

Mental Hygiene Executive Summary
Local Services Plan 2021
Monroe County Office of Mental
Health

The Monroe County Office of Mental Health (MCOMH) remains committed to ensuring quality in the local service system concurrent to executing State and Federal initiatives. While navigating a shifting healthcare landscape in response to and outside of COVID-19, and in our ongoing commitment to serve all of the people of Monroe County, MCOMH operates with the following priorities:

- i. Ensure individuals with the highest need are identified, prioritized and linked with services responsive to their identified needs.
- ii. Increase the availability of, access to, and coordination and/or integration of services/supports for individuals whose needs cross systems.
- iii. Identify gaps in the availability of a full range of prevention, treatment and recovery services to meet community need, leveraging resources to reduce gaps where identified.
- iv. Ensure a robust provider network exists within Monroe County to adequately meet the behavioral health (mental health, substance abuse, and developmental disability) needs of community residents.
- v. Ensure that delivery models are person-centered, strength-based and recovery-oriented.
- vi. Incorporate prevention/education, awareness, early identification and intervention approaches related to mental health, chemical dependence and developmental disabilities into systems of care.

As a result of evaluating the success of these priorities and informing the development of the 2021 Local Services Plan, MCOMH has continued to increase lines of communication with system stakeholders. Most importantly, over the last three years, MCOMH improved direct feedback from consumers and family members. MCOMH offered focus groups for consumers and family members in each disability area, as well as offering online surveys. Additional information was gleaned from providers, Monroe County Agency Executives, and the Community Services Board, through review of state and local data, and quality assurance activities. This collaborative, data-driven process has identified and highlighted key areas of impact for 2021 that are reflected in the Local Services Plan. These goals and the related objectives will be closely monitored for progress to continue to drive quality, achieve MCOMH priorities, inform future planning, and maintain LGU accountability to Monroe County residents.

Due to COVID-19 changing the way we do business beginning in March, most of 2021's goals and objectives remain the same as 2020's goals. This is primarily because other priorities involving community crisis response in regards to COVID-19 took precedence over work on the 2020 LSP goals. However, some additions and changes to the goals are warranted given the effect of COVID-19 and our community's need to increase racial/economic equity. Local and national stories and subsequent unrest have brought into focus the racial inequities experienced in relationship to law enforcement

interactions, in systems, and beyond. MCOMH is working hard to understand and mitigate the influence that racial inequities have on the care of people in the Monroe County. Furthermore, in response to the hardships related to COVID-19 and racism/inequities in the systems, a new goal regarding emergency preparedness and specific objectives highlighting the response to inequities were added to 2021's Local Services Plan.

2021 Priority Goals include:

- Maximize opportunities for safe and stable housing for individuals and their families across the age continuum
- Increase awareness for opportunities to improve and support responsive, efficient, accessible, and highly effective transportation options for people who use services and their families
- Collaborate with local providers to coordinate and improve how local crisis services meet the needs of Monroe County citizens
- Explore, develop solutions, and take action to mitigate workforce concerns in the provider community and for clients served
- Decrease the risk of advanced mental health disorders, behavior and/or substance use disorder progression through the enhancement of prevention efforts at all levels –primary, secondary, and tertiary
- Enhance the county-wide, cross-sector response to the overdose epidemic by increasing access to appropriate levels of care, including Medication Assisted Treatment
- Advocate for increased access to equitable services and collaborate with community stakeholders to prepare for potential gaps in services during widespread community crises

Through the focus provided by these goals and their related objectives, MCOMH is confident that there will be a significant impact on improving care, decreasing cost, and improving health outcomes for all Monroe County residents across the three disability areas. Executing and evaluating these target areas will accomplish the progress necessary in 2021, setting the foundation for future growth in Monroe County that is responsive to the needs of all our residents and achieves the vision established by State and Federal initiatives.

Mental Hygiene Goals and Objectives Form

Monroe County Office of Mental Health (70560)

Certified: [Bonnie Smith](#) (9/14/20)

Mental Hygiene Law, § 41.16 "Local planning; state and local responsibilities" states that "each local governmental unit shall: establish long range goals and objectives consistent with statewide goals and objectives." The Goals and Objectives Form allows LGUs to state their long-term goals and shorter-term objectives based on the local needs identified through the planning process and with respect to the State goals and objectives of each Mental Hygiene agency.

The information input in the 2020 Goals and Objectives Form is brought forward into the 2021 Form. LGUs can use the 2020 information as starting point for the 2021 Plan but should ensure that each section contains relevant, up-to-date responses.

Please indicate below if the overall needs of each disability population got better or worse or stayed about the same over the past year. Completion of these questions is required for submission of the form.

New To assist LGUs in the assessment of local substance use disorder (SUD) needs, OASAS Planning has developed a county-level, core-dataset of SUD public health data indicators. These reports are based on the recommendations of the Council of State and Territorial Epidemiologists and the regularly updated county-level datasets available in New York State. Each indicator compares county-level population-based rates to statewide rates. Reports for all counties are available in the County Planning System Under **Resources -> OASAS Data Resources -> Substance Use Disorder Key Indicators**

1. Overall Needs Assessment by Population (Required)

Please explain why or how the overall needs have changed and the results from those changes.

The question below asks for an overall assessment of unmet needs; however certain individual unmet needs may diverge from overall needs. Please use the text boxes below to describe which (if any) specific needs have improved, worsened, or stayed the same.

a) Indicate how the level of unmet **mental health service needs**, overall, has changed over the past year: ☐ Improved ☒ Stayed the Same ☐ Worsened

Please describe any unmet **mental health** service needs that have **improved**:

There have been some general improvements to the mental health service system since MCOMH submitted our 2020 LSP. An example is that Partners for Suicide Prevention became a program of NAMI Rochester, thus creating a structure that will allow for continued growth. Additionally, Hope Place, a peer-based Emergency Department Diversion Center, began operating in February 2020.

In the children's system there have also been improvements. Since June of 2019, Family Peer and Youth Peer services were available as a part of CFTSS services. Youth Peer services were going well prior to COVID, but Family Peer services were limited due to workforce shortages and challenges related to certification. Also, the URM Mobile Crisis team expanded their team to focus on the needs of children and youth. In addition, youth partial hospitalization services were moved to a new location right as COVID hit and while URM has been given the approval to add capacity, they cannot at this time due to COVID. They have been doing their program via telehealth, which has opened their services to those who may have a history of violence. It is our hope that these telehealth-based services can continue after COVID for those youth who cannot attend in person, due to violent histories or transportation barriers.

The COVID-19 pandemic, while creating many challenges, has opened the door to some improved communication. First, the widespread use of telehealth has helped clients stay connected. Some clients may prefer connecting via telephone or tele-video options and this has created opportunities for non-traditional engagement. Telehealth may also eliminate some very real barriers that keep some clients from accessing care, including lack of transportation and lack of childcare. MCOMH hopes that the flexibility created by COVID in the area of telehealth can be extended into regular practice. COVID has also created increased opportunities for communication and partnerships between MCOMH and: the homeless shelter system, OPWDD, 2-1-1, the local health systems, the United Way, and the local Health Systems Agency (Common Ground Health), to name a few.

Please describe any unmet **mental health** service needs that have **stayed the same**:

In the children's service system, alternatives to emergency room use, including respite and crisis services for youth, are scarce. This has remained the same since last year and the many years prior. Additionally, crisis service through CFTSS became available in January 2020, but there are no local providers who have been designated (due to the required 1 hour response time, per the verbal reports from potential providers). There is also no change in the lack of support and services for preparing transition-age youth for adult living/residential services.

In the adult serving system, there are still challenges in HARP and HCBS utilization, per provider reports at collaborative meetings. While crisis services for adults continues to be a focus of service providers, less attention has been given to children and youth in crisis.

Please describe any unmet **mental health** service needs that have **worsened**:

The workforce shortages continue in the mental health system. COVID-19's effect on the community in regards to isolation, increased anxiety, depression and trauma for community members and first responders are a concern that is hard to quantify at this time. As an LGU, we expect general mental health needs to increase:

- For first responders and/or other essential workers
- Once the eviction moratorium lifts
- As school starts, local mental health providers are concerned about youth generally, but particularly that those with school avoidance challenges may not engage as school resumes
- If unemployment persists and/or people aren't able to return to work due to caring for a family member

See also the COVID-19 survey supplement to the LSP for more details about COVID-19's effect on the system.

b) Indicate how the level of unmet **substance use disorder (SUD) needs**, overall, has changed over the past year: ☒ Improved ☐ Stayed the Same ☐ Worsened

Please describe any unmet **SUD** service needs that have **improved**:

Access to substance use services on the front end and in crisis related situations has improved over the last year. Nearly all outpatient programs have rapid access to appointments and/or walk in hours, access to Medication Assisted Treatment (MAT) has improved, most providers have started same day MAT induction, and the BHACC is serving people with SUD and connecting them to inpatient care often. The Open Access Clinic continues to operate 24/7 and saw over 664 people from 1/1/2020 to 7/31/2020. They provided 1464 services and 523 evaluations.

The adaptability of providers was something that improved and the ability to provide quality virtual care expanded dramatically due to the public health crisis.

Please describe any unmet **SUD** service needs that have **stayed the same**:

The main unmet need that stayed the same is Prevention of SUD. Monroe County prevention efforts remain relatively strong with school and community based prevention maintaining a robust representation in the area. Local prevention providers reach thousands of students each year. The challenge is that these efforts remain static and expansion to all community members is still difficult due to lack of adequate funding.

Another aspect of care that remains the same is that funding is primarily directed towards opioid specific service lines. The community has some concerns that this is ignoring other prevention needs, gambling addiction, and alcohol and other drug addictions. We recognize the lethality and immediacy of the opioid crisis and hope service development can continue to serve those with other drug, alcohol, and gambling needs.

There also remains some confusion, from the standpoint of the public, as to where to go for services when there are so many options for rapid access, open access, varying hours of these options, etc.

Please describe any unmet **SUD** service needs that have **worsened**:

The residential and workforce crisis has worsened over the last year in the SUD field. The transition to the 820 model of care has been extremely difficult for the one provider in Monroe County that transitioned and added levels of care. The residential provider community wanted it noted that the Congregate Care II payments for the service are too low to sustain the level of programming that is required for an extremely ill and increasingly complex client population.

Workforce recruitment and retention continues to be challenging in the field despite many efforts in adapting to workforce needs and wants. The lack of a COLA over the last year has made offering competitive wages challenging and community based providers note that it is even more challenging for those programs not connected to a hospital system. Reimbursement rates remain low for all levels of care and most programs are operating in a deficit, which makes salaries less competitive, and workforce attrition more likely.

c) Indicate how the level of unmet needs of the **developmentally disabled** population, overall, has changed in the past year: ☒ Improved ☐ Stayed the Same ☐ Worsened

Please describe any unmet **developmentally disability** service needs that have **improved**:

No unmet service needs have improved at this time. However, MCOMH as the LGU has begun convening the providers, initially to talk about challenges regarding COVID-19. The group is still working on what meetings will look like moving

forward, but now the door is open to community collaboration.

Please describe any unmet **developmentally disability** service needs that have **stayed the same**:

There continues to be a shortage of housing for those who need it, although the exact numbers locally are unknown. This has not changed since last year. We have been told that there is a waiting list of 300 people who are in crisis situations, in need of housing.

The DD subcommittee for the Community Services Board decided that needs stayed the same for this year because a lot of things have been put on hold. The group consensus was that by choosing “stayed the same” they all agreed that it was the same as 2020, which still means “worse” overall.

Please describe any unmet **developmentally disability** service needs that have **worsened**:

Because of COVID-19, we were unable to have the focus groups with families and individuals served in the OPWDD system, as we would have liked. See below for information from the focus groups held in preparation for the 2020 plan. One update came from the local DDRO office that let us know that as far as crisis services go, not as many people are accessing the services, but those that are have been engaged more intensively. There are also reports from parents and families of those served in OPWDD system about the negative effect of lack of contact with their loved ones who were staying at residences certified by OPWDD. MCOMH helped to gather thoughts about visitation best practices from a parent perspective and forwarded the document to the community. When visitation opened up with guidance from OPWDD on 7/10/2020, families were able to see each other in person once again.

From 2020 plan:

Participants in the DD Focus Groups and members for the DD Subcommittee of the Community Services Board indicate that the overall level of unmet needs for this population have worsened. Concerns persist in eligibility and access to services in general within the OPWDD system including quality care management, respite, housing, and educational/vocational opportunities.

Individuals and their families, as well as the provider network, identify significant unmet need related to workforce. Low rates of pay compared to high levels of responsibility for service providers yields high rates of staff turnover throughout the system. This trend interrupts continuity of care for individuals and results in fiscal challenges for providers in continual cost for recruitment, training, and support for new staff. Workforce

issues within the OPWDD have been especially challenging over the last year, mostly due to changes from Medicaid Service Coordination to Care Coordination via CCO/HHs. During MCOMH's focus groups and from the DD Subcommittee, it was learned that there has been a lot of turnover within the Care Coordination system.

The lack of crisis services and readily available housing options are a challenge in the OPWDD service system. Unavailable crisis options has led to some people (adults, youth, and children) with I/DD being stuck in hospital emergency rooms for days, weeks, and even months. MCOMH has worked closely with the hospitals and OPWDD to identify solutions in the individual cases, but there are fewer long-term answers to these situations. Much of the decision making concerning allocations for housing and crisis services for the I/DD population happens at the state level and resources across the state are increasingly scarce for individuals with behavior challenges.

