Greene County Mental Health Center

905 GREENE COUNTY OFFICE BUILDING
CAIRO, NY 12413

2016 Annual Report

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INTRODUCTION

The Greene County Mental Health Center is an Article 31 community mental health clinic licensed by the NYS Office of Mental Health. It employs a full contingent of professional staff, including Psychiatrists, Nurse Practitioners, Psychologists, Social Workers, and Mental Health Nurses. Our staff members work together to provide a comprehensive system of care for the mental health needs of Greene County residents.

Over the course of 2016, Greene County Mental Health Center (GCMHC) served a total of 1,765 unique individual clients (a decrease of 128 patients from 2015): 1,330 adult and 435 children; 737 male and 1,028 female. We provided 18,817 direct service contacts compared to 21,590 in 2015.

	2014	**2015**	**2016**
Unique Individuals Served	1,866	1,893	1,765
Direct Service Contacts	21,498	21,590	18,817

CENSUS INFORMATION

Total Visits – 18,817

Adults – 13,571

Children – 5,246

Total Unique Individuals Served – 1,765

Male – 737

Female – 1,028

Adults – 1,330

Children - 435

Evaluation of 2016 Goals

1. **During our OMH Site Visit there were some citations around using standardized screenings and risk assessments. It is our goal to provide staff training on completion of a more in depth risk assessment and its incorporation into the overall treatment plan.**

In 2016, we began implementing more standardized screens and risk assessments. As we continue to go through more transitions in 2017 with our electronic medical record, more screens will completed with the results of the screens being incorporated into treatment planning.

2. **Continue to provide Open Access Hours for Mobile Crisis Assessment Team (MCAT) referrals and use MCAT to check in on those who are post hospital discharge, on a watch list, or experiencing some type of personal crisis.**

OAC continues to provide services to MCAT referrals. Clinic personnel also use MCAT regularly for follow-up and engagement with many clients who are in crisis or deemed high-risk. While it was the original intent for MCAT to follow-up on all hospital discharges, their other demands were too high (per their report) to be able to do this at this point in time.

3. **Highlight the housing needs of those referred to our clinic by other providers. Stable housing is a social determinant of health. Unstable housing creates new health problems and exacerbates existing ones.**

The demand for stable, safe and affordable housing remains a high priority for the vulnerable population the clinic serves. The county received notification in the fall of 2016 that we were selected to receive 3 additional supportive housing slots in February 2017. These will be filled by eligible applicants who have been on a waiting list. This goal will continue into 2017

4. **Expand school-based mental health services to an additional school in Greene County.**

Greene County Mental Health was contacted by the Superintendent of Hunter Tannersville(now retired) to re-establish school based mental health services in the school district for 2016-2017 school year. The school based clinician began in the district in Sept 2016.

5. **Work with Greene County Information Technology to replace outdated Windows XP operating systems which are no longer supported by Microsoft.**

This goal was attained.

Goals for 2017

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.**

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

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

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

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 hosp visit. Using our EMR to generate a monthly report that can guide management.**

