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Greene County Mental Health Center

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Director's Report

January – December 2012

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Introduction

The Greene County Mental Health Center (GCMHC) maintained continued growth throughout 2012. At the time of this report, GCMHC has 1,192 open cases of which 42% are male and 58% female. Over the course of 2012 we served a total of 2,053 individual clients with 22,167 direct service contacts. As of December 2012, there were approximately 850 adults and 280 children/families receiving treatment. On average, GCMHC performs approximately 45 adult intakes per month and 24 child/adolescent intakes. GCMHC typically operates with a waiting list of 15-20 non-emergent clients. Most remain on the waiting list for an average of two weeks with no one waiting more than 30 days. There is no wait for psychiatric services. Increased Utilization Review Systems and other supervisory measures are aimed at assuring that all services provided are necessary, and those provided are relevant and impactful.

Evaluation of 2012 Goals

- 1. Utilize the Accumed Scheduler instead of the Quic Doc's Scheduler in order to make the billing process more efficient.**

This goal has been met. Accumed is now used as the scheduling/billing module, and Quic Doc's is strictly for the electronic medical record (EMR). This has resulted in increased accuracy and efficiency in both the billing and documentation.

- 2. Utilize E-Prescribing for MD's & NP's in the Quic Doc's system. One Adult Prescriber is slated to pilot the program**

Currently two prescribers utilize the E-Prescribing feature in Quic Doc's. The process for E-Prescribing is in the process of changing and all prescribers will need to be trained on the new system. We anticipate that all prescribers will be using the E-Prescribing feature by May 1, 2013.

- 3. GCMHC would like all new medical records to be paperless by June 2012 and begin the process of transitioning over current records by year end.**

This transition took longer than expected. As of March 1, 2013 all new medical records are electronic. We are in the process of scanning documents into the medical records. The slower gradual process has resulted in an easier transition for staff with management being able to target key areas that required additional training. Additionally, the Director of Clinical Services has been able to address significant problem areas that have been chronic in nature with our electronic medical record vendor.

- 4. Increasing the number of billable services that clinical staff are required to meet on a yearly basis.**

Staff productivity expectations have increased since 2011 with most staff meeting or in some cases exceeding the assigned goal. During supervision the quality and quantity of work assignment is discussed with staff.

- 5. Implementation of an Early Recognition and Screening Program for Ages 5-21.**

The Early Recognition and Screening Program has been very successful in 2012. See section on the Early Recognition & Screening Program.

- 6. Continue support of clinical staff members to obtain further credentialing/licensure in order to capture billing revenue.**

We had 2 clinicians get their LCSW licenses in 2012 with 2 pending examination in 2013. The clinic provides structured individual and group supervision to staff. This results in staff growth, the provision of evidence based care that is both meaningful and impactful. From a revenue standpoint it is imperative that newly trained Licensed Masters Social Workers (LMSW's) are provided with the clinical supervision and 3-years work experience to sit for the Licenses Clinical Social Worker (LCSW) exam since insurances such as Medicare will only reimburse for service provided by those with an LCSW.

- 7. Acceptance and participation in a Children's Technical Assistance Center (CTAC) that will help clinics in developing strong business and financial models to ensure sustainability. This initiative will be supported by a NYS Office of Mental Health grant.**

The clinic's involvement in this initiative has assisted the Director, Fiscal Officer, Director of Clinical Services, and Team Coordinators in optimizing our use of billing and electronic medical record to look at critical variables such as productivity numbers, payer mix, revenue per payer, accurate expenses, and then overlay things like now show rates, cancellation rates, time between first call and first visit, and time between first visit and psychiatric assessment.

- 8. Expansion of group therapy as a treatment modality.**

The clinic has expanded our group offerings to include a woman's support, women's therapy, and social skills group. The gardening group was developed further to engage those with serious and persistent mental illness who have difficulty relating in a verbal format. In 2012 the produce from this group was donated to a local pantry which had therapeutic benefit for those who wanted to give back to their community.

Goals for 2013

- 1. We will pursue the Medicaid Meaningful Use incentive which provides incentive payment to providers who use electronic medical records in a way that positively impacts client care.**
- 2. Now that we are progressing through the transition into using an Electronic Medical Record (EMR), we will also be revising, streamlining, and implementing a new Utilization Review process. We will establish a new UR procedure that is a more efficient use of the reviewers' time while also working toward the goal of ensuring that our services are utilized properly and that our clients are receiving the proper and appropriate level of care.**
- 3. As we continue with the EMR transition, we must make steps to ensure that maximum cyber-security is ensured for our clients' protected health information. This will require ongoing collaboration with the County's IT Department. Based on consultation with them, establishing a new but more secure way of connecting to the clinic's mainframe, such as through a VPN, may have to be established.**
- 4. Participation in the Children's Technical Assistance Program (CTAC) through 2013 that provides guidance on financial models to ensure sustainability as the clinic continue to provide clinically relevant, evidence-based mental health treatment.**

5. To establish a practice where clinicians can contact insurance companies to negotiate on behalf of the clients who have exceeded their utilization thresholds and to advocate for those who are approved for minimal authorized visits from their insurance company.