DD Focus group participants mentioned how precarious the arrangements in the Self-Direction program are, stating that staffing back up plans are not adequate. Parents and family members often have to step in to assist when staffing plans fall through. In addition, the aging parents in the group discussed their fear of what will happen when they are no longer around to intervene. They also expressed concern for people who do not have the resources of time and money, and how they would get their needs met in the Self-Direction program.

The second section of the form includes; goals based on local need; goals based on state initiatives and goals based in other areas. The form allows counties to identify forward looking, change-oriented goals that respond to and are based on local needs and are consistent with the goals of the state mental hygiene agencies. County needs and goals also inform the statewide comprehensive planning efforts of the three state agencies and help to shape policy, programming, and funding decisions. For county needs assessments, goals and objectives to be most effective, they need to be clear, focused and achievable. The following instructions promote a convention for developing and writing effective goal statements and actionable objectives based on needs, state or regional initiatives or other relevant areas.

2. Goals Based On Local Needs

Please select any of the categories below for which there is a **high level of unmet need** for LGU and the individuals it serves. (Some needs listed are specific to one or two agencies; and therefore only those agencies can be chosen). When considering the level of need, compare each issue category against all others rather than looking at each issue category in isolation.

- **For each need identified you will have the opportunity to outline related goals and objectives, or to discuss the need more generally if there are no related goals or objectives.**

- You will be limited to one goal for each need category but will have the option for multiple objectives.** For those categories that apply to multiple disability areas/state agencies, please indicate, in the objective description, each service population/agency for which this unmet need applies. **(At least one need category must be selected).**

Issue Category		Applicable State Agency(ies)		
		OASAS	OMH	OPWDD
a)	Housing	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
b)	Transportation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
c)	Crisis Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
d)	Workforce Recruitment and Retention (service system)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
e)	Employment/ Job Opportunities (clients)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
f)	Prevention	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
g)	Inpatient Treatment Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
h)	Recovery and Support Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i)	Reducing Stigma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j)	SUD Outpatient Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k)	SUD Residential Treatment Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l)	Heroin and Opioid Programs and Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m)	Coordination/Integration with Other Systems for SUD clients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n)	Mental Health Clinic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o)	Other Mental Health Outpatient Services (non-clinic)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p)	Mental Health Care Coordination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
q)	Developmental Disability Clinical Services			<input type="checkbox"/>
r)	Developmental Disability Children Services			<input type="checkbox"/>
s)	Developmental Disability Student/Transition Services			<input type="checkbox"/>
t)	Developmental Disability Respite Services			<input type="checkbox"/>
u)	Developmental Disability Family Supports			<input type="checkbox"/>
v)	Developmental Disability Self-Directed Services			<input type="checkbox"/>
w)	Autism Services			<input type="checkbox"/>
x)	Developmental Disability Front Door			<input type="checkbox"/>
y)	Developmental Disability Care Coordination			<input type="checkbox"/>
z)	Other Need 1(Specify in Background Information)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
aa)	Other Need 2 (Specify in Background Information)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ab)	Problem Gambling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ac)	Adverse Childhood Experiences (ACEs)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(After a need issue category is selected, related follow-up questions will display below the table)

2a. Housing - Background Information

The Background Information box is a free-text box for LGUs to provide any additional information or more details related to the need and the Goal, such as:

- Data sources used to identify need (e.g. hospital admission data)
- Assessment activities used to indicate need or formulate goal (e.g. community forum)
- Narrative describing importance of goal

This form will allow attachments, so in the Background Information box you could reference an attached document for more information.

Housing continues to be a needed focus area in 2021 due to the issues noted below, but also because of housing instability brought on by the COVID-19 pandemic. Specifically, people out of work and struggling financially may have not been able to pay their rent and not been evicted due to the statewide eviction moratorium, thus creating a group of people in poverty who will be subject to eviction once the moratorium ends. We expect this situation will result in increased anxiety and potential distress amongst those it affects in Monroe County. See also the updated Figure 1 (see appendix), which shows the numbers for homelessness including those who are chronically homeless, those who have serious mental illness, and those with substance use disorder. Historically, housing instability has disproportionately impacted those in traditionally

underserved populations (i.e. people in poverty, Black people, Hispanic/Latinx people, LGBTQ+ people, youth, etc.). MCOMH added to objective 1 below to highlight this challenge and work on breaking down barriers.

From 2020 plan:

Monroe County is not unique when it comes to challenges around affordable, safe, and stable housing. This concern is especially acute in people with mental health disorders, substance use disorders, and intellectual and developmental disabilities. Our community has 617 MH housing beds with the shortest waitlist being about 3-6 months for a community residence and over 2 years now for supported housing level of care. Our SUD housing totals 367 beds between all levels of residential care and the shortest wait lists are 4-6 weeks with supportive living waitlists up to 3 or 4 months. The SUD consumer focus group conducted earlier this year elicited some clear demand for recovery housing, peer housing, and expansion and closer monitoring of our current housing array. The OPWDD focus group that MCOMH conducted with parents of consumers shared that housing for their family member is unresponsive, burdensome, and very challenging to navigate. The adult OPWDD housing waitlist can exceed 20 years in some cases. The strain put on these housing providers and lack of available options for families and consumers causes homelessness, inadequate and unsafe housing, and the members of our most vulnerable populations not being cared for.

Additionally, homelessness is common among those with MH and SUD challenges. The primary cause of homelessness in 2017, according to the Monroe County Department of Human Services' Housing and Homeless Services 2017 Annual report, continued to be eviction by the primary tenant. Individuals and families residing in the homes of relatives or friends are often asked to leave due to overcrowded conditions, substance use, domestic disputes, family breakups and strained relationships. This cause represented 60% of the total temporary housing assistance placements made in 2017. The Point in Time study for 2015 and 2016 reflected that homelessness in Monroe County has increased amongst those with severe mental illness and substance use disorder (Figure 1).

Do you have a Goal related to addressing this need? ☒ Yes ☐ No

Goal Statement- Is this Goal a priority goal (Maximum 5 Objectives per goal)? ☒ Yes ☐ No

The Goal Statement should be a specific, clear, and succinct statement of a desired outcome. It should be focused on a change that is tangible, achievable and within the control of the LGU. Avoid vague statements that focus on "maintaining" or "continuing" activity that simply maintains the status quo.

Maximize opportunities for safe and stable housing for individuals and their families across the age continuum

Objective Statement

Objective Statements should describe a shorter-term action the LGU will take to achieve the longer-term goal. Each goal should have at least one objective. You may have multiple objectives for each goal. The objective should identify the approach to be taken to help achieve the desired outcome. It answers the question, "How will the goal be achieved?"

[Add an Objective](#) (Maximum 5 Objectives per goal) | [Remove Objective](#)

Objective 1: Advocate for safe, sustainable and stable housing options in the community, with acknowledgement of the disparities in traditionally underserved populations (i.e. people in poverty, Black people, Hispanic/Latinx people, LGBTQ+ people, youth, etc.).

Applicable State Agency: (check all that apply): ☒ OASAS ☒ OMH ☒ OPWDD

Objective 2: Explore independent living transition options for people currently in housing services supported by the OMH, OPWDD, and OASAS systems.

Applicable State Agency: (check all that apply): ☒ OASAS ☒ OMH ☒ OPWDD

Objective 3: Investigate innovative housing options that are being utilized in other communities to plan for future options.

Applicable State Agency: (check all that apply): ☒ OASAS ☒ OMH ☒ OPWDD

Objective 4: Collaborate with OPWDD local office, families, and providers within the OPWDD system to explore housing and support solutions for people with high medical and/or behavioral needs, including back-up support to ensure safety at home.

Applicable State Agency: (check all that apply): ☐ OASAS ☐ OMH ☒ OPWDD

Change Over Past 12 Months (Optional)

This optional, free-text box allows LGUs to describe any change in the need driving the goal or any progress made towards the goal in the last year. Where possible, include specific measurable accomplishments and milestones achieved. You may also want to identify barriers to achieving stated goals and objectives and describe the rationale for any changes made to the goal statement or associated strategies.

2b. Transportation - Background Information

The Background Information box is a free-text box for LGUs to provide any additional information or more details related to the need and the Goal, such as:

- Data sources used to identify need (e.g. hospital admission data)
- Assessment activities used to indicate need or formulate goal (e.g. community forum)
- Narrative describing importance of goal

This form will allow attachments, so in the Background Information box you could reference an attached document for more information.

We continue to see transportation as a priority for 2021. The transportation system in Monroe County, RGRTA, was scheduled to complete a reimagining of the transportation system in July 2020. Due to COVID-19, the process was delayed indefinitely.

From 2020:

Historically, access and availability of transportation has been beyond the scope of direct impact of the LGU. However, through focus groups with consumers, community provider feedback, and internal discussions it is clear that as the LGU, MCOMH must leverage our community partnerships to improve access, availability, and practicality of the public transportation to better meet general needs. The county's only public transportation system is undergoing a significant transformation which will impact not only urban utilizers but suburban and rural utilizers alike.

Do you have a Goal related to addressing this need? ☒ Yes ☐ No

Goal Statement- Is this Goal a priority goal (Maximum 5 Objectives per goal)? ☒ Yes ☐ No

The Goal Statement should be a specific, clear, and succinct statement of a desired outcome. It should be focused on a change that is tangible, achievable and within the control of the LGU. Avoid vague statements that focus on "maintaining" or "continuing" activity that simply maintains the status quo.

Increase awareness for opportunities to improve and support responsive, efficient, accessible, and highly effective transportation options for people who use services and their families

Objective Statement

Objective Statements should describe a shorter-term action the LGU will take to achieve the longer-term goal. Each goal should have at least one objective. You may have multiple objectives for each goal. The objective should identify the approach to be taken to help achieve the desired outcome. It answers the question, "How will the goal be achieved?"

[Add an Objective](#) (Maximum 5 Objectives per goal) | [Remove Objective](#)

Objective 1: Utilize collaborative platforms to explore, address, and alleviate barriers for transportation.

Applicable State Agency: (check all that apply): ☒ OASAS ☒ OMH ☒ OPWDD

Objective 2: Advocate for transportation networks to provide adequate and reliable transportation avenues that will meet the needs of its consumers.

Applicable State Agency: (check all that apply): ☒ OASAS ☒ OMH ☒ OPWDD

Objective 3: Engage in and promote the meetings surrounding the Reimagine RTS transportation initiative.

Applicable State Agency: (check all that apply): ☒ OASAS ☒ OMH ☒ OPWDD

Change Over Past 12 Months (Optional)

This optional, free-text box allows LGUs to describe any change in the need driving the goal or any progress made towards the goal in the last year. Where possible, include specific measurable accomplishments and milestones achieved. You may also want to identify barriers to achieving stated goals and objectives and describe the rationale for any changes made to the goal statement or associated strategies.

2c. Crisis Services - Background Information

The Background Information box is a free-text box for LGUs to provide any additional information or more details related to the need and the Goal, such as:

- Data sources used to identify need (e.g. hospital admission data)
- Assessment activities used to indicate need or formulate goal (e.g. community forum)

- Narrative describing importance of goal

This form will allow attachments, so in the Background Information box you could reference an attached document for more information.

The COVID-19 pandemic has caused some additional anxiety and stress amongst community members and has not allowed the MCOMH team to work on the proposed Crisis goal for the 2020 plan to the fullest extent. However, the LGU has convened many new groups to discuss current issues, thus strengthening relationships between the LGU and providers, and amongst providers. Additionally, Mobile Crisis has expanded their child-specific services and we anticipate it to be fully operational in 2020. This addition to the community will be most welcome, as crisis services for kids are limited. Figure 2a-d and Figure 3 have been updated showing service useage (see appendix). As MCOMH explored crisis efforts in our community, there are opportunities to reduce barriers to care for traditionally underserved populations (i.e. people in poverty, Black people, Hispanic/Latinx people, LGBTQ+ people, youth, etc.). MCOMH adapted objective 4 to encompass that work.

From 2020:

Crisis services were identified as a high unmet need by providers, consumers and their families, the Sub-Committees of the Community Services Board, and service use data. 2018 data showed an increase in the number of ED and Crisis visits to the highest number in the last 5 years for both adults and children/youth (Figures 2a and 2b). It should be noted that crisis numbers include some Monroe County ED diversion programs, so further analysis will be needed to see how ED diversion programs are affecting overall ED usage for mental health crises. Additionally, close monitoring of post-discharge care indicates that only 30% of adults and 40% of children/youth seen in emergency settings (non-inpatient) were seen within seven days post-discharge with little variability across time (Figures 2c and 2d).

This area is a priority across the lifespan, however, there are specific needs related to availability of quality care for children and youth in Monroe County. Capacity within the youth system has seen a variety of challenges in 2018 and 2019 related to quality of current services and fiscal viability of established providers. Additionally, with the changes to children's services in the Medicaid system that focus strongly on prevention of crisis, there is hope that crisis services utilization will be reduced.

Programs such as the Forensic Intervention Team (FIT) have yielded promising results in increasing supports for individuals in the community (Figure 3) and decreasing less optimal criminal justice outcomes. Through continued innovation in service delivery including FIT, increased respite options, and increased variety of immediate access points (Open Access for SUD evaluations, the launch of the CCBHC at URM, and RRH's BHACC), MCOMH expects greater impact in improving outcomes for individuals, increasing valuable community connections, and access to de-escalation supports while seeking to reduce cost and reliance on law enforcement and emergency levels of care.

Do you have a Goal related to addressing this need? ☒ Yes ☐ No

Goal Statement- Is this Goal a priority goal (Maximum 5 Objectives per goal)? ☒ Yes ☐ No

The Goal Statement should be a specific, clear, and succinct statement of a desired outcome. It should be focused on a change that is tangible, achievable and within the control of the LGU. Avoid vague statements that focus on "maintaining" or "continuing" activity that simply maintains the status quo.