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

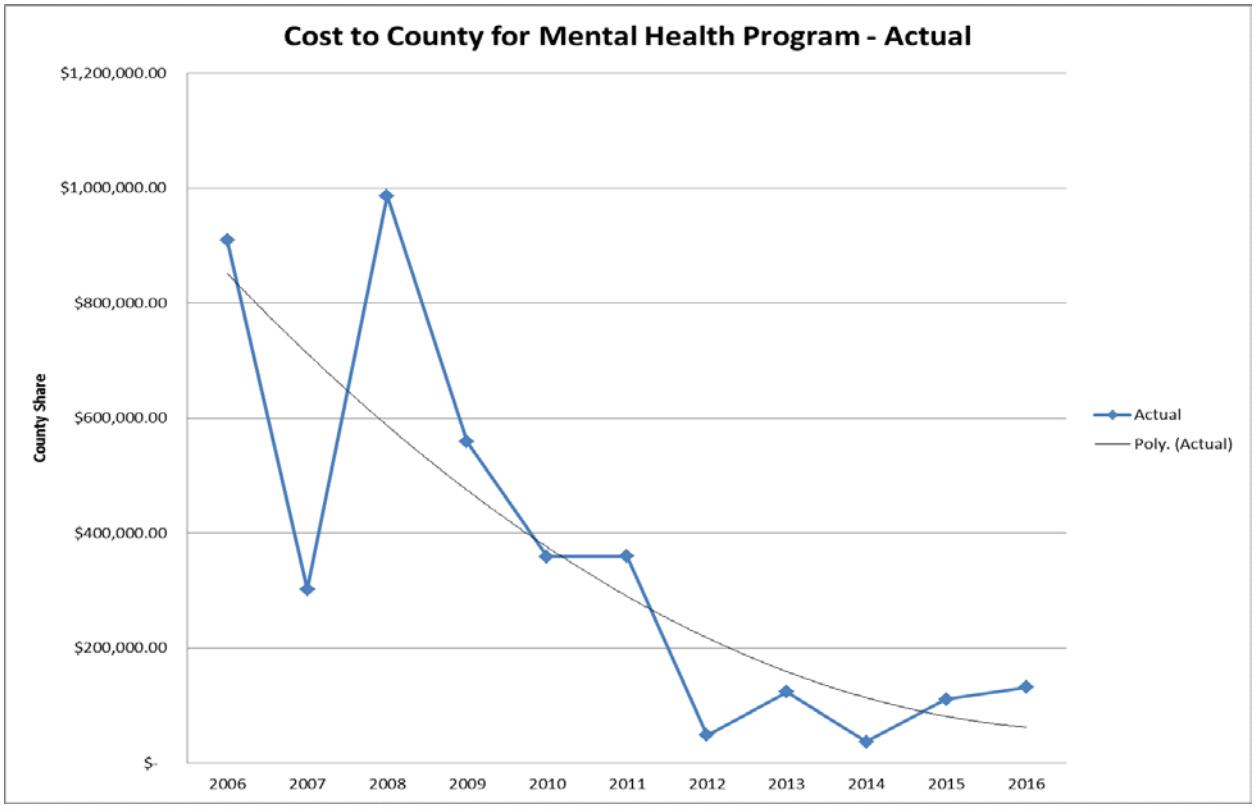
Fiscal Developments

In 2016, the clinic has continued to work with those who are uninsured and underinsured by referring them to our Healthcare Navigator network. Currently GCMHC has navigator services two days per week provided by the Healthcare Consortium and SUNY Albany School of Social Welfare. These qualified staff help to align the client's healthcare needs with a plan that is affordable. In April of 2016, Greene County Mental Health along with other community partners and the UAlbany Navigators were presented with the *President's Award for Exemplary Public Engagement* for addressing the health insurance needs of the Capital Region.

In addition the clinic made changes to staffing in the billing department following a recent retirement. The clinic hired a Medical Claims Processor (this position had existed in the clinic in the past) who can more closely monitor patient accounts and billing related issues. In addition this person can meet with those who are not meeting their financial obligations with the clinic and perform more internal audits to ensure the timeliness of revenue receipts, claim denials and billing compliance.

We used funding from a Health Information Technology grant from The Office of Mental Health (OMH) to support the startup costs of the new cloud based system from Docutrac, Inc., which will be better suited to all programs operating under the Greene County Community Services Board including but not limited to clinic activity, case management and peer advocacy services. By enhancing our Electronic Medical Record and Practice Management we are better able to run timely reports on claims data, eligibility, missing documentation as well as development of external connections to patient related data (ie. Lab work, hospital discharges, etc.).

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 2015 the department's cost to the county was $111,047, approximately $106,000 below our anticipated budgeted cost. In 2016, our cost to the county was $131,658 coming in $236,906 under budget.