Corporate Compliance Plan

To assure that all Medicaid and Medicare Billing requirements are fully followed, all staff members of GCMH participate in an annual comprehensive training, outlining aspects of the corporate compliance plan, signing a statement signifying their full understanding and agreement for full compliance to the policies and procedures of the plan. All new staff members and interns are trained as part of their orientation at GCMHC.

Over the past year, there have been some minor modifications and improvements made to the Corporate Compliance Plan in order to reflect changes in the clinic and to ensure that it properly serves its purpose. Among those changes, Jason Fredenberg, PsyD was identified as the sole Corporate Compliance Officer. Certain minor edits were necessary within the plan itself to reflect some of the changes in the clinic. Additionally, the clinic's recent transition to Electronic Medical Records (EMR) provides added security to ensure that users are in compliance with the plan. The Corporate Compliance Officer meets at least quarterly, with the Business Manager, Amanda Passaretti, and other pertinent parties to discuss the plan and any reports of fraud, waste and abuse.

Internal chart audits occur quarterly where the previous quarter is reviewed, and documented in meeting minutes. The Director is immediately notified of any issues. Any negative findings are corrected and adjusted, with paybacks made if necessary.

Fiscal Developments

The Greene County Mental Health fiscal department experienced a lot of growth in 2012. With the changes to APG billing starting early in the year and the transition to government rates beginning in September of 2012, many new systems were put in place to make the best use of the computer software as well as improve our collections technique.

With additional help from our software vendor we were able to increase the efficiencies in our system to support the additional codes and rules set forth in OMH's 599 Guidelines for Clinic Restructuring.

Major accomplishments for 2012 were an increase in the department's collections, to date 81% with additional monies outstanding from the Medicaid Managed Care Companies for the 3rd quarter of 2012 due to the changes to government rates. We increased the rates in our billable services to our approved Medicaid rates which resulted in higher reimbursement amounts for services rendered.

Goals for 2013 will be to create an open dialogue with those who are uninsured or underinsured, assist them to obtain insurance coverage whether public or private. We currently have an uncompensated care rate of 15%. This figure is on the increase as clients lose employment and others unable to afford the higher copayments and deductibles.

Technology Developments

In December 2011, the Management Team at Greene County Mental Health decided to embark on the transition to Electronic Medical Records. We initially set the target transition date of June 1, 2012. While we knew this was an ambitious target, the process ended up taking much longer than we anticipated. However, the longer process has proved successful and seems to have made for a smooth, gradual transition for the staff. On March 1, 2013, fourteen months after the process began; the clinic took one of the final steps towards being entirely paperless.

As of March 1, 2013, all medical documentation is now completed electronically and is electronically signed. We continue to keep paper copies of charts for another few weeks until our medical staff transitions to electronic prescribing. At that point we will no longer print copies of charts and all charting will be done entirely electronically.

Costs of this transition were minimal considering the fact that we did not purchase a new EMR system and instead, used the one we had. There were costs associated with some additional licensing, and some hardware upgrades, but in the long run, this transition will result in work being more efficient and less burdensome. It will also result in a drastic reduction in the need for printing, paper, toner, ink, and printing hardware.

Building & Safety

As part of the larger safety measures all staff and clients began to enter the building through the front door. The back door by soil & water was locked with a limited # of support and management staff being provided keys because of functions they have to perform in the bldg. The door at the end of the handicapped ramp was also locked with an intercom available for those clients who need to enter. It was wired into the front desk, who on confirming the identification of person and verifying that they have an appointment, the Sheriff's Deputy then goes to the door and escort the person to the waiting area. A Sheriff's Deputy assists with the flow of traffic through the front entrance each morning.

Security concerns, both inside and outside the building, are addressed in meetings that include the Director, County Administrator, Legislators, Sheriff's Department, Buildings and Grounds, and Emergency Operations.

Staffing News

The Greene County Mental Health Center experienced several staffing changes during 2012, some of major significance to the functioning of the clinic. Our Medical Director and part-time provider of psychiatric services of 10 years retired. The Registered Nurse who functioned as the coordinator of Assisted Outpatient Treatment (AOT), coordinator of intakes and crisis response, retired after 10 years of service. The loss of both has been stressful, but it has also provided an opportunity to streamline, re-organize, and become more efficient while the clinic continues to provide high quality mental health services.

During 2012 GCMHC continued to be a sought after clinical training site by several disciplines. It has included 3 doctoral level psychology interns from SUNY Albany; a social work intern from SUNY Albany, mental health intern from St. Rose, and a Nurse Practitioner intern from the University of Rochester. While interns require strict oversight and structured supervision, they are permitted to provide clinical service to a small number of Medicaid Fee for Service and Managed Medicaid clients under the direction of their supervisor. Our involvement with interns has provided a rich experience for all

ADULT SERVICES

Personalized Recovery Oriented Services (PROS) 2012 Report

The Greene County PROS Program operated by the Mental Health Association of Columbia-Greene Counties, at the Olde Firehouse in Catskill is running close to full capacity of 70 adult clients.

