to be the most utilized resource in the county for children and families. There were 61 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 (41), and Mental Health Association Respite (19) (which currently has a wait list of

13 children) and Parson's Home and Community Based Waiver Program (6), (this program serves the most intense cases which currently has a wait list of 5 children).

	2014	2015	2016	2017
Initial SPOA meetings	64	68	58	75
SPOA Reviews	23	19	13	8
Referrals to Case Management	64	49	49	61
Referrals to Waiver	8	7	12	6
Referrals to Family Peer Advocate	x	38	40	41
Referrals to Respite	x	20	10	19

COMMUNITY SERVICES BOARD

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) in addition to other stakeholders within the county. 2016 continued to be 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 hospitalizations over a 5 year period; Regional Planning Consortiums, transition of Children's Case Management into Health Home and enrollment of children into health home; adults with Health and Recovery Plans completing the assessment that determines their eligibility for Home and Community Based Waiver Services. The client experience of care including quality and satisfaction, improving health of populations and reducing the per capita cost of healthcare remain at the forefront.

As in the past, the CSB and Subcommittees reviewed 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 plan 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 2018 completed by the Director of Community Services (DCS) who is also the Director of Mental Health following collaboration with the Community Services Board:

1. Increasing access to safe, stable and affordable housing for those with mental health and substance use disorder.
2. Improving transportation to the public, disabled and low income in Greene Co.
3. Mobile Crisis Assessment services.
4. The Greene Co Community will increase their knowledge/understanding that Addiction is a chronic brain disease that requires a more dedicated and coordinated public health focus.
5. Increase mental health services, supports and resources available to children and families in Greene Co.
6. Meeting the needs of the intellectually and developmentally disabled in community.