Payer Demographics - 2016

Payer Mix by Visits Rendered	
Medicaid/Managed Medicaid	64.2%
Medicare	11.5%
3rd Party Insurance	16.3%
Un-Insured	4.6%
Other	3.4%
Total	100%

Payer Mix by Revenue	
Medicaid/Managed Medicaid	80.6%
Medicare	5.9%
3rd Party Insurance	8.7%
Un-Insured	3.5%
Other	1.4%
Total	100%

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.

Even though Greene County Mental Health transitioned to the EMR in 2013, our Medical Records Clerk is still in the process of scanning all hard copies of medical records that existed prior to the EMR transition in 2013. She does this in addition to her other substantial duties so this continues to be a gradual, steady, and time-consuming process.

Corporate Compliance, Quality Assurance, and Utilization Review

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

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

Each quarterly self-audit has resulted in some returned funds but they were always due to documentation errors. Never were they the result of intentional attempts at fraud or abuse of funds. Each return is addressed with the individual staff member who was responsible for the oversight or mistake. Additional training is provided whenever necessary.

In 2016, changes were made to address and enhance the area of quality assurance and compliance. One specific area focused on was the completion of timely clinical documentation and treatment planning. Through a collaborative effort between the clinical and fiscal departments GCMHC created a form to be completed on a random selection of client treatment charts for every service provider in the clinic on a quarterly basis. This new system will not only meet our needs for OMIG compliance but also create a full review of quality of care for the selected cases to ensure that quality and quantity issues when present are addressed in a timely manner with the clinician of record.

From a compliance and risk management stand point the fiscal office is working to develop a workflow that assesses potential compliance issues, ensures that proper documentation is in place to make sure treatment plans, therapeutic sessions and medication services are meeting all requirements of OMH and OMIG standards. Part of this workflow development was investing in a more robust practice management system that properly partners with our current EMR.

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. And 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 also 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 client and over 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 community, our clients and the clinic.

Staffing News

Greene County Mental Health Center experienced several staffing changes during 2016 due to retirement, those leaving to pursue career advancement and/or salary increase. This resulted in the loss of experienced clinicians, recruitment of new clinicians recently graduated from a Social Work program with limited clinical experience who require weekly clinical supervision and support as they transition to their new role. It can also effect assignments and revenue generation as Medicare and 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 (CHIP)

With its roots in prevention and crisis management, CHIP continues to operate throughout the rural Greene County area and provide vital outreach services to residents throughout the County.

In 2016 CHIP maintained four satellite offices in Greene County. One location has expanded hours covering two-days per week, shared between two clinicians. 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.

For the past nine years, the 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.

Materials for each office were provided as in past years. This included new, updated copies of the screening instrument, brochures, fliers, and education materials.

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, the National Council for Community Behavioral Healthcare, others as a result 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. CHIP was featured in a National webinar by the Office of Mental Health and SAMHSA in 2013. The coordinator has participated in presentations to local Graduate students in 2013, 2014, and 2015.

Annual Data Summary:

Service Description	2012	2013	2014	2015	2016
Total Scheduled Appointments	1130	996	1252	731	1049
Kept Appointments (face to face contacts: brief assessment, crisis intervention, referral, etc.)	882	781	958	506	783
Assessed/Intake Evaluation (billable services)	88	59	44	41	29
Home Visits	2	1	0	0	0

Two offices were unstaffed during the last quarter of 2014 and all quarters of 2015

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. Individuals under AOT receive priority access to case management, outpatient services and residential housing options.

To date, 81 Greene County residents have been referred to the AOT program. In 2016, 10 new AOT orders were issued and 10 pick-up orders were issued to AOT clients due to non-compliance with treatment or an increase in symptoms. Five (5) of the pick-up orders resulted in inpatient psychiatric hospitalization. Currently there are 14 clients on active AOT status.

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

Greene County Jail Services

Services provided by Greene County Mental Health Center (GCMHC) 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 574 interviews were conducted by the Forensic Mental Health worker; which included 126 suicide risk assessments and 448 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 99 medication related contacts.