Throughout the year there were regular collaborations between the Greene County Mental Health Center and staff at PROS around utilization and referrals. The building was renovated during 2012 to accommodate the increased number of program participants and to improve building security.

The Admissions Coordinator from PROS attended several adult team meetings at GCMHC during the year to review program offerings.

Community Health Integration Project

As previously demonstrated, the *Community Health Integration Project* (CHIP) continued to offer high quality services to the residents of Greene County throughout 2012.

In 2012 CHIP maintained the established six satellite offices in Greene County. CHIP clinicians continue to offer mental health assessment and treatment services directly to clients at the satellite locations as well as in-home, when determined necessary. For the past six years, the Rural Health Network has provided support of this program, including grants and outreach, which includes the 5 hr per week salary for the coordinator and a small budget for supplies, such as billboards, educational pamphlets and materials.

Historically the most significant development of the project has been the feedback from primary care physicians, staff, and residents of Greene County that most of the individual county residents reached through this project would not have been served otherwise. In addition to the barriers described, there is a strong negative stigma regarding traditional mental health care, which we believe this project mitigates to some extent.

In 2012 documentation and protocols for CHIP have continued to evolve as the needs of the client population and project have changed. Use of software to track productivity by satellite location was determined to be feasible in late 2012, and will likely go into effect in early 2013. This will streamline the reporting process. One unfortunate change this year is that the in-home screening through the Greene County Public Health ended mid-year when that organization terminated this service. Other avenues are being explored to provide services to home bound seniors in 2013.

Efforts to encourage community buy-in continue. Responding to feedback from clients and primary care physician's offices, the *Mental Wellness Screen* was revised and shortened, making the completion faster and easier than ever before. Early feedback on this change is that participants are more willing to complete the form. The Director and Coordinator of CHIP continue to meet with PCPC office to foster collaboration between agencies.

As in the past, in 2012 the coordinator had contact with all satellite locations for delivery of materials and training, via in-person visits, phone and fax correspondence. New correspondence was created that allowed additional information flow to and from the satellite offices, particularly in the area of the usage of the CHIP-developed *Mental Wellness Screen*.

With the success of the program, the coordinator has been receiving referrals from other organizations with a desire to collaborate and create similar models in their communities around New York State. These contacts occur

throughout the year, some originating from the Office of Mental Health, others from presentations made by the coordinator at local, regional and national conferences. Slideshow presentations and other materials generated as a result of CHIP are now posted on the State Office of Mental Health website.

Data from the last three years of service delivery is available and shown below:

2010

Service Description	Total
Seen (face to face contacts: brief assessment, crisis intervention, referral, etc)	976
Screened (Mental Wellness Screen <i>basic or enhanced</i>)	693
Verbal Therapy sessions (billable services, ongoing psychotherapy)	664
Assessed/Intake Evaluation (billable services)	87
Home Visits	24

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 <i>basic or enhanced</i>)	940
Verbal Therapy sessions (billable services, ongoing psychotherapy)	497
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 <i>basic or enhanced</i>)	418
Verbal Therapy sessions (billable services, ongoing psychotherapy)	555
Assessed/Intake Evaluation (billable services)	88
Home Visits	2

Table 3

Of the above data, it is important to note two things, that data was estimated for two months in 2010, and categories of services were added in 2011 and effecting all future reports. Satellite offices were staffed for nearly 150 days of service this reporting period. Overall the program has remained relatively consistent in the numbers of assessments completed. MWS completed in 2011 top all figures available for all reporting years, and may have been due to several strategies that occurred that year, including involvement of administration in annual satellite visits to increase buy-in. Lastly, two of the six offices were temporarily closed or unstaffed in 2012, contributing to decreased number of scheduled and kept appointments in 2012, as well as screenings and assessments for that reporting period.

In 2013, GCMHC will look towards expansion, improved access to care, improved use of screening tools and staff education, as well as maintaining connections to local agencies. Outcome measures, satisfaction surveys and updated screening instruments will be reviewed in 2013 to further improve the quality of care to residents of Greene County.

In summary, CHIP is continuing to meet the needs of many Greene County residents by providing quality, innovative care. GCMHC clinical staff remain enthusiastic and committed to CHIP as a means of service delivery within a rural community setting, and CHIP affords the best access to mental health services in a geographic area where there are no easy solutions to lack of transportation and private sector service providers.

Assisted Outpatient Treatment Program (AOT)

This State-wide initiative has been developed to assist non-compliant treatment clients to obtain mental health treatment they need. To date, 62 Greene County residents have been referred to the AOT Program. In 2012, 8 new AOT orders were issued and 2 clients were placed on enhanced status. Currently, there are 12 clients on active AOT orders and 2 on enhanced status. 2 clients were discharged from AOT status in 2012, 2 clients were discharged from enhanced status due to successful completion. During 2012, 6 pickup orders were issued for AOT clients due to non-compliance or psychosis.