Collaborate with local providers to coordinate and improve how local crisis services meet the needs of Monroe County citizens

Objective Statement

Objective Statements should describe a shorter-term action the LGU will take to achieve the longer-term goal. Each goal should have at least one objective. You may have multiple objectives for each goal. The objective should identify the approach to be taken to help achieve the desired outcome. It answers the question, "How will the goal be achieved?"

[Add an Objective](#) (Maximum 5 Objectives per goal) | [Remove Objective](#)

Objective 1: Foster relationships to create a centralized triage for behavioral health community-based crisis services.

Applicable State Agency: (check all that apply): ☒ OASAS ☒ OMH ☒ OPWDD

Objective 2: Assess crisis services needs for children/youth in the community and create an action plan that will address those needs.

Applicable State Agency: (check all that apply): ☒ OASAS ☒ OMH ☒ OPWDD

Objective 3: Improve access to a continuum of care for people in crisis in order to proactively reduce the likelihood of future crises. Services may include, but not be limited to, peer support, community mentoring and connections, inpatient and outpatient care, housing, mental health support for people with I/DD, safety planning, support for agencies that serve underserved people, etc.

Applicable State Agency: (check all that apply): ☒ OASAS ☒ OMH ☒ OPWDD

Objective 4: Strategize with providers to build awareness of local options for people in crisis beyond the emergency room with acknowledgement of the disparities in traditionally underserved populations (i.e. people in poverty, Black people, Hispanic/Latinx people, LGBTQ+ people, youth, etc.).

Applicable State Agency: (check all that apply): ☒ OASAS ☒ OMH ☐ OPWDD

Objective 5: Collaborate with providers and law enforcement to connect individuals involved in law enforcement who are in need of mental health, SUD, and/or behavioral supports with the services they need to live independently in the community, including eligibility for services as needed

Applicable State Agency: (check all that apply): ☒ OASAS ☒ OMH ☒ OPWDD

Change Over Past 12 Months (Optional)

This optional, free-text box allows LGUs to describe any change in the need driving the goal or any progress made towards the goal in the last year. Where possible, include specific measurable accomplishments and milestones achieved. You may also want to identify barriers to achieving stated goals and objectives and describe the rationale for any changes made to the goal statement or associated strategies.

2d. Workforce Recruitment and Retention (service system) - Background Information

The Background Information box is a free-text box for LGUs to provide any additional information or more details related to the need and the Goal, such as:

- Data sources used to identify need (e.g. hospital admission data)
- Assessment activities used to indicate need or formulate goal (e.g. community forum)
- Narrative describing importance of goal

This form will allow attachments, so in the Background Information box you could reference an attached document for more information.

Addressing workforce challenges continues to be a high need in our community. MCOMH had plans via our Workforce Champion group to work on some of the barriers to hiring and retaining quality staff members, but this work was largely set aside to work on challenges associated with COVID-19. Additionally, MCOMH was beginning to attend workgroup meetings to explore and address employment issues for people with MH and I/DD challenges, but could not attend this group temporarily due to COVID-19 priorities. MCOMH will continue this work as soon as possible. Figures 4a and 4b are the same as they were in the 2020 plan (see appendix).

From 2020:

Based on OASAS Treatment Program staffing surveys from 2018, Monroe County providers experience an average of 12.5 weeks to fill vacant positions with some reporting up to one year to fill medical staff vacancies. Participants in the DD focus groups identified that support staff have a tenure of less than 6 months and wait times to fill those positions can take well past one year. MH providers struggle with recruitment and retention as well. Of providers surveyed in 2018, 90% report extreme difficulty in recruiting a psychiatrist and 100% of providers found it somewhat or very difficult to recruit nurse practitioners. Retention is a significant concern with 56% reporting it difficult to retain all positions. Salary levels are identified as the being the most common contributor to challenges in retention. Per FLPPS 2017 Data (Figures 4a and 4b), the Finger Lakes region ranks high amongst those communities most challenged by high vacancy rates in multiple position types and that challenge is felt acutely at the service provider level. In 2018, MCOMH began convening providers around the issues related to workforce recruitment and retention. MCOMH is in the process of developing action steps from the following priorities that were identified: supply and demand for qualified workers (connecting with job fairs/colleges, investing in training, etc.), recruitment and retention of people of color and diverse workers at all levels, affordable health insurance, and health and wellness (or "creating an environment for longevity").

Do you have a Goal related to addressing this need? ☒ Yes ☐ No

Goal Statement- Is this Goal a priority goal (Maximum 5 Objectives per goal)? ☒ Yes ☐ No

The Goal Statement should be a specific, clear, and succinct statement of a desired outcome. It should be focused on a change that is tangible, achievable and within the control of the LGU. Avoid vague statements that focus on "maintaining" or "continuing" activity that simply maintains the status quo.

Explore, develop solutions, and take action to mitigate workforce concerns in the provider community and for clients served

Objective Statement

Objective Statements should describe a shorter-term action the LGU will take to achieve the longer-term goal. Each goal should have at least one objective. You may have multiple objectives for each goal. The objective should identify the approach to be taken to help achieve the desired outcome. It answers the question, "How will the goal be achieved?"

[Add an Objective](#) (Maximum 5 Objectives per goal) | [Remove Objective](#)

Objective 1: Gather and disseminate workforce recruitment and retention strategies and resources via stakeholder meetings, provider meetings, etc.

Applicable State Agency: (check all that apply): ☒ OASAS ☒ OMH ☒ OPWDD

Objective 2: Collaborate with local providers to work with high schools, colleges, community organizations, etc. to create awareness of career opportunities in the MH, SUD, and I/DD career fields.

Applicable State Agency: (check all that apply): ☒ OASAS ☒ OMH ☒ OPWDD

Objective 3: Leverage local resources to promote and expand a culturally and linguistically appropriate provider workforce through proposals, quality assurance measures, and multi-disciplinary community planning.

Applicable State Agency: (check all that apply): ☒ OASAS ☒ OMH ☒ OPWDD

Objective 4: Promote vocational opportunities for clients and other underserved populations through improved communication on Peer Credentialing /Peer Service professions and direct care workforce opportunities.

Applicable State Agency: (check all that apply): ☒ OASAS ☒ OMH ☒ OPWDD

Change Over Past 12 Months (Optional)

This optional, free-text box allows LGUs to describe any change in the need driving the goal or any progress made towards the goal in the last year. Where possible, include specific measurable accomplishments and milestones achieved. You may also want to identify barriers to achieving stated goals and objectives and describe the rationale for any changes made to the goal statement or associated strategies.

2e. Employment/ Job Opportunities (clients) - Background Information

The Background Information box is a free-text box for LGUs to provide any additional information or more details related to the need and the Goal, such as:

- Data sources used to identify need (e.g. hospital admission data)
- Assessment activities used to indicate need or formulate goal (e.g. community forum)
- Narrative describing importance of goal

This form will allow attachments, so in the Background Information box you could reference an attached document for more information.

As noted above in the system-focused workforce goal, this remains an important area of focus, but was largely put on hold due to COVID-19. MCOMH will continue with this work as soon as possible.

From 2020:

Changes in vocational, prevocational, and supported employment benefits for both youth and adults have led to an enhanced understanding of the meaningful role employment has on health and recovery. However, given the emerging nature of these supports, the full impact is yet to be observed. Within Monroe County, an area of targeted focus lies in the opportunity of paid Peer Support roles and direct care roles. As demonstrated in the OMH Provider Survey, generated as part of the 2019 Local Services Planning process, Peers of all types are less frequently integrated within Article 31 settings. Community Based Organizations (CBO's) remain the greatest employers of Peers, Youth Peer Advocates and Family Peer Advocates. These programs report high difficulty in recruitment due to a limited number of credentialed peers within the workforce, an unclearly defined Youth Peer credentialing process. Integration within programs can also lead to retention problems, as CBO's exist on a continuum of successfully defining the Peer role within an organization as well as how it connects with other professional roles. Additionally, CBOs report ongoing challenges with recruiting and retaining direct care workers, who are often from underserved communities. This environment creates a unique opportunity to enhance a needed workforce issue while simultaneously addressing a vocational opportunity for individuals served within the Behavioral Health Service System and/or from underserved populations.

Do you have a Goal related to addressing this need? ☐ Yes ☒ No

If "No", Please discuss any challenges that have precluded the development of a goal (e.g. external barriers):
Work in this area is supported through specific objective within the workforce and retention goal.

Change Over Past 12 Months (Optional)

This optional, free-text box allows LGUs to describe any change in the need driving the goal or any progress made towards the goal in the last year. Where possible, include specific measurable accomplishments and milestones achieved. You may also want to identify barriers to achieving stated goals and objectives and describe the rationale for any changes made to the goal statement or associated strategies.

2f. Prevention - Background Information

The Background Information box is a free-text box for LGUs to provide any additional information or more details related to the need and the Goal, such as:

- Data sources used to identify need (e.g. hospital admission data)
- Assessment activities used to indicate need or formulate goal (e.g. community forum)
- Narrative describing importance of goal

This form will allow attachments, so in the Background Information box you could reference an attached document for more information.

Prevention continues to be an important goal for the 2021 plan. In the beginning of 2020, MCOMH partnered with school prevention teams to explore Above the Influence and Sources of Strength models as opportunities for their schools. This was done with the support of the team at the University of Rochester that oversee implementation of the models. Additionally, MCOMH was engaged with the Resiliency Learning Collaborative (RLC) to explore ways to build resiliency amongst school-age youth. Despite the challenges presented by COVID-19, the RLC was able to virtually host their Education Camp in July 2020, for school staff to learn about ways to enhance resiliency. MCOMH partnered with the local Department of Health to analyze the results of the 2019 YRBS. We also met with schools and did outreach to local colleges and providers about YRBS data that could inform their work (see figures 5a, 5b, 5c, 5d in appendix showing middle school data included in last year's LSP and the new 5e, 5f, 5g, 5h showing high school data).

Because of COVID-19, traditional prevention services decreased as most are performed in schools, in person. They were able to offer them virtually but were not able to reach as many students and families as previous years. Due to COVID-19 and how it highlighted pre-existing disparities, those youth experiencing such disparities were less able to access prevention opportunities. Therefore these youth may be at higher risk moving forward. MCOMH added a focus on disparities in Objective 1 of this goal below.

From 2020:

Monroe County Office of Mental Health continues to strive to decrease the risk of mental health and substance use disorders in the community. Behavioral health is an integral part of health and well-being and like other aspects of health, can be impacted by socioeconomic factors that need to be addressed through prevention, treatment, and recovery. Despite considerable prevention efforts, our youth rate of suicide has increased since 2016 and our adolescent/teen tobacco use has risen for the first time in at least the last 15 years. While local provider and school systems are actively working on integrating trauma informed practices to create an upstream prevention approach, there is still work to be done to decrease the risk of mental health, substance use, and behavioral challenges. Through the use of the Youth Risk Behavior Survey data analysis for middle schools, which began in 2019 (Figures 5a, 5b, 5c, 5d), MCOMH will be able to highlight risks and protective factors for youth as they progress through the school system.

Do you have a Goal related to addressing this need? ☒ Yes ☐ No

Goal Statement- Is this Goal a priority goal (Maximum 5 Objectives per goal)? ☒ Yes ☐ No

The Goal Statement should be a specific, clear, and succinct statement of a desired outcome. It should be focused on a change that is tangible, achievable and within the control of the LGU. Avoid vague statements that focus on "maintaining" or "continuing" activity that simply maintains the status quo.

Decrease the risk of advanced mental health disorders, behavior, and/or substance use disorder progression through the enhancement of prevention efforts at all levels – primary, secondary, and tertiary

Objective Statement

Objective Statements should describe a shorter-term action the LGU will take to achieve the longer-term goal. Each goal should have at least one objective. You may have multiple objectives for each goal. The objective should identify the approach to be taken to help achieve the desired outcome. It answers the question, "How will the goal be achieved?"

[Add an Objective](#) (Maximum 5 Objectives per goal) | [Remove Objective](#)

Objective 1: Leverage collaborative efforts to ensure that community members have access to resources that they need, with acknowledgement of the disparities in traditionally underserved populations (i.e. people in poverty, Black people, Hispanic/Latinx people, LGBTQ+ people, youth, etc.).

Applicable State Agency: (check all that apply): ☒ OASAS ☒ OMH ☒ OPWDD

Objective 2: Support the enhancement of trauma-informed care and resilience initiatives through data-trend analysis and engagement with key stakeholders on the Monroe County Youth Risk Behavior/Adverse Childhood Experiences analyses.

Applicable State Agency: (check all that apply): ☒ OASAS ☒ OMH ☒ OPWDD

Objective 3: Actively address social-emotional health and trauma-informed care practices through proposals, quality assurance measures and multi-disciplinary community planning.

Applicable State Agency: (check all that apply): ☒ OASAS ☒ OMH ☒ OPWDD

Objective 4: Support school-based prevention using evidence based and best practices (such as Too Good for Drugs, Botvin's Life Skills Training, Above the Influence, and Sources of Strength).

Applicable State Agency: (check all that apply): ☒ OASAS ☒ OMH ☒ OPWDD

Objective 5: Support community-based prevention across the age spectrum by providing universal education in both lay and professional settings (service clubs, faith-based, town halls, etc.) and advocating for policy change and community awareness using the evidence based environmental prevention efforts.