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

There was one admission to Central New York Psychiatric Center (State Operated Forensic Inpatient Unit) CNYPC. 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 CNYPC. There were 8 inmates that met criteria for hospitalization but there were no beds available at CNYPC. Our local Article 28 hospital Columbia Memorial Hospital will not accept inmates for psychiatric care due to concern about safety as well as confidentiality issues on the unit. Typically, we are able to stabilize these inmates with medication and/or supportive therapy before a bed becomes available at CNYPC.

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

The Greene County Mental Health Clinic on-call services are available as needed after hours, holidays and weekends.

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 daily to provide counseling services to inmates, providing 2-3 hours per week of psychiatric medication therapy by a Psychiatrist, on-call 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. 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. In the Fall of 2016 the Clinic Director began tracking the number of inmates seen at the jail on a monthly basis. During the months of Oct (19), Nov (18) and Dec (17) inmates received either verbal therapy, medication management or a combination of both at the jail.

The Substance Abuse problem in the County can also impact services at the jail. Those 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.

Family Court Services

Greene County Mental Health currently provides 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.

Sex Offender Treatment Program

For many years, Greene County Mental Health has maintained The Sex Offender Treatment Program in collaboration with Greene County Probation. 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, emotional maturity, and sobriety issues are often at the forefront of the focus in the groups.

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

From its inception, the Sex Offender Treatment Program was managed and facilitated by Greene County Mental Health Center's Associate Psychologist in partnership with senior Probation Officer. It was in 2016, however, that the Associate Psychologist retired from the County. At that time though, Greene County Probation entered into contract with Associate Psychologist so that the program continued in the county. Consequently, GCMH no longer has a direct role in the program, but its legacy continues.

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 2016 no additional supports were requested from other community agencies or entities other than those listed above.

2016 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).

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.

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

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 2015 were placed in housing in 2016; individuals are carried over from other years; (3) internal moves occur within each residential program that are not tracked here.

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.

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.

Many recently released inmates, psychiatrically impaired or not, have limited, if any, family or social supports. Upon incarceration, many individuals lose their housing, as well as their belongings, and find it necessary to start over upon release. With limited funds, this becomes difficult, many resorting to whatever services they may be able to acquire through DSS. These individuals have a difficult time finding safe, permanent, affordable housing after release from jail.

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

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

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.

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 assist individuals in developing and maintaining viable living, working and social situations in the community by helping them to identify their needs and formulate realistic and attainable goals for self sufficiency, support and economic independence. The Adult ICM's visit their clients minimally once (1x) per week. In the newly formed Hudson River Health Home, 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, 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.

Only data for Care Management has been provided below.

In 2016, a procedure was developed to link the referral process from Care Coordination to Care Management. Specifcally, this process is enacted when an individual requires a higher level of care. In 2016, two such reviews were requested by clinical teams representing individuals in the community who were at risk for hospitalization.

The following reflects applicants in 2016:

2016 Care Management (trad. ICM and SCM srvs.)	**2014**	**2015**	**2016**
Submitted applications	5	7	8
Removed/Inactive	0	0	0
Determined eligible/referred	8	4	8
Pending	0	0	0
Admitted	8	4	8
Wait List	0	0	0

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. The reduced numbers in individuals applying for a single service is demonstrated below.

Enrollment and engagement in this service is not tracked by the SPOA for several reasons. It is at the time of intake for MHA Care Coordination program that some applicants are found to have relocated or refuse the service, or ineligible due to primary payer.

In late 2016, an additional administrative position was added to the SPOA committee when a SPOA Assistant was made available. The SPOA Assistant as thus far been employed to update forms, complete meeting minutes, and send agendas to members.

CHILDREN'S SERVICES

Clinic Based Mental Health Services

The clinic has 2 designated clinic-based children's therapists on staff, with satellite therapists providing clinic services at least one day per week. There are also 2 therapists who have blended (adult and child) caseloads and provide counseling to a number of youth and families. The clinic has a children's RN who triages initial calls for services, schedules intake appointments, and manages crisis calls from schools, parents, and other agencies throughout the week. This RN is also the SPOA coordinator for Greene County Children's Services, so she is aware of which families are at risk, assists in connecting them with available services, and monitors appropriate levels of supports.