Greene County Jail Services

The services provided 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 590 interviews were conducted by the Forensic Mental Health worker which included suicide risk assessments, supportive counseling requests, and evaluations for medication. The psychiatric Nurse Practitioner provided an additional 181 medication related contacts.

The severity of psychiatric needs of inmates continues to increase. Typically, inmates meeting criteria for hospitalization and in need of hospitalization are stabilized (with medication) before a bed opens at Central New York Psychiatric Center (CNYPC). There was only 1 CNYPC admission during the year.

There were 31 Court Ordered Mental Health Evaluations conducted at the jail by the Forensic Worker; as well as 3 inmates receiving 730 competency exams at the clinic.

On-call services are available and provided as needed after hours, on weekends, and holidays by the on-call mental health worker.

Additional Information:

- A Suicide Risk Assessment is completed on each inmate at booking, by the booking officer. These are given to the Forensic worker for review at the beginning of each business day.
- All inmates determined to be at risk or have a prior Mental Health history are usually seen by the next business day; but no longer than 2 business days of booking.
- Inmates are kept on Active Watch and cell locked until they have been cleared by both the medical and mental health staff.
- All Jail staff has the ability to make a Mental Health referral on behalf of the inmate, as well as based on their own concerns.
- Inmates referred by Jail Staff are usually seen by the next business day; no longer than two business days of the referral.

- Inmates self requesting to be seen by a Forensic worker are seen within three days of request.
- All interviews include a Suicide Risk Assessment.
- CNYPC Discharges are usually seen within one business day; no longer than two business days after their return from CNYPC. They remain on Active Watch until cleared.
- Court Ordered evaluations are seen 1 –3 times before a report is written and submitted to the Court.
- Jail Shift Supervisors have the ability to call the On-Call Worker after hours as needed.
- All inmates seen by an on-call worker, and placed on constant watch, are reassessed the next day by the on-call worker or forensic worker for re-evaluation of watch status. All others are seen the next business day by the forensic worker.
- Medication referrals for the Nurse Practitioner are made through the Forensic worker or Jail Nurse only.
- Shift Supervisors are notified immediately of at risk inmates and consulted regarding level of security inmate will be placed on.
- Shift Supervisors and CO's are the most valuable source of information regarding inmates; they are consulted daily regarding risk and security measures of inmates, and to monitor ongoing concerns of inmates.
- Discharge Planning begins at the first meeting with an inmate requesting Mental Health services. Each inmate seen is given referral information regarding available Mental Health Services in the community. Formal Discharge Planning is available for inmates with known release dates.
- Inmates receiving Mental Health services at the jail are given information for follow-up Mental Health services prior to release. Referrals to other agencies are made as needed.
- Released inmates are given an appointment for follow-up at the clinic within one to two weeks from release.
- Inmates are provided with 2 weeks medication (by prescription) when released to cover them until seen at GCMH.
- The Jail Superintendent, LT, supervisors have daily access to the Forensic worker to share concerns. Concerns are followed-up on immediately.
- A copy of the Clinical Log (documenting who was seen and current watch status) and daily report is given to, and received from, the shift supervisor regarding concerns, risks, and watch status changes of inmates.
- Case management services are available to inmates requesting assistance. This can include, but certainly is not limited to, assisting with phone interviews for rehab; collaboration with Public Defenders office; notifying care providers of incarceration; completing paperwork for SPOA housing or case management referrals; collaboration with the courts on inmates behalf; facilitating referrals to other agencies upon release.
- Veterans and those having served in the military are referred to Veterans Justice Outreach Services. When appropriate, interviews are coordinated through the forensic worker and the outreach coordinator to determine available services for those eligible.

Comments:

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; establishing individualized mental health records, copies of which are included with inmates medical records; providing a Licensed Clinical Social Worker daily to provide services to inmates; providing 3 hours per week of psychiatric medication therapy by a Nurse Practitioner; providing on-call services through the clinic on-call service for weekend and holidays; providing follow-up services for inmates upon release; providing case management services during incarceration; and providing Court Ordered Evaluations. These services are provided with the intention of lowering the risks of psychiatric and behavioral emergencies and to increase the safety of inmates and staff, as well as facilitate 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. The ability to provide these services within GCJ has enabled inmates with psychiatric impairments to be identified, treated, and offered follow-up care.

Family Court Services

Over the course of 2012, Greene County Mental Health initiated significant changes to the services we provide to Greene County Family Court. Historically, GCMHC provided Child Custody Evaluations for Greene County Family Court. These were extensive evaluations to produce recommendations to the judge regarding child custody, visitation and parenting capacity, based on the best psychological interests of the children. Such evaluations are extremely time-consuming, often in excess of 30 hours, for which the clinic was barely reimbursed. These were always performed on a sliding scale fee basis and most times, the fee was completely waived for these services.