Applicable State Agency: (check all that apply): ☒ OASAS ☒ OMH ☒ OPWDD

Change Over Past 12 Months (Optional)

This optional, free-text box allows LGUs to describe any change in the need driving the goal or any progress made towards the goal in the last year. Where possible, include specific measurable accomplishments and milestones achieved. You may also want to identify barriers to achieving stated goals and objectives and describe the rationale for any changes made to the goal statement or associated strategies.

2g. Inpatient Treatment Services - Background Information

The Background Information box is a free-text box for LGUs to provide any additional information or more details related to the need and the Goal, such as:

- Data sources used to identify need (e.g. hospital admission data)
- Assessment activities used to indicate need or formulate goal (e.g. community forum)
- Narrative describing importance of goal

This form will allow attachments, so in the Background Information box you could reference an attached document for more information.

See Crisis goal above, as the Inpatient Treatment Services work is encompassed in that goal, as part of the continuum of services.

From 2020:

Through local efforts tied to the State and Federal initiatives, significant resources are allocated to help all individuals avoid unnecessary inpatient admissions. Collaboration and special reviews occur between both Child & Youth and Adult Priority Services, local emergency departments and inpatient units to support individualized planning and wrap around services to meet an individual's need through alternative means. However, there continues to be appropriate presentations for admission that periodically exceed capacity. This creates unnecessary burden for individuals and/or families when admissions must be sought in other communities or there are significant wait times within CPEPs for boarding to inpatient units. Inpatient beds are allocated at the State level in partnership with hospital systems. The LGU will continue to remain actively involved in all efforts to decrease demand for inpatient use wherever clinically appropriate as well as advocating with State and provider partners for appropriate capacity to meet local demand that's clinically warranted.

Do you have a Goal related to addressing this need? ☐ Yes ☒ No

If "No", Please discuss any challenges that have precluded the development of a goal (e.g. external barriers):
Inpatient treatment services are part of the continuum of care for crisis services in our community and therefore are included as part of the crisis goal.

Change Over Past 12 Months (Optional)

This optional, free-text box allows LGUs to describe any change in the need driving the goal or any progress made towards the goal in the last year. Where possible, include specific measurable accomplishments and milestones achieved. You may also want to identify barriers to achieving stated goals and objectives and describe the rationale for any changes made to the goal statement or associated strategies.

2l. Heroin and Opioid Programs and Services - Background Information

The Background Information box is a free-text box for LGUs to provide any additional information or more details related to the need and the Goal, such as:

- Data sources used to identify need (e.g. hospital admission data)
- Assessment activities used to indicate need or formulate goal (e.g. community forum)
- Narrative describing importance of goal

This form will allow attachments, so in the Background Information box you could reference an attached document for more information.

The Monroe County Crime Analysis Center (MCAC) data indicates that there were 839 non fatal overdoses in 2019 and 127 fatal overdoses. This number typically rises when the number from the medical examiner's office is released. It should be noted that these numbers include only overdoses that involve a 9-1-1 call and many more overdoses and reversals are occurring without contacting emergency personnel. Thus far, in the year 2020 (year to date), there have been 468 non fatal overdoses with 87 fatalities. There does appear to be a downturn in overdoses. 2015 to 2017 official medical examiner data show a huge increase in the rate of overdoses in Monroe County, from 10.9 per 100,000 to 30.8 per 100,000 (Figure 6 in appendix). The same community efforts noted below are still in place as much as possible given the current situation with COVID-19. There is a group formed this year to implement a better ED response called Monroe Matters, modeled after the Buffalo Matters project. The aim is to have rapid connection to treatment and MAT upon entry to a local ED, along with a connection to a peer program. The county is also responding with hiring a Director of Addictions Services along with six other support positions to address the addiction crisis.

From 2020:

As the county continues to be ravaged by the opioid epidemic, The Monroe County Crime Analysis Center (MCAC) data indicates that there were 1133 overdoses in 2018 with 166 of them being fatal. That number that will likely rise to well over 200 once official data from medical examiner's office is released. It should be noted that these numbers include only overdoses that involve a 9-1-1 call and many more overdoses and reversals are occurring without contacting emergency personnel. Thus far, in the year 2019, MCAC reports that we have had well over 200 overdoses with 26 fatalities. 2015 to 2016 official medical examiner data show a huge increase in the rate of overdoses in Monroe County, from 10.8 per 100,000 to 21.3 per 100,000 (Figure 6). The penetration of widespread Narcan training in the community, education efforts, multiple robust task forces, and more access to MAT seem to be making a positive impact. However, the overdose response process within hospital EDs needs improving, rapid access and harm reduction best practices remain a challenge, and improving the overall criminal justice response is vital. The SUD consumer focus group echoed these concerns especially concerning responses within the ED

Do you have a Goal related to addressing this need? ☒ Yes ☐ No

Goal Statement- Is this Goal a priority goal (Maximum 5 Objectives per goal)? ☒ Yes ☐ No

The Goal Statement should be a specific, clear, and succinct statement of a desired outcome. It should be focused on a change that is tangible, achievable and within the control of the LGU. Avoid vague statements that focus on "maintaining" or "continuing" activity that simply maintains the status quo.

Enhance the county-wide, cross-sector response to the overdose epidemic by increasing access to appropriate levels of care, including Medication Assisted Treatment

Objective Statement

Objective Statements should describe a shorter-term action the LGU will take to achieve the longer-term goal. Each goal should have at least one objective. You may have multiple objectives for each goal. The objective should identify the approach to be taken to help achieve the desired outcome. It answers the question, "How will the goal be achieved?"

[Add an Objective](#) (Maximum 5 Objectives per goal) | [Remove Objective](#)

Objective 1: Advocate for a formalized overdose response in emergency departments, including immediate access to MAT through collaborative multi-disciplinary planning.

Applicable State Agency: (check all that apply): ☒ OASAS ☐ OMH ☐ OPWDD

Objective 2: Increase numbers of staff and community members trained in using Narcan through frequent training in order to decrease the likelihood of opioid related overdose deaths.

Applicable State Agency: (check all that apply): ☒ OASAS ☐ OMH ☐ OPWDD

Objective 3: Leverage resources in the Behavioral Health System to support the achievement of goals as defined by the Opioid Task Force of Monroe County.

Applicable State Agency: (check all that apply): ☒ OASAS ☐ OMH ☐ OPWDD

Objective 4: Collaborate with Monroe County Jail and Correctional Facility, law enforcement, providers, and diversion courts to increase access to MAT, improve re-entry post-incarceration, and promote rapid engagement in all levels of care.

Applicable State Agency: (check all that apply): ☒ OASAS ☐ OMH ☐ OPWDD

Objective 5: Partner with community efforts (i.e. Project CLEAN), working in neighborhoods that have been negatively impacted by excessive drug activity.

Applicable State Agency: (check all that apply): ☒ OASAS ☐ OMH ☐ OPWDD

Change Over Past 12 Months (Optional)

This optional, free-text box allows LGUs to describe any change in the need driving the goal or any progress made towards the goal in the last year. Where possible, include specific measurable accomplishments and milestones achieved. You may also want to identify barriers to achieving stated goals and objectives and describe the rationale for any changes made to the goal statement or associated strategies.

2z. Other Need (Specify in Background Information) - Background Information

The Background Information box is a free-text box for LGUs to provide any additional information or more details related to the need and the Goal, such as:

- Data sources used to identify need (e.g. hospital admission data)
- Assessment activities used to indicate need or formulate goal (e.g. community forum)
- Narrative describing importance of goal

This form will allow attachments, so in the Background Information box you could reference an attached document for more information.

In light of experiencing a community health crisis with COVID-19, we learned about difficulties in providing services and seeking care amongst community members. MCOMH mobilized the community during this crisis, but there are opportunities for increased proactive planning for the future. Most agencies lacked a formalized process in response to a communitywide public health crisis. It was noted by many providers that people in poverty were less able to access online options for receiving services. Black and Hispanic/Latinx people are disproportionately represented within the population of those in poverty and are more likely to contract COVID-19 (see figure 7 in appendix).

Do you have a Goal related to addressing this need? ☒ Yes ☐ No

Goal Statement- Is this Goal a priority goal (Maximum 5 Objectives per goal)? ☒ Yes ☐ No

The Goal Statement should be a specific, clear, and succinct statement of a desired outcome. It should be focused on a change that is tangible, achievable and within the control of the LGU. Avoid vague statements that focus on "maintaining" or "continuing" activity that simply maintains the status quo.

Advocate for increased access to equitable services and collaborate with community stakeholders to prepare for potential gaps in services during widespread community crises

Objective Statement

Objective Statements should describe a shorter-term action the LGU will take to achieve the longer-term goal. Each goal should have at least one objective. You may have multiple objectives for each goal. The objective should identify the approach to be taken to help achieve the desired outcome. It answers the question, "How will the goal be achieved?"

[Add an Objective](#) (Maximum 5 Objectives per goal) | [Remove Objective](#)

Objective 1: Collaborate with agencies to reduce disparities in technology access for providers and people who use services.

Applicable State Agency: (check all that apply): ☒ OASAS ☒ OMH ☒ OPWDD

Objective 2: Convene stakeholders to collaborate on closing gaps in services/supports in emergencies, with a special focus on underserved populations. Some topics of consideration include, but are not limited to: people with I/DD needing increased consideration of back up supports, stigma related to seeking and attending treatment for MH and SUD for people of different cultures, accessing natural supports in the community, and offering training to faith leaders and community touchpoints in how to meet basic MH, SUD and I/DD needs, etc.

Applicable State Agency: (check all that apply): ☒ OASAS ☒ OMH ☒ OPWDD

Objective 3: Work with providers to ensure they have plans in place for widespread emergencies that affect the community and service provision.

Applicable State Agency: (check all that apply): ☒ OASAS ☒ OMH ☒ OPWDD

Change Over Past 12 Months (Optional)

This optional, free-text box allows LGUs to describe any change in the need driving the goal or any progress made towards the goal in the last year. Where possible, include specific measurable accomplishments and milestones achieved. You may also want to identify barriers to achieving stated goals and objectives and describe the rationale for any changes made to the goal statement or associated strategies.