Children's therapists provide both individual and family therapy to a case load of children and transitional age youth (18-21.) They coordinate with collateral agencies including schools, case managers, medical professionals, law guardians, hospitals, and probation to best meet the often complex needs of high risk youth in the community. Children's therapists also provide individual parenting support and training to adult clients upon request. Several therapists have provided in-service training and support in the community upon request as well as providing crisis intervention and support in and outside of the clinic.

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

School-Based Mental Health Services

GCMHC continues to have school-based satellite programs in several school districts. These include Windham/Ashland/Jewett school district 3 days per week, Cairo/Durham Middle/High School 4 days per week, Cairo Elementary 2 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.

Child & Family Single Point of Access (SPOA)

The Greene County SPOA Committee continues to work diligently to identify and provide supportive services to high risk children and their families so that they can successfully meet goals and avoid hospitalization and placement. The committee meets every Thursday morning at Greene County Mental Health with one meeting per month dedicated to a census update and utilization review. The working committee is made up of representatives from Greene County DSS, Greene County Youth Bureau, Parsons Waiver program, Greene County Mental Health, Mental Health Association of Columbia and Greene Counties, and a Parent 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 6 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 continues 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. Greene County continues to employ two full-time, and one half time care managers designated to serve children with serious mental health needs. Greene County has 24 Supportive Case Management slots through the Mental Health Association which are reserved for children not receiving Medicaid, or who do not meet the criteria for Health Homes.

The SPOA committee has been a referral source and tracking entity for both Planned/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. This past year 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. She works with parents to build parenting skills, improve self-care, and advocates for quality care and appropriate services with and on behalf of clients. 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. The Family Peer Advocate attends weekly SPOA meetings, and facilitates a monthly support group for parents of children who are receiving 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 2016 the committee received 50 new SPOA referrals and completed 13 SPOA reviews to follow-up on previous SPOA meetings for a total of 63 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 49 new referrals made to case management services (combined ICM, SCM and MHA). Other top referrals include the Office of Mental Health Waiver Program (12), (this program serves the most intense cases which currently has a wait list of 7 children), Family Peer Advocate Services (40), and Mental Health Association Respite (10) (which currently has a wait list of 9 children).

	2014	**2015**	**2016**
New SPOA Referrals	64	60	50
SPOA Reviews	23	19	13
Referrals to Case Management	64	49	49
Referrals to Waiver	8	7	12
Referrals to Family Peer Advocate	x	38	40
Referrals to Respite	x	20	10

COMMUNITY SERVICES BOARD & NAMI

Greene County Community Service Board

The Greene County Community Service Board (CSB) and its Sub-committees continued their active role in overseeing the Mental Health, Substance Abuse, and Developmental Disabilities programs in Greene County. The CSB is comprised of members from the following sub-committees; Mental Health, the Office of People with Developmental Disabilities (OPWDD) and the Office of Alcohol and Substance Abuse Services (OASAS) 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; 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 2017 completed by the Director of Community Services (DCS) who is also the Director of Mental Health following collaboration with the Community Services Board:

1. Focus on housing availability and stability
2. Transportation
3. Reducing/eliminating suicide deaths in our community
4. Enhancing and integrating local OPWDD services within Greene County
5. Providing community education that highlights addiction as a chronic disease that can respond to treatment, having a more dedicated and coordinated public health focus on mental health and addiction as chronic diseases
6. Coordination and collaboration with local Behavioral Health Providers, Local Dept of Social Services, Managed Care Organizations, DSRIP in evaluating our current infrastructure and care continuum, identifying and prioritizing areas of concern around access, capacity and system improvement.

Greene County NAMI - National Alliance of the Mentally Ill

Greene County NAMI is now in under the umbrella of NAMI New York State. The President and another volunteer continue to do outreach within the community, provide phone support and advocacy with the plan to re-establish support groups locally.