Over the years, the court's request for this service was extremely high and eventually exceeded our ability to provide them. As other demands on the clinic increased by February 2012, GCMHC administration was left with no choice but to begin to cut back on the provision of these Child Custody Evaluations. In light of this, the clinic and court agreed to a 10-month moratorium on new referrals for these evaluations so the clinic could catch up with the backlog of these referrals. By the end of the moratorium however, GCMHC was not in a position to resume performing these evaluations and GCMHC determined the service must be cut. We did, however, agree to keep an open dialogue with the Family Court judges and if there was a case with extreme circumstances that would require a full Child Custody Evaluation we would try to perform them on a limited basis.

In attempt to still meet the needs of the court, a briefer evaluation was offered to the courts in lieu of the full Child Custody Evaluation. While this new evaluation is not as extensive and cannot produce the same types of recommendations, it is aimed at providing the court with helpful information from Mental Health Professionals that might still assist them in their decisions. These evaluations, unlike the Child Custody Evaluations, often require 1-2 hours to complete and are usually billable to the clients' health insurance.

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. Two groups are currently in operation: Tuesday 9am – 10:30 am and Wednesday 4:30pm – 6pm. Both groups run at Greene County Probation. Thirteen (13) offenders were actively attending the program at the start of 2012. During 2012, 4 new members were added to the program, 4 members left the program. Of the members who left the program, 3 successfully completed their probation sentences with out re-offenses and 1 member moved to another county near the end of his probation sentence. No known sexual re-offending has occurred from existing program members.

Currently attending members are all supervised in the community by the Senior Probation Officer. There are 3 members who are mandated to attend Sex Offender Treatment who are not on the New York State Sex Offender Registry. The remaining 12 members include 2 members at Level III, 1 member at Level II, and 9 members at Level I on the Sex Offender Registry.

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 reoffending behaviors.

Residential Single Point of Access (SPOA)

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.

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 breakdown of the SPOA Referral Process for residential assignments throughout 2012 is as follows:

2012	
# Submitting application to Housing SPOA	16
# Determined eligible/referred to Housing Providers by SPOA	14
Admitted to Housing Programs through SPOA	13
Wait List	1

(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 their 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 2011 were placed in housing in 2012; (3) wait includes individuals carried over from other years.)

Applications that were submitted but found to be incomplete are returned to the referral source. Applicants that are determined inappropriate for housing resources above 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 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.

Unfortunately, an increasing number of psychiatrically impaired individuals 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.

CHILDREN'S SERVICES

School-Based Mental Health Services

GCMHC continues to have school-based satellite programs in Windham/Ashland/Jewett and Hunter/Tannersville school districts three days per week. Our satellites at Cairo/Durham Middle/High School and Catskill Elementary are 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 and the Clinical Coordinator for the Children's Team met with the school superintendents to discuss our satellites in these school districts and across-the-board the feedback is that Greene County Mental Health provides an invaluable and positive service.

The Clinical Coordinator of Children's oversees all clinical services provided within the school-based treatment program.

Child & Family Single Point of Access (SPOA)

The Greene County SPOA Committee for Children had another successful year. Once again the ability of all county, public and private, agencies to work collaboratively for the good of the counties' children and families has benefited every child and family who has worked with the SPOA committee. Families involved in the provider meetings report that the meetings are helpful and very personalized. The committee continues to meet at Greene County Mental Health. The working committee is made up of representatives from Greene County DSS, Greene County Youth Bureau, Parsons Waiver program, Greene County Mental Health, and Mental Health Association of Columbia and Green Counties. Greene County Probation, Ulster/Greene ARC, the Reach Center, and Catholic Charities continue to work with the committee on an "as needed" basis. 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 Home and Community Based Waiver (HCBW) slots for severely emotionally disturbed children continue to be utilized to full capacity. We currently have no waiting list for these services. The New York State Office of Mental Health continues to fund these slots. Parson's Childcare Agency continues to be the contract agency that provides all services to the Greene County children/families that apply for and are accepted for HCBW's. 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.

New to SPOA in 2012, Ulster/Greene ARC has agreed to attend SPOA meetings when a child has a possible developmental disability. This has been a great addition to our process.

SPOA also continues to be the conduit for all case management referrals. Greene County currently has approximately 62 slots for case management services: 38 slots through the case managers at Greene County Mental Health and 24 lots through case managers at the Mental Health Association. Of these, there are three transitional slots for adolescents 18-21.

SPOA also serves as a referral mechanism for two other important programs in the county: IAPP and Respite Services. IAPP (Intensive Aftercare Prevention Program) is administered by DSS for families in the most need of home-based family work. Two social workers go into the home several times per week to establish and help at-risk families meet specific goals designed to keep the family intact and successful. The Respite program is administered by the Mental Health Association and is used for families where the child (and adult) could use a break and some time outside of the home for fun and learning new life skills. Respite workers meet with the family to establish a positive working relationship and then take child out for approximately three hours every week or every other week.

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 2012, we had several children in the county placed in these facilities.

The position of Parent Advocate continued to be an important part of SPOA. This position was temporarily vacant but refilled in 2012. The role is to serve as a support and resource to connect the parents attending SPOA meetings with other available services in Greene County. The parent advocate is currently in a training program to become an educational advocate for families coming through SPOA, An educational advocate helps families understand and negotiate their legal rights when it comes to educational opportunities for their children, especially children with special needs.