Office of Addiction Services and Supports

Accessibility

Contact

Disclaimer

Language Access

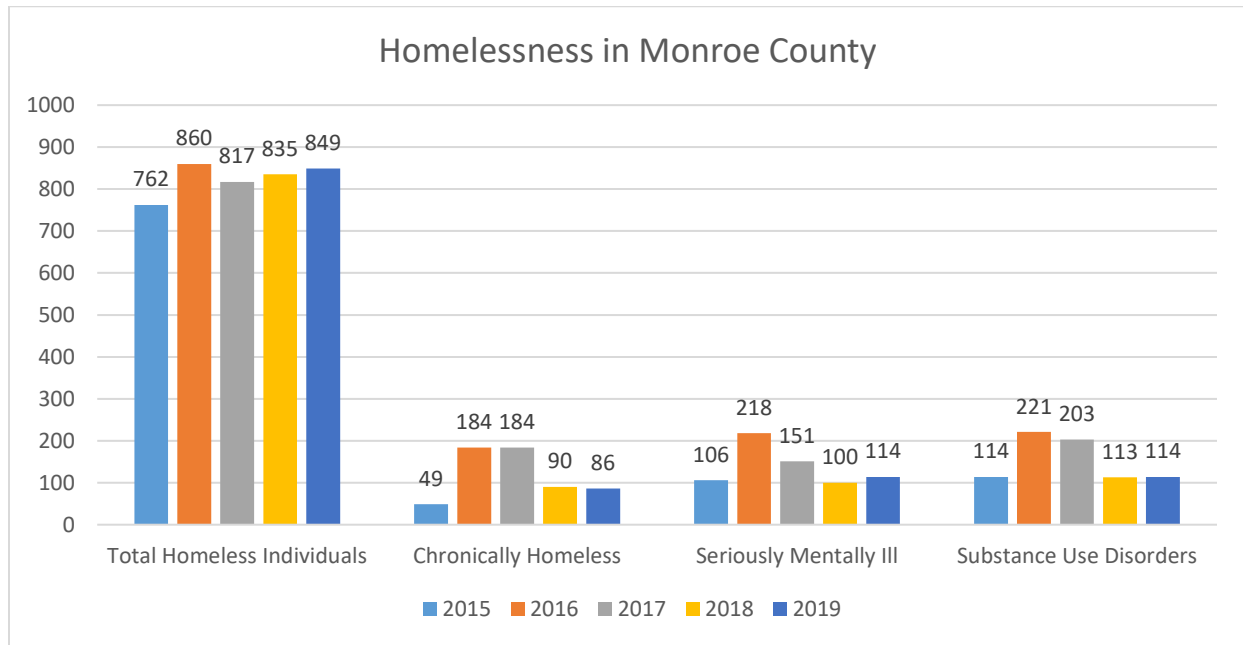
Privacy Policy



Appendix A 2021
Monroe County Supporting Data

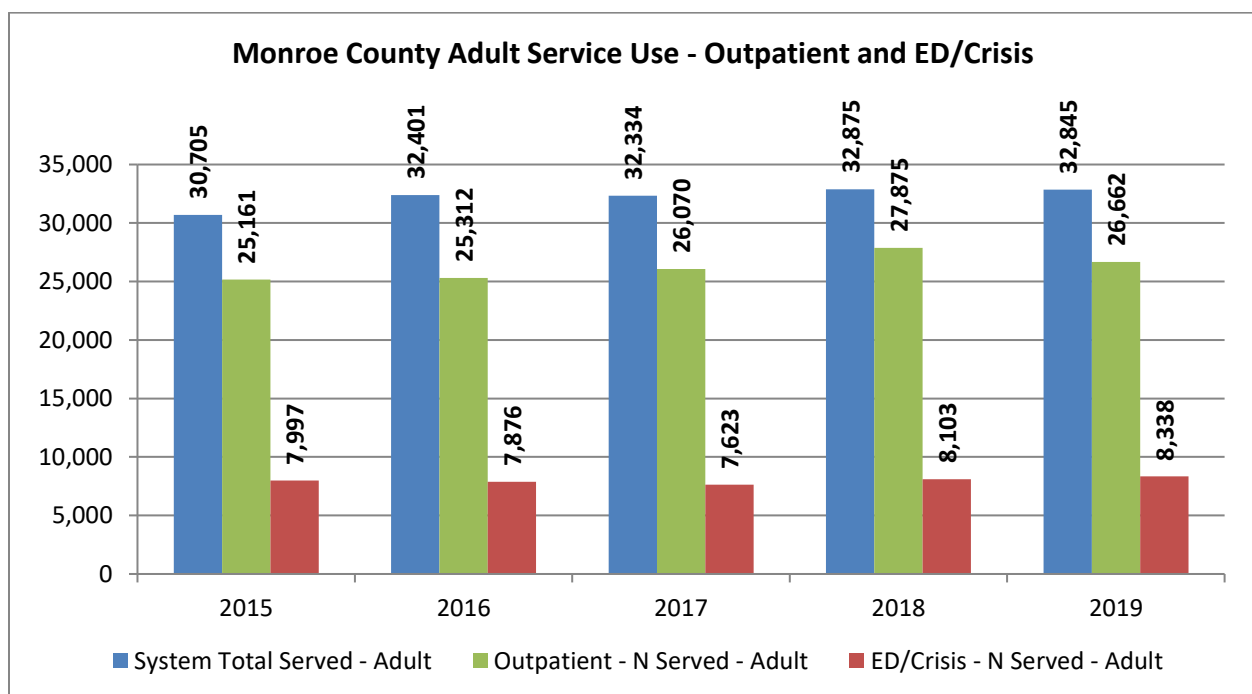
Monroe County Housing

Figure 1.



Monroe County Crisis

Figure 2a. Outpatient and ED/Crisis Utilization Adults



Appendix A 2021 Monroe County Supporting Data

Figure 2b. Outpatient and ED/Crisis Utilization Children and Youth

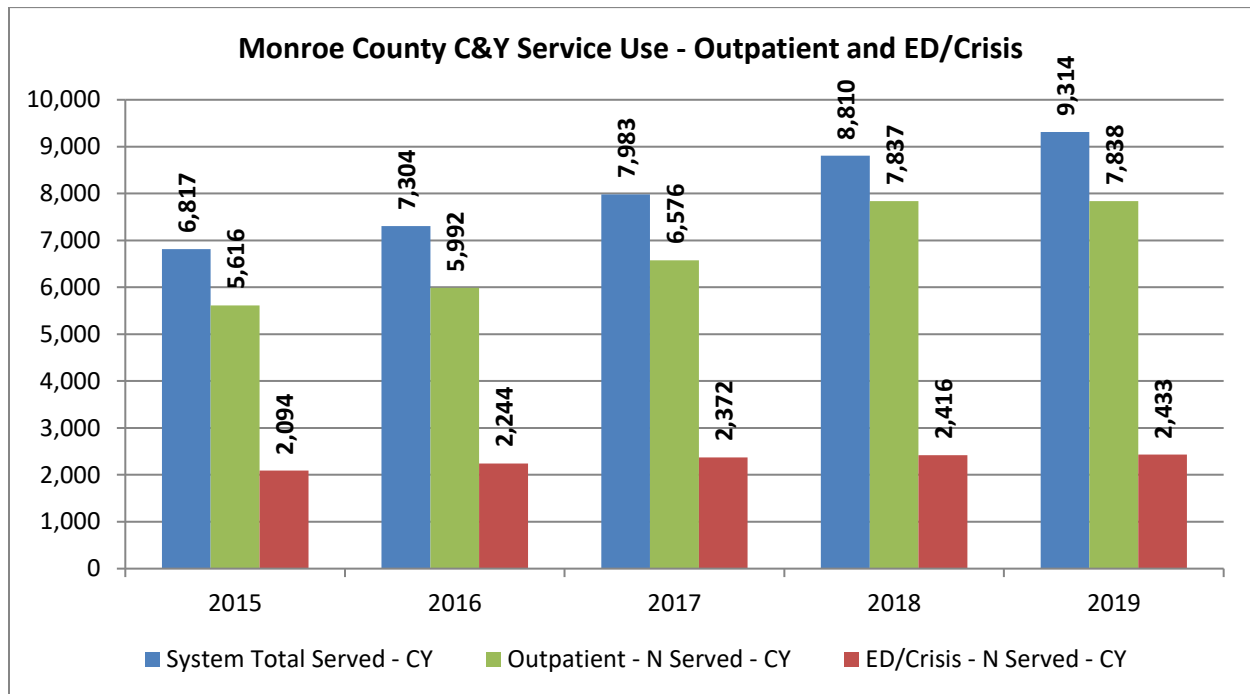


Figure 2c. Adult Follow up After Discharge – 7 Days

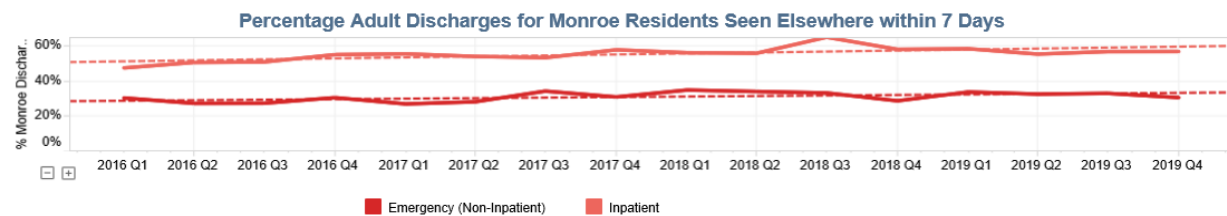
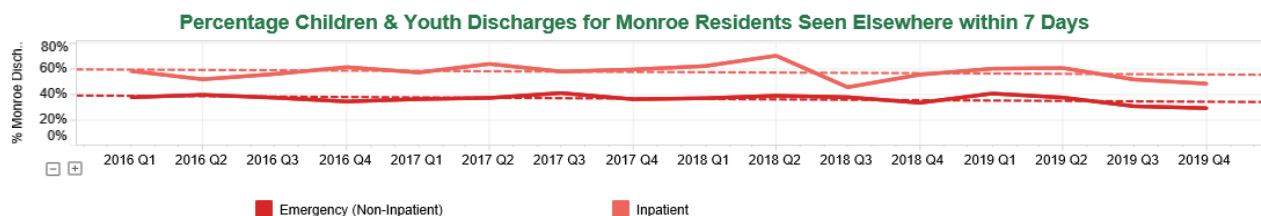
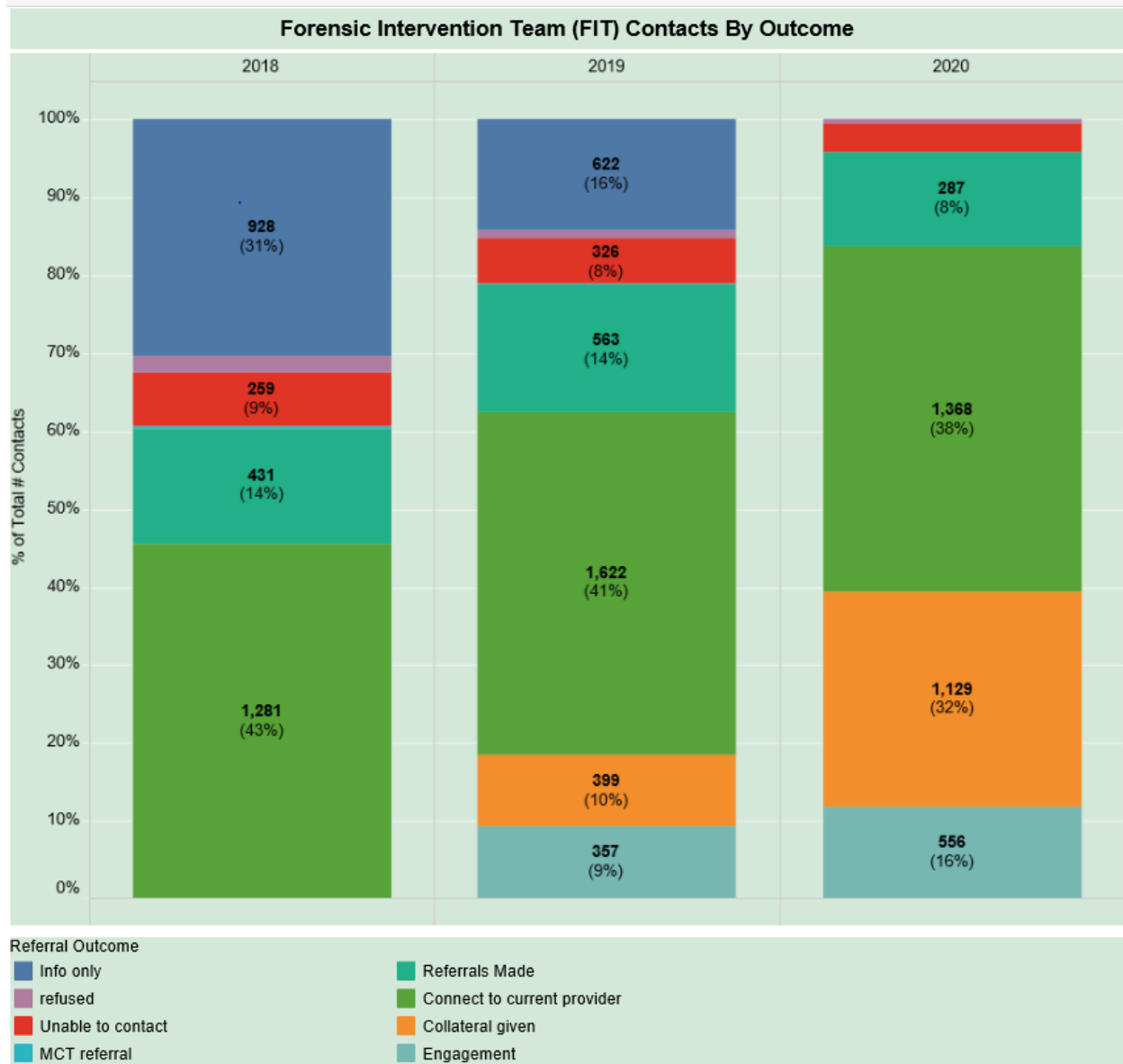


Figure 2d. Children and Youth Follow up After Discharge – 7 days



Appendix A 2021
Monroe County Supporting Data

Figure 3. Forensic Intervention Team (FIT) Outcomes



Notes:

2020 represents January to June

Outcomes categories changed during 2019 to the following:

- Connect to current provider (linkage to current provider)
- Revised: Referrals made (referrals of any kind being made – now includes MCT, instead of separate category)
- New: Collateral given (information given for planning purposes – includes Info only)
- New: Engagement (engaging client in follow-up without agreement on additional linkages yet)
- Unable to contact
- Refused

Appendix A 2021 Monroe County Supporting Data

Monroe County Workforce

Figure 4a. NYS PPS High Vacancy Rates (same as 2020)

Summary Snapshot: PPSs with High Vacancy Rates

Number of Job Titles with 8%+ Vacancy Rates, by PPS

PPS	# of Job Titles with 8%+ Vacancy Rate	PPS	# of Job Titles with 8%+ Vacancy Rate
Suffolk Care Collaborative	0	Central NY Care Collaborative	9
Nassau Queens PPS	5	Finger Lakes PPS	12
Advocate Community Partners	8	Montefiore Medical Center	5
NYU Lutheran PPS	10	WMCHealth PPS	9
Maimonides Medical Center	14	Bassett PPS	12
SBH Health System	15	Adirondack Health Institute	14
New York-Presbyterian/Queens	8	Care Compass Network	8
OneCity Health PPS	7	North Country Initiative	16
Alliance for Better Health Care	10	Community Partners Western NY	11
Albany Medical Center Hospital	9	Millennium Care Collaborative	9
Bronx Health Access	1	Mount Sinai	7
		New York-Presbyterian	8

Fewest Job Titles

Most Job Titles

Note: Only 23 PPSs submitted vacancy rate data
Note: Only 22 key job titles were considered for this analysis



Figure 4b. Finger Lakes Region Specific Job Titles Vacancy Rates (same as 2020)

Finger Lakes PPS

Reported Data for Key Job Titles

8%+ Vacancy Rate

Non-Licensed Emerging Job Titles

Job Title	# Responding Organizations	Response Rate	# Employees	# Vacancies	Vacancy Rate
Primary Care Physician	Unreported		112	12	10.71%
Primary Care Nurse Practitioner			1,127	451	40.02%
Psychiatric Nurse Practitioner			1,127	451	40.02%
Staff Registered Nurse			14,662	3,989	27.21%
Licensed Practical Nurse			4,952	826	16.68%
RN Care Coordinators/Case Managers/Care Transitions			14,662	3,989	27.21%
Psychiatrist			88	122	138.64%
Psychologist			988	27	2.73%
Medical Assistant			1,129	102	9.03%
Social and Human Service Assistants			3,091	33	1.07%
Substance Abuse and Behavioral Disorder Counselors			647	82	12.67%
Nursing Aide/Assistant			8,587	666	7.76%
Certified Home Health Aide			5,874	231	3.93%
Personal Care Aide			11,233	115	1.02%
Licensed Clinical Social Worker			899	21	2.34%
Bachelor's Social Worker			899	21	2.34%
Licensed Master's Social Worker			899	21	2.34%
Social Worker Care Coordinator/Case Manager/Care Transition			Unreported		
Care Manager / Coordinator			3,091	33	1.07%
Care or Patient Navigator			228	22	9.65%
Community Health Worker			228	22	9.65%
Peer Support Worker			647	82	12.67%