In 2012 the committee received 67 new SPOA referrals and 67 SPOA reviews to follow-up on previous SPOA's. These referrals came from many different sources:

- Case Management
- Psychiatric Hospitals
- Community Mental Health
- Schools
- Greene County Youth Bureau
- Greene County Social Services
- Other community mental health providers
- Greene County Probation

Case management continues to be the most utilized resource in the county for children and families. There were 80 new referrals made to case management services (combined ICM, SCM and MHA). Many referrals were also made to Parent Advocate Services (15), DSS Prevention and IAPP Services (13), MHA Respite (15), Greene County Mental Health (38), and the OMH Waiver program (14) for the most intense cases.

Systems of Care Project

Greene County Mental Health was awarded an additional \$5,000 to our Systems of Care Grant in 2012 bringing the total amount funded to \$10,000. For our System of Care project, Greene County will develop a "Community Prevention Team" to assist families with youth who meet the Persons in Need of Supervision (PINS) and Juvenile Delinquent criteria. The team will focus on providing the family with local agency resources and natural community supports to help prevent placement and support the family in developing positive internal resources. The implementation of the project has been delayed as the mechanics of hiring a parent advocate and peer advocate are being worked out. The team will consist of:

- Parent Partner
- Peer Advocate
- Greene County Probation
- Greene County Mental Health
- Greene County Youth Bureau
- Greene County Social Services
- Twin Counties Recovery (substance abuse recovery services)
- School Support Representative (as chosen by school)
- Family and other Natural Supports

The unique aspect of the program is the involvement of the identified Adult Support and Peer Support individuals who will be responsible for supporting the peer towards positive life changes and reporting back to the team.

Multi-Family Group

Greene County Mental Health participated in the CTAC (Children's Technical Assistance Center) initiative developed by the Office of Mental Health (OMH). The first piece of this initiative was the formation of a multi-family group called the 4 R's and 2 S's. Six families participated in the program. Greene County was awarded a \$750 mini grant to hire a parent advocate and support the group leaders. The parent advocate provided additional support to the families' in-between group sessions.

Performance Based Early Recognition Screening Project

In 2011 the “Clinic-Plus” Program ended. The Clinic Plus program provided funding for the clinic to screen children in the community for mental health issues. Greene County Mental Health was one of ten agencies in the Hudson Valley Region awarded funding to participate in the new “Performance Based Early Recognition Screening Project” which funds a staff person and related expenses to continue screening children in the community and also requires us to develop an “anti-stigma” campaign to promote the importance of addressing emotional wellness in the community. This project will be the most ambitious effort to date in our county to create a collaborative network of county agencies and community healthcare providers combining resources with the goal of getting services to children in a timely manner. In support of our proposal for this grant we received commitments from Greene County Social Services, School Superintendents, local pediatricians, Twin Counties Recovery Center, Greene County Early Intervention and Family Planning to name a few of the stakeholders who will be involved in this project.

To date 580 screens have been scored. Of the 580 screens 71 have been “high risk” or 12.24% of the students have scored “high risk”. Of the 71 “high risk” students about half have contacted the Greene Co. Clinic, private therapists, or school counseling services.

CASE MANAGEMENT SERVICES

Case Management Services

Greene County Department of Community Services, in conjunction with the Mental Health Association of Columbia/Greene Counties and NY State Office of Mental Health: Capital District Psychiatric Center (CDPC) continues a working partnership in providing various levels of Case Management Services to children, adolescents and adults of Greene County. The levels of case management services are as follows: Supportive Case Management (SCM); Intensive Case Management (ICM); Blended Case Management (BCM) and MHA Family Based Case Management; assignment to services vary based upon the client’s level of need for intervention and support. All of the aforementioned levels of case management services, except for the latter model, are Targeted Case Management (TCM) services reimbursed by Medicaid for Medicaid eligible clients. A percentage (sometimes as much as twenty-five percent (25%)] of the recipients of case management services are non-Medicaid).

Throughout the course of 2012 NYS OMH and NYS DOH have rolled out a new billing and service delivery model for Adult Case Management services throughout New York State. This plan of action is the result of the Deficit Reduction Act and The Health Care Reform Act and was put forth by the NYS Medicaid Redesign Team. The plan consists of the formation of Health Homes throughout the major regions of NYS; wherein an identified Health Management entity or Managed Care entity becomes the lead provider in coordinating all health care services in a given region (medical, psychiatric, HIV and substance abuse). What has been traditionally known as TCM for the past twenty-four years will become “Care Management” and will be billed to Medicaid with different level of fees for reimbursement. The targeted populations for the Health Homes are individuals identified as high users of Medicaid services (medical, psychiatric, HIV and substance abuse). The overall goal and desired outcomes for this change in service delivery is to improve quality of integrated health care and decrease the rising costs by preventing repeated inpatient admissions and ER visits. All adult case managers throughout NYS have been required, throughout 2012, to participate in a series of Webinar and Face-To-Face trainings on the tenets of Care Management and Care Coordination. This training is financed by DOH and has been provided by NY Association of Psychiatric Rehab Services (NYAPRS).

The targeted populations for case management services are children, adolescents and adults residing in Greene County who carry a diagnosis of serious and persistent mental illness; in the case of children and adolescents have a serious emotional disorder and/or a learning disability; have a history of repeated psychiatric inpatient admissions and or repeated use of crisis / ER services; children/adolescents at risk for placement; the mentally ill homeless population and persons with psychiatric disabilities in need of additional supports to maintain tenure in the community. For the adult population, the Health Home model also considers the following as factors determining eligibility for care management services: at least one chronic medical diagnosis, HIV diagnosis, Substance Abuse diagnosis and being a high user of Medicaid services. Additionally, as a result of Kendra's Law passed in 2000, Adult ICM's are obligated to give priority ICM services to individuals who are court mandated to receive outpatient mental health treatment: Assisted Outpatient Treatment (AOT). These are individuals who pose a high risk to themselves or others in the community.

Children & Youth Case Management Services

The Greene County Mental Health Center has one (1) C&Y Supportive Case Manager (SCM) with a caseload of twenty (20); one and a half (1.5) C&Y Intensive Case Managers (ICM) comprising a caseload capacity of eighteen (18). The half (.5) item for C&Y ICM is provided to Greene County by CDPC since August 2006. The Mental Health Association of Columbia / Greene County (MHACGC) has two (2) Community Based Family case managers, each with a caseload of twelve (12) families. Each of these services reflect varying levels of recipient need and are vital in coordinating and facilitating services provided to children/adolescents and providing overall support to family caregivers as well. The C&Y ICM provides a minimum of four (4) contacts per month with the assigned child/family/school/ mental health, educational, social service providers; the C&Y SCM provides a minimum of two (2) contacts per month with the child/family/school, mental health, social service, etc. systems.

The target populations for C&Y Case Management services are children and adolescents with a diagnosis of emotional/psychiatric disorder and/or learning disabilities; children/adolescents who may be at risk for placement or have a recent history of inpatient psychiatric admissions or recent frequent use of crisis/ER services. Children who are at risk for placement through the juvenile justice system or Pre-PINS, but without a mental health diagnosis/learning disability may be appropriate to receive services through the MHA Family Based CM Program. Characteristic of each of these populations are children with learning disabilities; a history of trauma; serious emotional disturbances marked by behaviors that hinder their ability to be successful at home, school or in the community environments. These identified children/youth could benefit from the linkage, monitoring and support offered by case management services.

C&Y Case Managers serve as advocates and catalysts of change for the population they serve. The service is strengths based, recovery oriented and proceeds with an initial functional assessment of strengths and needs engaging the family and child in a goal focused service plan. The case managers provide linkage, coordination of services and facilitate referrals to services and community based agencies in response to clients needs. Through their consistent contacts with clients they provide ongoing assessment of needs, monitoring of progress and provide ongoing support for clients to attain identified goals. The desired outcome for C&Y case management services is to prevent psychiatric inpatient admissions and/or residential placement by providing optimal access to services and resources in the community.

The C&Y Case Manager meets with their clients in the community, in the school setting and at home. Case Managers may accompany clients and families to court or to Probation appointments. When indicated as a need, the case manager links and facilitates structured social/recreational activities for clients. In 2012 such activities included bowling, hiking, summer camp programs, boxing and horse back riding. Case Management service dollars were utilized creatively in 2012 to provide individuals with driving lessons; defensive driving course; linkage with Boy Scouts; camping and car repairs / new attires to assure parents could safely transport their children to treatment. Also throughout 2012 case management service dollar funds were utilized to assure that each child/adolescent had adequate shelter, food, clothing, transportation, and medication to adequately meet their needs.

Throughout 2012 the C&Y Case Managers worked collaboratively with all providers in the client's system, such as: DSS, CPS, Probation, Youth Bureau, REACH Center, School Personnel, ACCESS-VR (formerly VESID), Independent Living Center and Mental Health treatment providers. Case Managers facilitate, coordinate and link in respect to service delivery via ongoing communication and collaboration with aforementioned providers, assuring accessibility of services for their clients.

Referrals for C&Y Case Management come from the Greene County Children's Single Point of Access (SPOA), which meets weekly at GCMHC. Overall there were eighty (80) new admissions to C&Y Case Management Services in 2012. Referral sources included psychiatric inpatient child and adolescent units in the Capitol District Region, local school districts, residential programs, DSS, Probation, Greene County Mental Health Center and families. The following figures show the total number of children/adolescents provided with CM services in Greene County in 2012:

<u>C&Y Supportive CM</u>		<u>C&Y Intensive CM</u>	<u>MHA Family Based CM</u>
2011	36	30	48
2012	37	30	62 Children (42 Families)

The total number of children and adolescents receiving varying levels of case management in 2012 was one hundred and twenty-nine (129). The wait list to receive services fluctuated at times from no wait list to a possible six to eight weeks due to staff vacancy and rehire.