Most Common Reported Degree Requirement for Non-Licensed Care Coordination Positions: None



Appendix A 2021 Monroe County Supporting Data

Monroe County Prevention

Figure 5a. Monroe County Middle School ACEs Score Distribution Data 2019

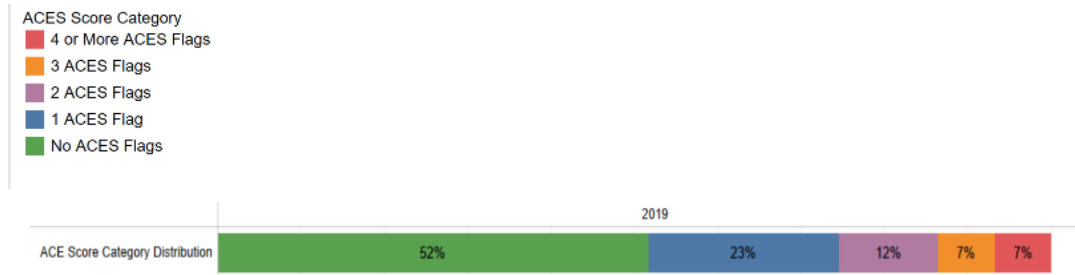


Figure 5b. Monroe County Middle School 11 ACEs Questions Distribution

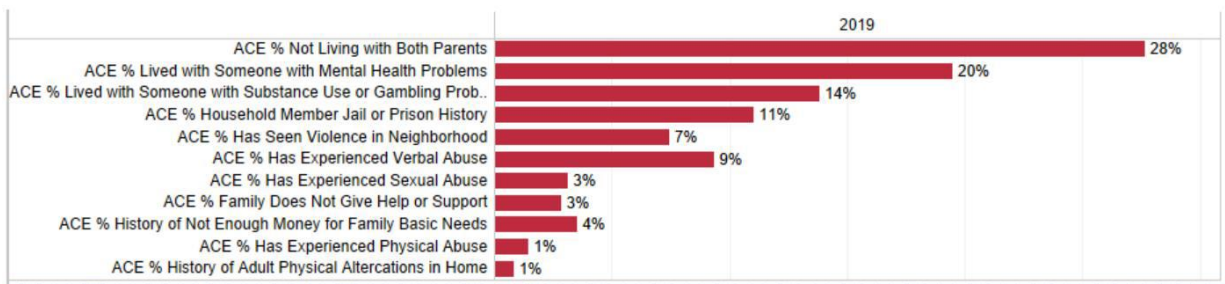


Figure 5c. Monroe County Middle School Risk Behaviors Data

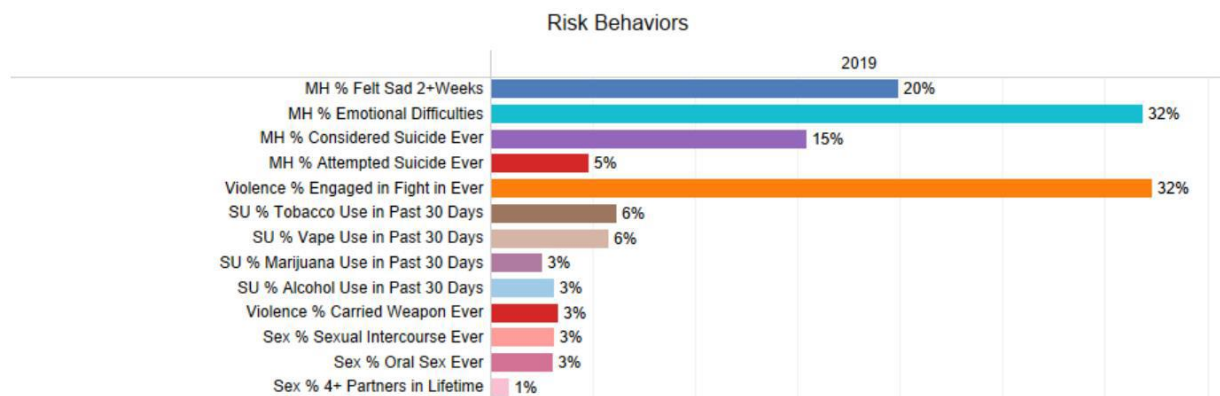
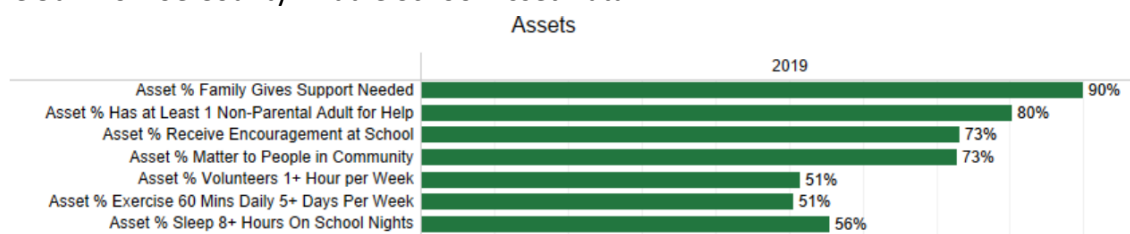


Figure 5d. Monroe County Middle School Asset Data



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Figure 5e. Monroe County High School ACEs Score Distribution Data 2019

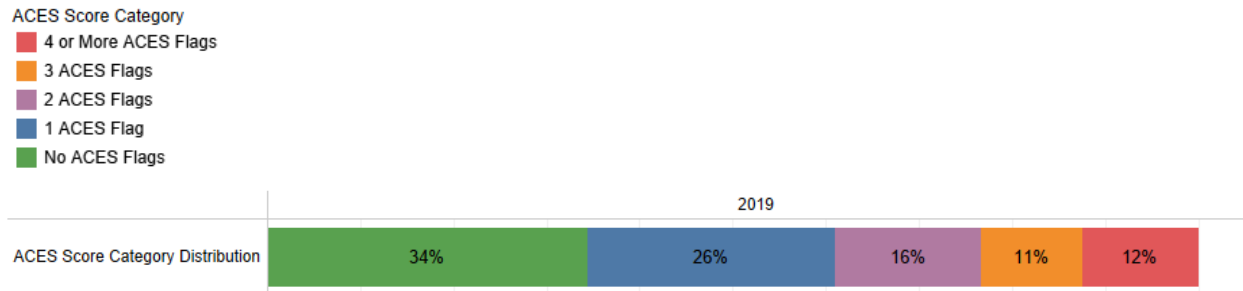


Figure 5f. Monroe County High School 11 ACEs Questions Distribution

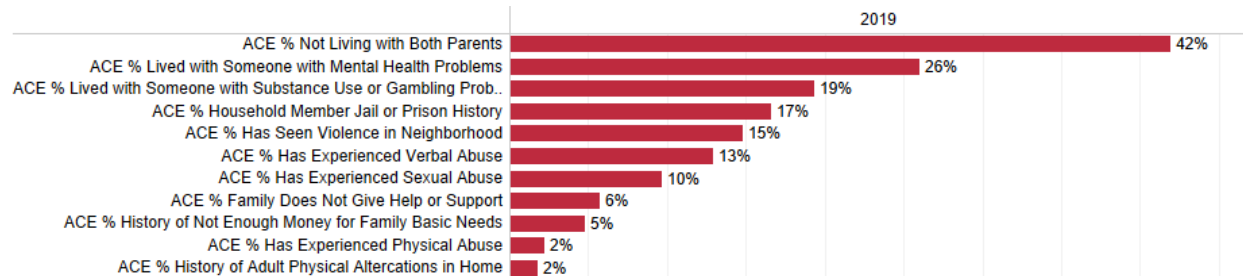


Figure 5g. Monroe County High School Risk Behaviors Data

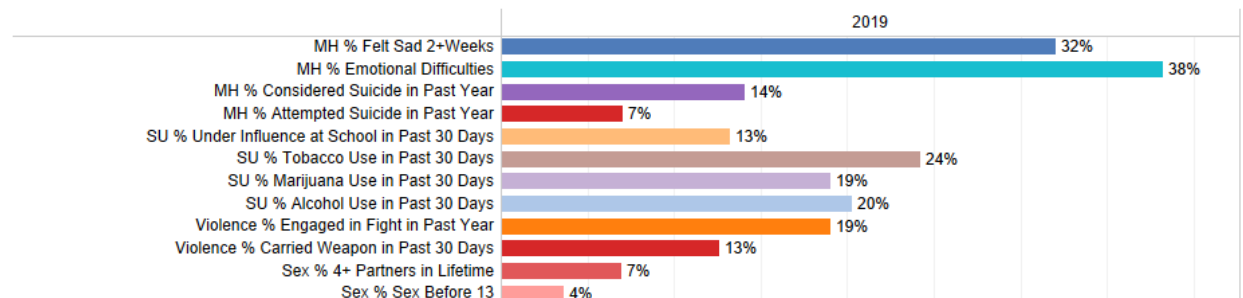
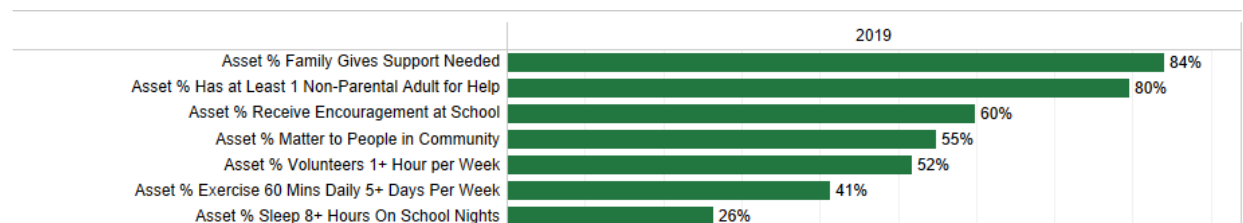


Figure 5h. Monroe County High School Asset Data

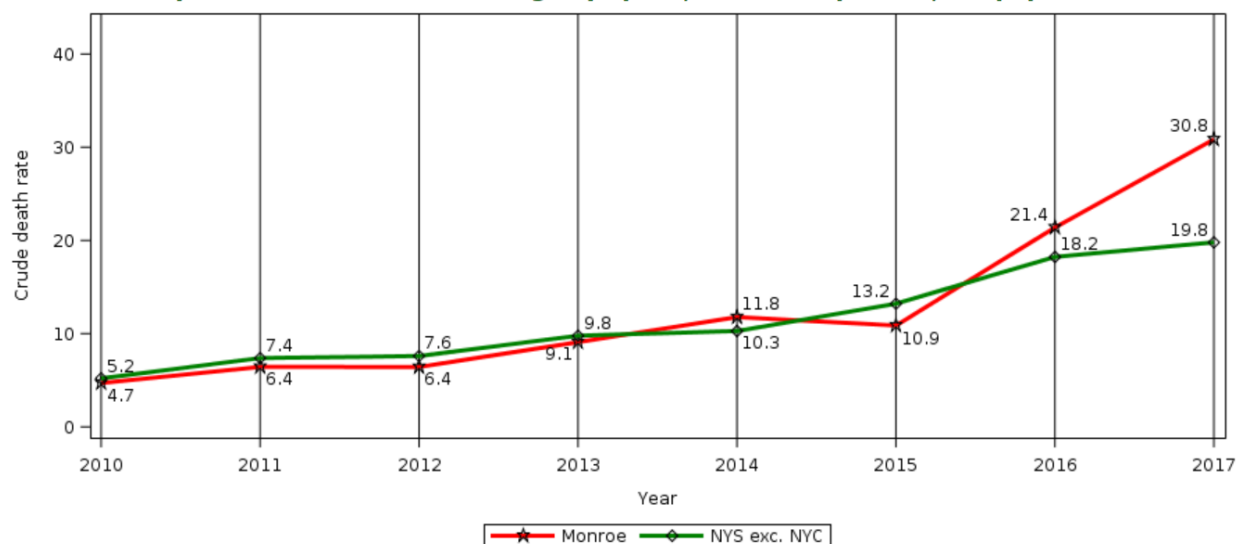


Appendix A 2021 Monroe County Supporting Data

Monroe County Heroin and Opioid Programs and Services

Figure 6. Monroe County Opioid Overdose Deaths

Monroe County - Overdose deaths involving any opioid, crude rate per 100,000 population



Data Year(s)	Monroe	NYS exc. NYC	NYS
2010	4.7	5.2	5.0
2011	6.4	7.4	6.6
2012	6.4	7.6	7.0
2013	9.1	9.8	8.2
2014	11.8	10.3	8.7
2015	10.9	13.2	10.9
2016	21.4	18.2	15.6
2017	30.8	19.8	16.8

Data Source: Vital Statistics Data as of December 2019

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Emergency Preparedness

Figure 7. Monroe County COVID-19 Infection Rates by Race/Ethnicity

Monroe County Data as of July 8th, 2020

Age-Adjusted Rates by Race, Ethnicity, and Sex

Race / Ethnicity	Cases		Hospitalizations			ICU		Deaths			In-Hospital Deaths	
	Total to Date	Age-Adjusted Rate per 100,000 Population	Total to Date	Percent of Total Cases	Age-Adjusted Rate per 100,000 Population	Total to Date	Percent of Hospitalized Cases	Total to Date	Percent of Total Cases	Age-Adjusted Rate per 100,000 Population	Total to Date	Percent of Hospitalized Cases
White	1961	327.6	403	20.6%	60.6	109	27.0%	200	10.2%	27.1	91	22.6%
African American	1397	1350.1	259	18.5%	297.7	95	36.7%	42	3.0%	63.4	26	10.0%
Latinx	429	831.9	80	18.6%	197.5	24	30.0%	17	4.0%	64.8	13	16.3%
Asian	105	418.1	14	13.3%	68.4	4	28.6%	4	3.8%	28.9	1	7.1%
Other	116	*	25	21.6%	*	4	16.0%	3	2.6%	*	2	8.0%
Unknown	178	*	6	3.4%	*	1	16.7%	5	2.8%	*	3	50.0%
Total	4186	548.9	787	18.8%	113.1	237	30.1%	271	6.5%	36.6	136	17.3%

COMPLETE

Monday, September 14, 2020 2:33:22 PM

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Q1

Contact Information

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Q2

Monroe County Office of Mental Health

LGU:

Q3

a. Indicate how your local mental hygiene service system (i.e., mental health, substance use disorder and problem gambling, and developmental disability populations), overall, has been affected by the COVID-19 pandemic: Please specifically note, Any cross-system issues that affect more than one population; Any specific racial/ethnic groups or populations that have been disproportionately impacted by COVID-19; and Any differences between adult services and children's services.