Adult Case Management Services

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 one (1) Adult supportive Case Manager (SCM) and one (1) Adult Intensive Case Manager (ICM). They provide services utilizing a Blended Case Management model; this model allows for a cumulative total of visits between both SCM and ICM for purposes of Medicaid billing. Capital District Psychiatric Center employs two (2) Adult ICM's for Greene County and they operate and bill Medicaid in the traditional model. The Supportive Case Manager maintains a caseload of twenty (20) clients; each of the three Intensive Case Managers maintains a caseload of twelve (12) clients.

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. Case Managers 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.

Adult Case Management Single Point of Access (SPOA)

All referrals for Adult Case Management services come through the Greene County Adult Case Management SPOA, which meets monthly to review new referrals and to update rosters. The SPOA is attended by various providers who service the needs of Greene County residents diagnosed with a psychiatric disability and in need of support services. Some of these agencies include: WILLCARE Homecare, GC Adult Protective Services, MHA PROS, MHA Residential and the State and MHA Adult Case Managers attend the monthly SPOA. On occasion the referral source and the individual being referred may attend the SPOA.

In the latter half of 2012 the Director of Community Services initiated a series of meetings to review the current framework for the Adult Case Management and Housing SPOA's which have been two separate entities. The outcome of these meetings resulted in a merging of both Adult SPOA processes and a plan to meet bi-weekly as opposed to monthly in hopes of providing greater continuity in the delivery of services and to enhance integration of services. Another focus of the planning meetings was to develop an electronic form that would include both the Adult Case Management Referral and the MHA Housing Referral forms, making them both uniform and integrated. The restructured SPOA was scheduled to commence in January 2013; having representation from MHA Housing, Adult Case Management, GCMH Adult Clinic, GCDSS Adult Protective Services and any other provider pertinent to the incoming referrals.

In 2012 the Adult Case Management SPOA reviewed a total of thirty-four (34) new referrals. Thirty-one (31) of the referrals were rostered and assigned; three (3) were deemed ineligible / inappropriate for CM services and recommendations were made to the referral source for alternative services. Of the thirty-one rostered / assigned clients, nine (9) were Transitional Youth. The client referral sources in 2012 included: Greene County Mental Health Center (15 referrals); Colombia Memorial Hospital (08 referrals); Greene County DSS (02 referrals); the remaining nine (9) referrals came from other sources, including Parson's Day Tx Program, LaSalle Residential Program, CDPC, St. Vincent's of Westchester County, Catskill High School, Colombia County MH and Clearview MH in Albany. At the close of 2012 six (6) individuals remained on Roster awaiting ICM services and six individuals waiting for SCM services.

The total number of adults provided with Adult SCM/ICM services in 2010 is as follows:

	<u>MHA Adult Blended Model</u> <i>(32 slots)</i>	<u>State Adult ICM</u> <i>(24 slots)</i>
2011	39 Adults served	35 Adults served
2012	45 Adults served	32 Adults served

In moving forward to 2013 many changes are anticipated as Phase III of the Health Home roll out will begin and will include not only Greene County, but surrounding Ulster and Colombia counties as well. Hudson River Health Care is the Health Home that was approved by NYS DOH for our County for all adults who receive Medicaid; Medicaid Managed Care or Medicaid / Medicare individuals with a Medicaid spend down and who meet eligibility criteria re: a chronic medical condition; or serious mental health diagnosis, substance abuse disorder and HIV diagnosis. Coupled with diagnostic criteria will be their degree of use of Medicaid services: ER's, inpatient admissions, diagnostic tests, etc. NYS DOH will provide an initial list of targeted individuals who meet criteria for Health Home services. Existing Adult Care Management programs will do outreach and engagement to admit

these individuals to the Health Home. The Adult SPOA will continue to be a vehicle for receiving and screening new referrals of mental health recipients in need of care management. In the Health Home there will be varying levels of need for care management: high, medium and low touch. There will no longer be a minimum number of visits required for purposes of billing and caseloads will no longer be rigidly fixed to a certain number of individuals to be served at a given time.

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.

As in the past, the Mental Health (Office of Mental Health), OASAS (Office of Alcohol & Substance Abuse Services) & OPWDD (Office for People with Developmental Disabilities) 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. Out of the CSB and sub-committees Greene County has joined with Columbia County in forming task forces that are addressing controlled substance misuse/overuse/abuse and suicide prevention. Greene County Public Health and Greene County Mental Health have also collaborated on aligning their priority areas through the involvement in the Mobilizing Action Planning Partnerships (MAPP) process.

Greene County NAMI (National Alliance of the Mentally Ill)

Greene County NAMI celebrated its tenth anniversary with its annual dinner celebration and fundraiser at the Quarry Steakhouse in October 2012. The NAMI president continues to attend regional and NAMI NYS meetings is bringing back important program and funding 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. Outreach and name branding for NAMI has been accomplished through radio and media ads. NAMI Greene continues to offer high caliber educational programs and family support groups in Cairo and Windham.

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