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Monroe County providers and service users have been challenged with increasing their use of technology as the primary mode of service delivery was switched from in-person to telephone and televideo contact. This switch has highlighted disparities in the access to technology, particularly in parts of the community with high poverty, which is also part of the community with the most people who are Black and Hispanic/Latinx. Schools have provided technology to some children in need, but not all. For example, the largest school district in our county, Rochester City School District, has only been able to deploy technology to students in older grades as of the end of the school year. More technology (chrome books and Wi-Fi devices) are slated to be provided to all students in need in September 2020.

Additionally, there has been general feedback that some services and/or services for some people are not able to be delivered as effectively via telehealth as they are in person services. For example, children's providers noted how challenging it can be to engage young children or children with attention challenges in virtual sessions.

Anecdotally, there has been increased fear and anxiety in the community related to COVID-19. In the beginning of socially distancing, it seemed that fears and anxiety centered on catching and becoming ill from COVID-19. As time wore on, there was increased stress related to parents/caregivers who are responsible for watching children or other loved ones and workers who were furloughed or laid off. We anticipate that this collective stress, fear, and anxiety will have implications for the wellbeing of community members over time.

Across the community, there have been financial challenges for providers. In March, providers had to cancel services and quickly pivot to a delivery method that would put their employees and clients at the least possible risk. Thankfully, the state-level oversight agencies were quick to loosen regulatory restrictions to provision of tele-services. Additionally, there have been funding withholds of 20% to certain programs. Initially this was just affecting OASAS and OMH funded services, but we just learned that OPWDD will also be included. We await more details about OPWDD withholds.

Adult residential services have been impacted due to space constraints. Providers were required to dedicate space for isolation and socially distancing as needed. This has caused fewer available beds in the community for those in need. Additionally, there has been less movement of people out of residential placements, leaving even fewer available housing placements for those with emerging needs.

Providers have noted a general decrease in the amount of new people seeking services. As an LGU, our concern is that people may not be seeking services right now, but it doesn't mean the need is not there.

All criminal justice involved people had disruption in their normal processes with probation, court, etc. because courts were closed and/or workers were working remotely.

https://www2.monroecounty.gov/files/health/coronavirus/Final_%202020%20COVID-19%20Monroe%20County%20Surveillance_%20data%20as%20of%207-8-20.pdf

See Page 3: In looking at data through July 8th for Monroe County, the age-adjusted rate per 100,000 people is 1350 for African American and 832 for Hispanic/Latinx, compared with 328 for white people. The rate is more than 4x higher for African American people and more than two times higher for Hispanic/Latinx people.

Since Black and Hispanic/Latinx people in Monroe County are disproportionately affected by poverty, their access to adequate technology and internet connectivity is limited. Thus, their access to televideo services is likely limited, as well.

Covid highlighted the lack of equity in services, which has started a conversation about formal vs. informal behavioral health services in the community, specifically for Black and Hispanic/Latinx people. One goal with this conversation is to break down barriers to care that works for people based on their culture.

Per provider reports, services for children and youth may not work as well via technology due to the hands-on nature of some services. Children's crisis services were less utilized, but it does not mean the need is less. There is concern in the community is that abuse and neglect of children and youth is increasing. Per reports from our local Child Protective services, the number of CPS reports went down, but intensity/severity of reports increased.

Q4

b. Indicate how your mental health service needs, overall, have been affected by the COVID-19 pandemic: Please specifically note, Any specific racial/ethnic groups or populations that have been disproportionately impacted by COVID-19; and Any differences between adult services and children's services.

- CPEP and Mobile Crisis: Adult numbers stayed the same, but kids referrals went down. It is thought that this is because of the lack of school referrals.
- Children's residential referrals have increased, per our C&Y SPOA team.
- Children's respite resources have not been available or are very limited. Smith Road's state run respite beds have been available, but they are limited. The local Emergency Respite Beds through Hillside (foster care-like model) have not been available except for special circumstances.
- For children and youth inpatient care: numbers were lower and overall the unit is not full. The thought is that this is partially due to social distancing and partly due to lack of seeking care.
- Some youth and adults who typically had challenges with engaging in services were able to be served due to them being able to access services more readily via telehealth. Others are choosing to wait for services to start again in person.
- There were a lot of conversations between providers in the beginning of COVID about strategies for engagement to meet the minimum duration of services for billing. Providers were able to use creativity and things like the white board on zoom to engage.
- Law enforcement has reported an increase in suicide attempts that are related to financial stress, loss of jobs, etc.
- Children & Youth and Adult SPOA has received significantly fewer referrals resulting in more openings in community support programs like CFTSS, HH CM, etc. Many of the programs with openings have been providing mostly tele-based care. Programs providing in-person care have become overtaxed, more recently.

As an LGU, we expect general mental health needs to increase:

- For first responders and/or essential workers
 - Once the eviction moratorium lifts
 - As school starts, local supports are concerned about youth generally, but particularly that those with school avoidance challenges may not engage
 - If unemployment needs change or people don't go back to work
-

Q5

c. Indicate how your substance use disorder (SUD) and problem gambling needs, overall, have been affected by the COVID-19 pandemic: Please specifically note, Any specific racial/ethnic groups or populations that have been disproportionately impacted by COVID-19; and Any differences between adult services and children's services.

- There was an increase in overdoses compared to the data from March-May 2019. In June, the number of overdoses started to look similar to 2019. Time will tell what the numbers will look like going forward.
 - Gambling has decreased overall because access has not been there as readily: Casinos closed, lack of sports, etc.
 - There has been a decrease in people seeking bedded services, specifically detox, due to fear of contracting COVID.
 - Drug screening stopped, so trying to gauge actual drug/alcohol use has been challenging. Local providers are looking at other ways to collect data about actual use, particularly prior to intake into residential services. One thing being explored is mail in drug screening, involving swabbing the cheek while on zoom with the screening company.
 - Those experiencing poverty, which includes a lot of people from Black and Hispanic/Latinx communities, are more likely to have difficulty accessing telehealth services due to cost and technology barriers and SUD providers noted this disparity.
-

Q6

d. Indicate how the needs of the developmentally disabled population, overall, have been affected by the COVID-19 pandemic: Please specifically note, Any specific racial/ethnic groups or populations that have been disproportionately impacted by COVID-19; and Any differences between adult services and children's services.

- People with I/DD were isolated from their families and the community largely due to health and safety guidelines implemented to keep those individuals most susceptible to COVID-19 safe. If the individual was living in a certified setting, families had to make the decision about whether to keep their loved home with them and care for them without support or have them stay in their certified setting and not be able to see them. This situation continued for months and family members were in touch with MCOMH advocating for the well-being of their loved ones. As a part of a congregate care group that was convened in our county because of COVID, MCOMH was able to develop a visitation best practice document with the help of those family members. Shortly after development, OPWDD began allowing visitations to residential locations in our county.
 - Changes in routines can be challenging for people with I/DD and their schedules changed drastically due to social distancing. Agencies were able to come up with alternate plans for people to keep them somewhat engaged, but parents report that these plans varied by agency and residential location.
-

Q7

a. Mental Health providers

Summarizing policies, discussing applicability, and providing examples would be helpful. There is a need for TA in real time across all systems. Many stakeholders are looking for resources re: SDOH and BH – lists were made by several groups. Providers wanted the materials for COVID-19 to put up in their locations – to be consistent and not have to dedicate their staff time to produce them and while these were not initially provided, they were after some time.

Q8

b. SUD and problem gambling service providers:

Summarizing policies, discussing applicability, and providing examples would be helpful. There is a need for TA in real time across all systems. Many stakeholders are looking for resources re: SDOH and BH – lists were made by several groups. Providers want the materials for COVID-19 to put up in their locations – to be consistent and not have to dedicate their staff time to produce them and while these were not initially provided, they were after some time.

Q9

c. Developmental disability service providers:

Summarizing policies, discussing applicability, and providing examples would be helpful. There is a need for TA in real time across all systems. Many stakeholders are looking for resources re: SDOH and BH – lists were made by several groups. Providers want the materials for COVID-19 to put up in their locations – to be consistent and not have to dedicate their staff time to produce them and while these were not initially provided, they were after some time. Guidance was not as timely as other systems and restrictive, leaving individuals served and their families unable to see one another for long periods. This situation has resolved.

Page 2

Q10

a. Since March 1, 2020, how would you describe DEMAND for mental health services in each of the following program categories?

INPATIENT (State PC, Article 28/31 Inpatient, Residential Treatment Facilities)	Decreased
OUTPATIENT (Clinic, ACT, Day Treatment, PROS, Continuing Day Treatment, Partial Hospitalization)	Decreased
RESIDENTIAL (Support, Treatment, Unlicensed Housing)	Decreased
EMERGENCY (Comprehensive Psychiatric Emergency Programs, Crisis Programs)	Decreased
SUPPORT (Care Coordination, Education, Forensic, General, Self-Help, Vocational)	Increased

Q11

If you would like to add any detail about your responses above, please do so in the space below:

MCOMH used admission data from March-June 2020 as reported into the Behavioral Health Community Database. Admission numbers are down compared to 2019, however, MCOMH is unsure about the actual need in the community as this is hard to measure. People are isolated/isolating due to COVID-19 and may not be seeking needed services as they normally would for their behavioral health needs. Inpatient numbers were only slightly lower overall from 2019-2020, while Outpatient, Residential, and Emergency care numbers were quite a bit lower. The Support category was slightly higher for admissions overall, but this was because of a much larger admission number in March. The admissions were lower than numbers in 2019 for April, May, and June. For the Support category, the services varied somewhat from those listed.

Q12

b. Since March 1, 2020, how would you describe ACCESS to mental health services in each of the following program categories?

INPATIENT (State PC, Article 28/31 Inpatient, Residential Treatment Facilities)	Decreased
OUTPATIENT (Clinic, ACT, Day Treatment, PROS, Continuing Day Treatment, Partial Hospitalization)	Decreased
RESIDENTIAL (Support, Treatment, Unlicensed Housing)	Increased
EMERGENCY (Comprehensive Psychiatric Emergency Programs, Crisis Programs)	Decreased
SUPPORT (Care Coordination, Education, Forensic, General, Self-Help, Vocational)	Decreased

Q13

If you would like to add any detail about your responses above, please do so in the space below:

MCOMH used total clients served data from March-June 2020 as reported into the Behavioral Health Community Database. Total clients served numbers are down compared to 2019, however, MCOMH is unsure about the actual need in the community as this is hard to measure. People are isolated/isolating due to COVID-19 and may not be seeking needed services as they normally would for their behavioral health needs. The Inpatient and Support numbers are slightly lower overall, while Emergency services' numbers are significantly lower. The Outpatient numbers were lower overall, but rose steadily March-June and June 2020 was higher than June 2019. Residential clients were higher overall and every month from March-June was higher than 2019. For the Support category, the services varied somewhat from those listed.

Q14

a. Since March 1, 2020, what number of mental health program sites in your county closed or limited operations due to COVID-19, apart from transition to telehealth?

9

Q15

If you would like to add any detail about your responses above, please do so in the space below:

Within a week, clinics and many other local services were providing support via teleservices. Did not count housing that was limited due to residential providers planning and preparing for potential COVID-19 infection to occur in their housing.

Q16

b. What number of mental health program sites in your county remain closed or are offering limited services now, apart from transition to telehealth?

1

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Q17

If you would like to add any detail about your responses above, please do so in the space below:

Children's Emergency Respite Beds are still limited due to host homes being wary of allowing youth to stay with them for short periods of time. Did not count housing that was limited due to residential providers planning and preparing for potential COVID-19 infection to occur in their housing.

Q18

N/A

c. If your county operates services, did you maintain any level of in-person mental health treatment

Q19

Respondent skipped this question

If you would like to add any detail about your responses above, please do so in the space below:

Q20

No

d. As a result of COVID-19, are any mental health programs in your county closing operations permanently? If yes, list program name(s) and type(s).

Q21

If you would like to add any detail about your responses above, please do so in the space below:

Many programs are experiencing great financial challenges and if withholds turn to permanent cuts and lower census' continue, some may be in danger. We would classify several programs as high risk of closure if current withholds are made permanent.

Q22

No

e. Did any mental health programs in your county close due to workforce issues (e.g. staff infections, recruitment/retention issues)?

Q23

If you would like to add any detail about your responses above, please do so in the space below:

Workforce issues continue to be challenging to organizations. One relief during this time has been the ability to hire more quickly because of background checks carrying over from other agencies. We hope that in this time of digital collaboration, this practice of sharing information across the "O" agencies can continue to aid providers with hiring more efficiently.

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Q24

a. Apart from telehealth, during COVID-19, did your county or mental health providers within your county develop any innovative services or methods of program delivery that may be continued post-COVID? If yes, please describe.

Yes (please describe):

MCOMH collaborated with homeless services and were able to rehouse people to make sure infections did not spread in the normally close quarters of homeless shelters. This collaboration formed new partnerships that are likely to continue to aid people who are homeless in finding housing and getting support services as needed.

Q25

b. During COVID-19, did any mental health providers within your county form any partnerships with other providers that may be continued post-COVID? If yes, please describe.

Yes (please describe):

- 211 is reaching out more proactively to create or strengthen working relationships with MH programs. - In homeless services, providers have been willing to serve people in the hotel setting and we hope this collaboration will continue after COVID. - United Way partnerships and networking across disability areas has increased markedly.

Q26

a. During COVID-19, how many mental health providers within your county implemented existing continuity of operations plans?

4

Q27

If you would like to add any detail about your responses above, please do so in the space below:

MCOMH surveyed all the mental health providers in the community and received responses from 9. The challenge in answering this question seems to be in the interpretation of the word, "existing." While 4 providers answered that they used their existing plans, 2 of these 4 also said they needed to update their plans to encompass all the work related to the COVID-19 pandemic.

Q28

b. During COVID-19, how many mental health providers within your county did not implement existing continuity of operations plans?

5

Q29

If you would like to add any detail about your responses above, please do so in the space below:

MCOMH surveyed all the mental health providers in the community and received responses from 9. The challenge in answering this question seems to be in the interpretation of the word, "existing." All 5 of the providers said they had existing emergency plans but they had to be updated significantly to take into account all the factors related to COVID-19, so they answered this question as, "No."

Q30

None

c. During COVID-19, did your county LGU or Office of Emergency Management (OEM) assist any mental health providers in the development or revision of continuity of operations plans?

Q31

If you would like to add any detail about your responses above, please do so in the space below:

No one reached out to the LGU or OEM of the 9 who responded.

Q32

During COVID-19, what OMH guidance documents were beneficial to your disaster management process?

Program-level Guidance,

Telemental Health Guidance,

Infection Control Guidance,

Fiscal and Contract Guidance,

FAQs,

Please provide any feedback on OMH's guidance resources::

This guidance created consistency in practices in the community when needed.

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Q33

1. Please indicate any needs for or issues with SUD and problem gambling prevention, treatment, and recovery providers acquiring Personal Protective Equipment (PPE), face masks, cleaning or disinfectant supplies, or similar materials related to the COVID-19 pandemic:

Due to cost and lack of supply, the providers in our community had difficulty obtaining these items. After some coordination, the United Way was able to provide PPE and supplies across the community. The timeliness of getting these supplies has been challenging.

Q34

a. How has COVID-19 affected the delivery of and demand for SUD and problem gambling prevention services in your county?

With a COVID-19 closure of schools and communities so immediate, we had little time to shift gears. Schools had to prioritize their academic needs and took at least 3 weeks to begin working with most prevention providers and incorporating virtual opportunities for them.

Parental attendance increased in many cases and even greatly with foster parents with one of our providers.

All previously confirmed events, luncheon, conference keynotes, community, and school presentations were cancelled. Very few shifted to a virtual platform and those that shifted, did so only after several months of retooling their conference. Media awareness campaigns, radio interviews were delayed as well until each partner navigated their new parameters and platforms.

For youth, virtual connection was problematic and uneven. For parents it improved greatly.

Q35

b. How has COVID-19 affected the delivery of and demand for SUD and problem gambling recovery services in your county?

We have a very robust community of recovery providers. The local recovery community and outreach center had some difficulty transitioning to virtual programming due to lack of resources, very few personnel, and utilizing technology not used previously. It took months for them to return to a calendar of virtual offerings and took another month to navigate in person services after they were permitted.

Other recovery offerings in our community shifted to virtual options, but since most were in person community-oriented gatherings and efforts, it proved difficult and they proceeded with with negligible engagement. It could be argued that with lower engagement in recovery services, it may have been a contributing factor to lower demand in treatment services.

Many recovery community events were cancelled and some recovery walks moved to virtual walks. The recovery community thrives on in person connection so this transition proved difficult and most persons in recovery shared that the virtual experience did not offer the same sense of connection they are often seeking.

Q36

c. How has COVID-19 affected the delivery of and demand for problem gambling treatment services in your county?

As previously mentioned, outpatient treatment services had to transition to all telehealth services which varied widely in ease and effectiveness. Some providers had little or no experience in this delivery method and others had already been practicing telehealth. This likely impacted quality of services, as well. Some patients shared that they enjoyed the option of virtual treatment while others found it ineffective. Most providers found conducting group sessions in this manner problematic, with few exceptions. The demand for services also dropped dramatically with some providers sharing their assessment numbers dropping 75% from the previous year at the same time.

The lack of demand and challenge in connecting with current care led to serious financial problems for nearly all providers.

Our bedded programs saw census cut in half or a third to create isolation space and follow OASAS recommendations. This led to an increase in out-of-county treatment requests for residential services, which is still the case at present. Residential providers saw an increase in persons leaving treatment, lapses in recovery, and staffing challenges across the board.

Q37

d. Since March 1, 2020, how would you describe DEMAND for SUD Treatment services in each of the following program categories?

INPATIENT	Decreased
OUTPATIENT	Decreased
OTP	Decreased
RESIDENTIAL	Decreased
CRISIS	Decreased

Q38

If you would like to add any detail about your responses above, please do so in the space below:

MCOMH used admission data from March-June 2020. Admission numbers are down overall compared to 2019, however, MCOMH is unsure about the actual need in the community as this is hard to measure. People are isolated/isolating due to COVID-19 and may not be seeking needed services as they normally would for their behavioral health needs. Admissions for inpatient, outpatient, and OTP decreased. Residential admissions also decreased, but April and May last year were also much higher than other 2019 months. Crisis services admissions were decreased overall, but March's numbers were much higher for 2020 than 2019. For crisis services, admissions and episodes (counted below for the access question) are the same.

Q39

e. Since March 1, 2020, how would you describe ACCESS to SUD Treatment services in each of the following program categories?

INPATIENT	Decreased
OUTPATIENT	Increased
OTP	Increased
RESIDENTIAL	Decreased
CRISIS	Decreased

Q40

If you would like to add any detail about your responses above, please do so in the space below:

MCOMH used episode data from March-June 2020. Episode numbers are up overall compared to 2019. MCOMH is unsure about the actual need in the community as this is hard to measure. People are isolated/isolating due to COVID-19 and may not be seeking needed services as they normally would for their behavioral health needs, so the need in the community may be even greater than the increased numbers show.

Access decreased in inpatient, residential and crisis because they had to increase the amount of space allotted for each individual they served in order to decrease the opportunity for COVID-19 transmission. Outpatient access decreased for a short amount of time, but then markedly increased per provider report, because there were more ways (telehealth) the people could be engaged. OTP also slightly increased. Crisis services admissions were decreased overall, but March's numbers were much higher for 2020 than 2019. For crisis services, episodes and admissions (counted above for the demand question) are the same.

Q41

a. Apart from telehealth, during COVID-19, did your county or SUD and problem gambling service providers within your county develop any innovative services or methods of program delivery that may be continued post-COVID? If yes, please describe.

Yes (please describe):

Delivery of outside groups, prescribing and delivering medication assisted treatment in a remote way, Narcan training developed weekly virtual training for any adult community member, which included delivery of Narcan after the training.

Q42

b. During COVID-19, did SUD and problem gambling service providers within your county form any partnerships with other providers that may be continued post-COVID? If yes, please describe.

Yes (please describe):

The hospitals worked together to provide homeless people with MAT and it seems this may continue post-COVID. Overall, the community has seen more cross-system collaboration. There has also been more partnering between provider programs and peer programs.

Q43

1. Has your county conducted analysis on the impact of COVID related to IDD services/OPWDD service system? If yes, please explain.

Yes (please explain):

MCOMH conducted a family/individual served survey that asked questions about care during this time. While the survey was not specifically about COVID, the answers given were colored by the challenges associated with this time. Additionally, we have been meeting with congregate care providers, initially a cross-disability group, but more recently specific to OPWDD providers. MCOMH has learned about challenges specific to OPWDD services related to COVID and has been able to problem-solve with providers at a local level. This partnership is likely to continue after COVID, although contact will likely be less frequent. Per our contact at the DDRO: - Individuals are receiving primary program services in residential settings, via telehealth, altered service duration or had services on pause. Face to face and/or onsite programming is being increased gradually. - Children with school and clinical supports on pause or that cannot benefit from remote learning require additional cross system supports. -I/DD children and adults that require consistent routines and/or who have highly complex needs have had a strain on their available resources (family and residential setting). -Individuals living independently and with families have been impacted by the limited capacity of available cross system resources and necessary precautions for in-home supports. -Residential screening and placements were paused initially and have resumed gradually as OPWDD and all providers continue to maintain necessary COVID precautionary measures. -Day services were initially paused with the onset of the pandemic. Providers were given flexibilities in delivering day services such onsite in residential setting and via telehealth. OPWDD agencies were provided with site based day services re-opening guidance compliant with all necessary COVID-19 precautions (social distancing, PPE, disinfecting/cleaning, signage, etc...). Site based day program re-opening plans are gradually being implemented. - OPWDD respite services were limited with the onset of COVID-19 and the need for necessary precautions. Various types of in-home or onsite respite services is gradually becoming more available. -There has been an increase in requests for Family Support Services (FSS) respite reimbursement to meet the needs of individuals residing with families and to meet the needs of children (re: unable to attend school). -As noted, OPWDD has seen an increase in hospitalizations, psychiatric destabilization; homelessness, mental health problems and in the need for crisis services. Insufficient cross system and community supports has increased the burden on working families, family dynamics and with fully meeting the needs of individuals with highly complex medical, psychiatric and behavioral needs. -OPWDD provided guidance to Care

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Coordination providers to assist with safely delivering services during the pandemic (both face to face and via telehealth) to ensure individual's service needs were met. Also, to ensure emergency needs were identified and addressed. -OPWDD has provided guidance to providers to ensure individuals can be safely transported to critical services and to accommodate the reopening of day services.

Q44

2. What are the greatest challenges your county will be facing over the next 12 months related to IDD services?

- Housing shortages for people with I/DD continue to be unacceptably high, especially for those with challenging behaviors, high medical needs, overlapping mental health diagnoses, transition-age youth, elderly, etc. It continues to be that the only way to get a housing placement is to be in a dire emergency, thus eliminating any ability to plan proactively and plunging families and people with I/DD into turmoil as they navigate this broken system.
- Meaningful activity for those transitioning out of high school are increasingly scarce for those able to work or be in traditional day habilitation, and nearly non-existent for those that have challenging behaviors or high medical needs.
- Workforce shortages for those who are in direct care roles continue to challenge even the most nimble OPWDD provider agencies. The low pay and high amount of responsibility placed on the shoulders of direct care workers is a recipe for high turnover. It was also recently reported by a local agency that there is an increasing pay gap between those direct care workers who work in traditional settings vs. those that work in a self-directed setting, with those in the self-direction program making more. Additionally, staff who provide self-directed services are often those who identify as Caucasian/white. This pay gap, if it is true across agencies, may be creating a situation where the disparities are reinforced.
- True crisis services that understand how to work with people with I/DD are rare in our community. While APIC does come in from Buffalo to provide some services, the program does not have a true community presence in Rochester. NY START has not been helpful in ameliorating acute crises in the past, but some recent changes have helped with some response. A major barrier to people with I/DD not getting care is sometimes the eligibility process. In a number of cases, the person in crisis has not gone through OPWDD eligibility and therefore cannot access START services.

Per our contact at the DDRO:

-It will be necessary to maintain all COVID-19 precautions and flexibility in service delivery for the duration of the pandemic. The impact noted above will continue be prevalent for I/DD individuals and their families. Continued efforts of providing cross system services and supports will be critical to I/DD individuals and their families.

Q45

3. Is there data that would be helpful for OPWDD to provide to better information the local planning process? Please list by order of priority/importance.

- It would be helpful to have person-specific data that we can check against our existing person-specific data in real time in order to proactively track ED usage, jail stays, crisis service usage, and law enforcement involvement by those that are eligible for OPWDD services. We are able to work together with an OPWDD liaison for this info, but it would be helpful to have greater access in order to be able to perform our own analyses.
 - The PSYCKES indicator re: people with I/DD would be helpful to understand more fully since we have access to PSYCKES and can use that data more readily.
 - It would be helpful to see the type of census data provided to us by county, also by provider. When looking at disparities in race/ethnicity for those receiving services, it would be helpful to know which providers are serving the most diverse people, and therefore may have experience to share or need additional attention to ensure they have the resources to serve additional marginalized people.
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Q46

Respondent skipped this question

Please use the optional space below to describe anything else related to the effects of COVID-19 on Mental Hygiene service delivery that you were not able to address in the previous questions:
