2020
Local Services Plan
For Mental Hygiene Services

Columbia County Dept of Human Services
September 5, 2019
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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:

Columbia County has experienced a slight expansion of HCBS assessment and use of HCBS services for the adult population. New York State Medicaid Adult HCBS Access Dashboard data show that 75% of HARP eligible individuals were enrolled in the first quarter of 2019, whereas only 58% of those eligible were enrolled during the first quarter of 2018. Similarly, we saw an increase in those assessed for HCBS services, from 38% in the first quarter of 2018 to 64% in the first quarter of 2019. It is also important to note that the rate of HCBS services being claimed more than doubled between the first quarter of 2018 and the first quarter of 2019 (from 24% to 51%).

Use of peers has increased, but financially sustainable rates are not accessible. The cost of market rate compensation of a 1.0 FTE Certified Peer Advocate (or the like) cannot be supported by the current reimbursement rates in rural regions, due to limited volume, and lack of compensation for travel time and expenses and no-shows for HCBS services.

Participation by Columbia County OMH, OPWDD and OASAS providers in regional collaborative efforts, including Better Health Northeast New York's (BHNNY) PPS, various IPAs, and Capital Behavioral Health Network's (CBHN) BHCC have increased cultural awareness of Value Based Payment models and, more specifically, expansion of integrated care of co-occurring chronic medical conditions. Participation in these collaborative efforts have also served to increase attention to social determinates of health impacts to behavioral health outcomes. Finally, participation in the aforementioned networks has expanded regional service awareness and provider collaboration.

Exploration between the LGU and Questar III/BOCES regarding utilization of "Co-Ser" funding for otherwise unfunded necessary wellness services in school districts has occurred. Questar III/BOCES provided the LGU with a contract template in May of 2019 for approval-as-to-form by the County Attorney so that the mental health clinic can be reimbursed by Questar III/BOCES for services provided to the school districts.

The LGU has taken the lead in developing a Behavioral Health Navigation mobile app. Once completed, the app will help Columbia County residents locate appropriate behavioral health services in Columbia and Greene Counties.

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

While there was an initial flurry of education and activity surrounding the use of SBIRT (Screening, Brief Intervention, and Referral to Treatment), proliferation of the use of the tool has not occurred with the ambulatory medical practices.

Mental health prevention funding is not available but is desperately needed, given the scope of the public health crisis.

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

Geographic, financial and stigma related barriers persist in Columbia County. These limit access for residents to prevention, screening, referral, treatment and recovery. Of the county's estimated 12,000 residents (20% of 60,000) impacted by a diagnosable mental illness, only 2,000 individuals are estimated to be engaged in public or private treatment.

Transportation continues to be one of the largest barriers for residents to receive treatment. Like many rural counties, Columbia County lacks a cohesive public transportation system. In a county that spans 650 square miles, residents living outside of the city of Hudson must either have their own vehicle or rely on expensive and/or difficult-to-book transportation. Taxi and ride-share services are often more than residents can afford for regular visits. Medicaid transport requires days of advance notice and is often overbooked resulting in residents being late to appointments and waiting up to several hours to be picked up, and friends or family may not be available during the most common weekday appointment times. Residents living in the eastern corridor are more negatively affected due to the time required to travel and limited transportation options when compared to the western corridor. Non-medical Medicaid transportation support for socialization, vocation, education, and self help is not accessible, but would promote recovery.

According to the New York State of Health's Coverage 2019 Enrollment Report, NY State of Health enrolled over 4.7 million New Yorkers in comprehensive health coverage in 2019, an increase of more than 335,000 people from 2018 (7%) and an increase across all 62 counties in New York State. Marketplace enrollment is at its highest point ever. In Columbia County alone, the number of individuals signed up for Medicaid increased from 4,410 to 8,674 (97% growth) between 2016 and 2019. Additionally, Children’s Health Plus enrollment increased from 349 in 2016 to 1,468 in 2019 (320% growth), and Essential Plan enrollment increased from 446 in 2016 to 1,611 in 2019 (260% growth). However, Medicare, ACA bronze plans and private insurance premiums continue to rise. In-network coverage is inadequate when such factors are compounded by high co-pays, high deductibles and low provider cost reimbursement rates.

Routine Patient Health Questionnaires (PHQ9) and Screening, Brief Intervention, and Referral to Treatment (SBIRT) screenings (or the like) at the ambulatory, emergency department or inpatient medical services level of care are uncommon. Referrals to behavioral health specialists by primary care physicians (PCPs) are not common unless the patient requests it or explicitly shows signs of behavioral health issues. PCPs are attempting to bridge this gap but in cases of county residents who do not regularly see a PCP, it leads to a lack of services.

Since the implementation of NYS Medicaid Redesign in 2016, fully managed Medicaid, HARP and HCBS service delivery rollout has been slow. In the case of existing programs such as the Health Homes program, financial cuts have created barriers for agencies to receive adequate reimbursements. Changing requirements have caused an unease among providers when enrolling clients for programs that are still developing when so much is changing and unknown. More individuals than ever before have some degree of care coordination services but with new clients being referred, the programs are often reaching staff caseload maximum limit. According to the 2019 New York State Medicaid Adult HCBS Access Dashboard, the number of Columbia County residents enrolled in a Health Home decreased from 31% to 28% between the first quarter of 2018 and the first quarter of 2019.
OMH Supported housing stock increased since the most recent plan completion as 38 new MH set aside bed at MHACG's Greenport Gardens Apartments rented up during the Summer and Fall of 2018. This briefly reduced our Adult housing SPOA wait list and Section 8 wait lists, but since late 2018, the waits lists have increased once again and they are now at an all-time high. The 2018 OMH Residential Program Indicators Report shows that, throughout 2018, occupancy exceeded 80% for all housing programs in Columbia County. Additionally, the percent of individuals whose length of stay was greater than two years was 72.5% for Supported Housing Community Services and almost 33% for Apartment/Treatment programs. The Hudson housing market continues to increase in price and the available market rate rental stock has decreased due to an increase in second homes and Air B and B housing in the city.

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:

While the overall unmet Substance Use Disorder need has worsened in the past year, there are several notable projects and efforts that have improved our prevention, treatment and recovery services. First, the proliferation of use of the HIDTA ODMAP software by Columbia County first responders has generated partial real-time data related to overdoses. This has given the LGU the ability to more effectively track local opioid overdoses and has led to the formation of an Opioid Spike Alert Response Task Force, tasked with creating a formal notification system that will be activated when numerous overdoses occur in Columbia and/or contiguous Counties. Implementation of the ODMAP system has also shown a reduction in non-fatal opioid overdoses in 2019 and zero fatal overdoses. Though this data is limited, as use of ODMAP is not mandatory or uniform throughout the County, the outcome is encouraging.

Funds received through OASAS to our OASAS-licensed treatment provider (Twin County Recovery Services, Inc.) via State Targeted Response and more recently State Opioid Response have assisted us in expanding our hours of service and geographic reach. In April 2018, Greener Pathways, a community-based outreach program committed to building connections and pathways to strategies and solutions for opioid use disorder (OUD) and substance use disorder (SUD) crisis in Columbia and Greene Counties, was established. The program, which provides transportation, warm hand-offs, CRPA counseling, and other services has been funded for another year.

Columbia County Department of Health and Greener Pathways have been actively engaged with CMH ED staff to increase the use of peers (on-call CRPAs) when they encounter an individual with SUD who is willing to meet with a peer. According to K. Frederick, approximately 40 people have been served through the end of March 2019 and the use of peers is now expanding to Inpatient Services.

Columbia and Greene Counties were 2 of 16 Counties awarded National Institute of Drug Abuse (NIDA) funding for research and initiatives related to eradicating the opioid epidemic. Funding amount and parameters are not yet known. Finally, Twin County Recovery Services, Inc., the only OASAS-licensed treatment provider in the County, recently received funding from OASAS to provide treatment and support to inmates post-release who have been impacted by Substance Use Disorder. This program is anticipated to begin in June of 2019.

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

The level of funding support from OASAS for prevention services has remained unchanged, despite requests for expansion based upon school district identification of un-met need. Additionally, the lack of financial support from the school districts for prevention has remained unchanged (excluding small in-kind donations) due to reported budgetary constraints.

Our inventory of MAT providers and available slots has remained low, inadequate and unchanged. As of May 2019, there are 6 prescribers in Columbia County who provide these services. 5 of the 6 provide suboxone, 5 provide vivitrol, and only 2 provide methadone.

Data indicates that opioid use, mortality, Emergency Department use, and hospitalization remains high in Columbia County. "NYS COUNTY RANKINGS REPORT" puts Columbia County in the lowest quartile for both opioid overdose hospitalization rate and opioid overdose mortality rate (21.3%).

Reimbursement rates for SUD providers remain insufficient to financially sustain our clinics, caps on administrative costs continue to have a deliterious effect on the oversight quality and continuity and COLAs are too small and cannot be applied across the workforce continuum. Jail services for SUD impacted inmates have remained stable, but so has our inaccessibility to medical and MAT prescribing, in large part, due to the prohibitive cost (due to Medicaid suspension)

Please describe any unmet SUD service needs that have worsened:

Columbia County has a history of complex socio-economic issues, partially centering around the rural nature of the community. According to New York State Community Action Association, using data provided by the local agency Columbia Opportunities, Inc., the poverty rate in Columbia County continues to hover around 11%. This rate is compounded by a lack of viable public transportation, lack of healthcare providers, limited health literacy and barriers to access of quality healthcare. Community Health Assessments, as well as the local hospital's Community Service Plan, have recently identified several critical health issues, the most urgent being mental health and substance use. Anecdotal and prevalence data demonstrate a compelling need for substance use prevention, treatment, and recovery efforts in Columbia County.

2017 OASAS admissions data demonstrates that the need for SUD services has worsened over time, despite the targeted efforts of local providers. The 2017 data reveals that Columbia County has seen an increase in admissions for marijuana (from 11.2% in 2016 to 13.7% in 2017) and crack cocaine (from 3.8% in 2015 to 9% in 2017). Admissions for alcohol have remained steady, with a slight decrease from 30.8% in 2015 to 29.1% in 2017, while the percentage of admissions for Heroin has decreased slightly from 2015 to 2017 (from 43.9% to 38.2%). However, this decrease in admission rates could be explained by the substantial increase in Emergency Department visits for Heroin overdoses. The February 2019 Department of Health County Opioid Quarterly Report indicates that the number of visits to the ED for Heroin Overdoses in the first nine months of 2018 (January - September) was 43, while there were only 27 ED visits for Heroin Overdoses in all of 2017. The same report also shows that the crude rate of opioid overdoses (excluding heroin) visiting the ED in the first nine months of 2018 was 7.63, compared to the crude rate for all of New York state, excluding NYC, which was 3.6, a difference of 57%. Finally, 2016 New York State Opioid Dashboard Data show that the crude rate per 100,000 population for overdose deaths involving any opioid was 21.3 for Columbia County, compared to the Capital Region crude rate of 11.3.

Columbia County is a rural county and as such, our population of roughly 60,000 has a smaller absolute number when compared to more urban
neighbors. This creates a challenge in getting reliable data using crude rates, and puts the county at a disadvantage for funding opportunities which are often associated with an absolute number impact.

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

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

OPWDD sharing of limited local data has been helpful for meaningful local planning to occur. Data related to requests for (AROC) Tier 1, Tier II and Tier III service requests has still not been provided to LGUs by OPWDD. Data related to volume, type disposition and disposition turnaround time has also not been provided to LGUs as requested.

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

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

In Columbia County, the absence of a "sheltered workshop" is still affecting many of the consumers who have been served by agencies such as COARC for years. Plans to turn these workshop spaces into places of integrated and competitive employment for consumers are slow due to OPWDD requirements about space sharing and program overlap. With these changes, consumers have had to endure increased social isolation and self esteem loss instead of the community integration which was intended. Family members supporting loved ones in the community have also experienced similar distress due to the closing of these workshops.

Competitive employment is an unrealistic goal for some individuals living with one or more developmental disabilities. According to the agency Northeast Career Planning, Columbia County has been dealing with a lack of steady employment aside from retail and manual labor for years. As a result, consumers with disabilities can find themselves competing with individuals without disabilities for the same position. Employer and employee misconceptions create barriers for individuals who are potentially capable of competitive employment.

Lack of transportation affects those with developmental disabilities by creating isolation while increasing the dependence on family members and paid providers. Permanent supported subsidized housing model eligibility requirements are excessively rigid and underfunded, limiting achievement of residential independence. The level of independence required to locate, obtain, and retain an independent level of housing is either beyond the capabilities of certain consumers, unachievable due to a lack of affordable housing or both.

It is suspected that the 2014 OPWDD decentralization of the local I/DD SPOA process and the implementation of the "Front Door" eligibility and service assignment process has delayed service access. This process change has eliminated the Local Governmental Unit’s capacity to determine local un-met need for future planning.

The July 1, 2018 conversion from FFS Medicaid Service Coordination model to the managed-care pre-curser CCO Care Coordination Model was ambitious and has been challenging for recipients, families and providers. Significant confusion, service delays and lack of provider continuity due to turnover and workforce hiring challenges and software difficulties have contributed to the tumultuous transition.

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

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<td>m) Coordination/Integration with Other Systems for SUD clients</td>
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<td>n) Mental Health Clinic</td>
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2a. Housing - Background Information

In Columbia County, supported housing units (rental subsidy with case management supports) are continuously needed for SMI, SUD and I/DD adult populations. Waitlists continue to be long due to high occupancy rates. According to the 2018 year end OMH Residential Program Indicator Report, the Columbia County occupancy rates for treatment apartments was over 82%, congregate facilities over 93% and supported housing (excluding PC long-stay beds, and a new program beginning during the 2017 year) 87%.

The 05/01/19 Adult Housing SPOA wait list is listed below. Waitlisted individuals may be repeated on several lists. To resolve this duplicate count, you will find unique individuals not repeated under other categories listed in parentheses.

- Congregate/Treatment:
  - Capacity: 14
  - Waitlist: 14 (2 unique applicants)
- Treatment Apartments:
  - Capacity: 42
  - Waitlist: 29 (4 unique applicants)
- Supported Housing Community Services:
  - Capacity: 47
  - Waitlist: 35 (31 unique applicants)
- Supported/Single Room Occupancy (SRO):
  - Capacity: 25
  - Waitlist: 3 (2 unique applicants)
- Total unique waitlisted applicants: 39

Of those listed above, 10 individuals are currently homeless.

The Greenport Garden Apartments opened in June 2018 as a 65-unit mixed housing development. 38 units are reserved for individuals with Serious Mental Illness (SMI), and 27 units are for those meeting income eligibility requirements.

Individuals experiencing homelessness is on the rise in Columbia County, as documented by the Columbia Greene Housing Coalition's annual US HUD "Point In Time" survey. Between 2016 and 2019, the County has experienced a 98% growth in the homelessness population (from 52 in 2016 to 103 in 2019).

These increases are troubling as housing stability is essential for successful treatment with individuals suffering from SMI or SUD.

Even when plans have been approved by the CSB and New York State to expand housing facilities, barriers prevent this from taking place. Twin County Recovery Services, Inc. had approval from OASAS 5 years ago to relocate and expand residential services for men under their Part 819 Community Residential program, "The Red Door Community Residence." As of May 2019, this program has 2 people on the waitlist and has maintained a waitlist since opening. Due to the state’s program requirements, potential promising properties that the agency had identified are not being inspected and approved by OASAS in a timely manner, resulting in the properties being purchased by other parties. The agency St. Catherine's Center for Children does supply Columbia and Greene County a shared 7 units to be used for OASAS SUD HUD homeless housing. These have remained consistently full. The combined factors have resulted in a lack of SUD housing stock within the county.

Lastly, in regards to the I/DD population, anecdotal reports state that beds continue to be insufficient for individuals requiring 24 hour supports. Even when individuals do not require that level of supervision, availability of affordable and safe rental properties is limited in the area. The stock of affordable non-supported rental subsidy opportunities is also very limited, and presents a substantial barrier in finding housing.

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

Increase the availability of housing, including emergency, transitional, and permanent for individuals experiencing mental health illness, substance use disorder, and/or intellectual/developmental disabilities.
Objective Statement

Objective 1: Create a comprehensive directory of local development corporations

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

Objective 2: Conduct direct outreach to all local developmental corporations

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

Objective 3: Collaborate with new and existing partners to develop and increase affordable housing by holding at least 2 partner meetings

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

Objective 4: Advocate for additional support and supplemental funding for OPWDD-licensed supportive and supported housing and OMH-certified supported housing beds

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

Objective 5: Obtain local unmet need data from OPWDD

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

Change Over Past 12 Months (Optional)

Galvan Civic Motel is expected to open in the Summer of 2019. 25 homeless individuals will be served at this congregate site with on-site services and security.

2b. Transportation - Background Information

In rural communities with a low volume of ridership such as Columbia County, scheduled public transportation can be difficult to finance. Even on-demand models can be cost prohibitive due to townships being separated by large distances with fewer riders than urban communities. This is true in Columbia County, where approximately 60,000 residents live in an area more than twice the size of New York City.

Public transportation is still very important to the community, especially for those impacted by mental hygiene diseases with limited financial means. According to the Mobility Management Study for New York State, published February 2017, the following is true:

“No consistency or clarity in transportation coordination or funding mechanisms exist. Agencies may contract with transportation providers, own and operate their vehicles directly or simply funnel transportation dollars directly to the county to administer the service.”

In rural areas like Columbia County, the transportation options are restricted. Public transportation is limited, resulting in individuals with disabilities relying on private vehicles, taxi services, or friends and family for transportation. This can severely limit access to necessary medical needs and non-medical recovery support needs such as access to employment, education, self help and socialization/ community connection.

Multiple agencies, providers, individuals with disabilities, families and advocates across New York State, validate the importance and apparent lack of transportation options for individuals with disabilities. Transportation is frequently cited as a barrier to accessing all activities of daily life for individuals with disabilities. All facets of daily living that include travel (including medical appointments, day services, and work and/or school) are negatively impacted by the lack of transportation, in many cases preventing residents from being active members of their community.

While the study’s focus was on individuals with disabilities (physical, developmental or both), the concerns hold true for all of the county’s residents. Without access to reliable, wide spread transportation, residents living outside of the main city center can find it difficult to complete daily tasks, including those that can greatly improve their conditions.

Additionally, other rural counties have found that public transportation systems can be used with positive results. Greene County is approximately the same size in area as Columbia County but has around 15,000 fewer residents. However since its implementation of its public transportation in 2015, funded by Medicaid Redesign Team’s Balancing Incentive Program, Greene County Transit has reported success and sufficient sustainable ridership. From June to December 2016, they had 6,500 riders. Following in 2017, they had 11,400. Their program is funded 85% by Medicaid transportation funding, Federal Transit Administration (FTA), NYS Department of Transportation (NYSDOT), and local tax payer dollars. 15% is through revenue and advertising. If these funding sources and models were able to be replicated in Columbia County, a similar success could be had.

Some expansion of Hudson/ Greenport area and Hudson River crossing public transportation routes and stops has been experienced and been a helpful first step.

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):

Transportation is an ongoing concern for Columbia County. Due to the rural location, any public transportation remains almost exclusively within the city of Hudson and town of Greenport. These buses are not heavily advertised, and run on very limited schedules. The Community Services Board has included expanding public transportation as a priority for several years. Budgetary restraints, difficulty reaching rural areas and concerns of low volume of riders have stymied progress and, since no significant relief from these barriers is apparent, it was not included in our priority goals.

Transportation has been included within the 2020 plan as an objective. It is listed under, "Foster the independence of individuals with mental illness, substance use disorder, and/or intellectual/ developmental disabilities." Specifically, the Board chose the following objective: coordinate a presentation by Ulster-Greene ARC to the County's transportation committee, describing the BIP-funded Greene County transportation project. By including this as an objective, the Board feels that they can focus their efforts more on publicizing the existing limited bus routes, which can increase ridership, and show the county the need for a more expansive transportation system.

One CSB member and current MH Subcommittee Chair and another CSB subcommittee participant have been selected for inclusion in the Board of Supervisors’ Transportation Committee. This inclusion provides some measure of hope that the urgency of this matter for our
constituents will be included in considerations for expansion of transporation options.

Change Over Past 12 Months (Optional)

2c. Crisis Services - Background Information

Crisis services in Columbia County have been a focus of planning for years. It has been well documented that residents use in-patient hospital services and/or behavioral health services (MH and/or SUD) above the state average. Anecdotal reports shared by stakeholders within Columbia Memorial Health also reveal that children under the age of 12 seeking immediate mental health assistance are regularly required to wait between 3 and 5 days for an open bed within the hospital. During this time, the children are kept within the emergency room which may not be as well equipped to deal with long-term mental health issues as pediatric wards in other areas of the facility.

Efforts to combat climbing inpatient and ER stays have been made by the CSB, including the expansion of the Mobile Crisis Assessment Team (MCAT). Originally offering services for only 8 hours per day, additional funding from DSRIP (via the Better Healthcare Northeast New York Performance Provider System) has allowed the service to expand to 14 hours per day. Since becoming operational in July 2015, MCAT has received more than 51,000 calls; has been dispatched more than 2,900 times to homes, schools, and hospitals; and has offered a total of 8,800 client contacts. Since January of this year alone, MCAT has fielded more than 6,500 calls and served more than 950 clients. However there is still a lack of 24/7 coverage, as from 10 PM to 8 AM, the 1300 square mile region they service has no crisis team. This may be a factor in the above average BH hospital visit rate.

In 2017 Columbia County LGU paired with Greene County LGU to create the Behavioral Health Mobile Crisis System and Implementation Plan at the request of OMH HRFO. Concerns listed within the document include:

- OMH Article 28/31 RIV funds 1 hospital diversion bed for SMI diagnosed adults, for a period of only 9 months a year
- Only one BH crisis option offers face-to-face on-site intervention, and does not operate 24 hours a day
- Peer volunteer providers have began emerging, but currently operate only with volunteers and no funding
- No single point of contact exists to connect with all available services, resulting in community confusion regarding which agencies provide which services, to whom, and how to contact them

OMH HRFO feedback concerning our proposal was that it was cost prohibitive. In addition our current MCAT provider did not feel confident that competent third shift staff could be attracted and retained given the workforce shortage even with expanded financial support.

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):

Change Over Past 12 Months (Optional)

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

According to Northeast Career Planning, Inc. (an agency that focuses on helping individuals find employment), the number of employment opportunities in the county is insufficient, especially in concern to those with SUD, MH or IDD related issues. Local agencies, including the Mental Health Association's "Employment Works!" program and several employment programs at Coarc are working to bridge this gap and cater to employees of different needs. However, even with these programs in place, employers are often slow to accept individuals with disabilities and disorders.

During 2018, Northeast Career Planning served 45 clients within Columbia County. 30 of the clients (67%) worked for part or all of the year. It is important to note that Northeast Career Planning has greatly reduced their contract with ACCES:VR as it was not cost effective given the expense of sending Supported Employment Counselors from the Capital District to serve clients in Columbia County. This limited their ability to serve Columbia County residents. That, coupled with staff turnover, led to only 7 new jobs being obtained in 2018. They also faced reoccurring barriers, listed below.

- Criminal backgrounds prevent those being released from jail or prison to find steady jobs
- Transportation is a huge barrier, as mentioned above. A majority of the jobs are located within the city of Hudson, but with many residents living in rural locations if they do not have reliable transportation such as a car or a ride, they will have difficulties getting to interviews and work.
- Columbia County has very limited types of work. Clients regularly only have the options of retail, fast food or manual labor. Office positions are in high demand within the area, resulting in clients being overlooked.
- Many of the jobs available to clients are part-time without benefits.
- Relapse, psychiatric decompensation, and recidivism causes clients to lose employment.
- Lack of education about benefits results in clients believing if they obtain employment, all public assistance will be cut. This results in clients who are fearful of taking job opportunities, especially if they are working over a certain threshold of hours or wages.

To combat employment barriers, greater support from employment coaches that is not time limited could take away some concern from employers who may believe the employee will require too much attention and/or training.

Due to the lack of full-time or limited types of work, employees often look out of county for sustainable work when possible, an action that can cause services such as employment coaching to be inaccessible.

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):

To better address the differing populations, this was included within the goal, "Foster the independence of individuals with mental illness, substance use disorder, and/or intellectual/ developmental disabilities." The Community Services Board believes that employment concerns are part of a person's overall goal to achieve independence, and do not want to separate it from that goal. They also did not want to specifically focus employment just on the OPWDD population, as it is a requirement to live independently for all populations. Instead, the Board decided to address employment in the following objectives for the OMH, OASAS, and OPWDD populations:

Provide support, and continue to monitor activities, for individuals to prepare them to live in a self-sufficient way, for example:
• How to access and navigate transportation
• Employment training and support
• Financial literacy
• How to access and secure housing
• Health and wellness literacy

This allows the CSB to address external barriers that were listed above in the background information. In addition, two other objectives that will indirectly affect employment are included under this same goal:

• Co-sponsor an Employer Recognition event to highlight successful partnerships and educate other local businesses about hiring individuals with disabilities;
• Encourage the use of peer-led supports to increase connections to community resources.

Change Over Past 12 Months (Optional)

Throughout 2018-2019, the I/DD subcommittee attempted to partner with the Columbia County Chamber of Commerce to host a recognition ceremony for outstanding community employer partners. While the Chamber has been unable to participate, the Mental Health Association's "Employment Works!" program currently hosts an annual Employer Recognition event and they are interested in collaborating on a future event. The goal of this event is to not only honor the partners, but get the word out to prospective employers regarding the benefits of employing individuals with different abilities.

2f. Prevention - Background Information

New York State-funded aid and insurance reimbursable financially supported mental health prevention and education services are not available. This gap creates a population which is not health literate regarding mental hygiene diseases, symptom recognition, models of self care, the effectiveness of treatment and the hope of recovery. Extremely limited funding for suicide prevention has historically provided minimal lasting impact.

In regards to substance abuse, additional prevention funds are desperately needed to try and battle the severe opioid crisis within the county. However, Columbia County agencies that address substance abuse, such as Catholic Charities of Columbia and Greene Counties, have been unable to obtain additional state funding requested for additional prevention staff. This results in staff who cannot keep up with the needs of the community. Catholic Charities of Columbia and Greene Counties reports that multiple requests from school districts for expanded prevention services have had to remain unfulfilled. However without state or school district aid to supply Catholic Charities of Columbia and Greene Counties with funding for community and school based education and prevention, the unmet need will remain.

In regards to mental health, it has been noted by the National Alliance for Mental Illness (NAMI) in their 2018 Legislative Action Agenda: Mental Health in Schools that early signs of serious and persistent mental illnesses (such as schizophrenia and bi-polar disorders) start to become identifiable in late adolescents. Additionally, NAMI states in the same report that clinical depression can become prevalent at the onset of puberty. But without the appropriate funds to supply schools with the prevention needed, it’s difficult to notice these signs.

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):

Prevention is a concern within Columbia County. During the period of 1988 to 2011, Columbia County had a second SUD prevention project called the “School and Community Services Project.” This was well regarded by multiple stakeholders, but NYS OASAS eliminated 100% of the funding in 2011.

Change Over Past 12 Months (Optional)

The following progress has been made in the past year:

• A collaborative prevention service mapping project underway involving all six Columbia County school districts and Questar III/BOCES.
• Mentor Foundation, which had a presence in 4 school districts (Hudson, Ichabod Crane, Germantown and Taconic Hills) was eliminated in the 2018-19 school year. There is a plan in place to partially replace it with a program operated by the Columbia County Department of Health, but that is still in development
• Catholic Charities resubmitted a funding expansion request to OASAS in January of 2018
• The LGU continues to pursue the possible contracting with BOCES for use of Co-Ser funding

2h. Recovery and Support Services - Background Information

Recovery and support services are a critical component of an individual managing and recovering from either mental health or substance abuse disorders and Columbia County is fortunate to house several recovery and support services. In 2017, the Mental Health Association of Columbia-Greene Counties, Inc. opened two Youth Clubhouses—one in Columbia County (Hudson) and one in Greene (Catskill). The Clubhouses provide safe, supportive, substance-free environments for youth ages 12-21 who are in recovery or are at risk of developing a substance use disorder. The Mental Health Association of Columbia-Greene Counties also operates the Apogee Center in Hudson and Water Street Studio in Catskill, peer run recovery centers in Columbia and Greene Counties. In addition, Columbia County Pathways to Recovery (CCPR) continues to grow since its inception in 2016. The Recovery Community Organization, which is made up of individuals in recovery, and friends, family members, professionals and other community members with lived SUD experience, provides comprehensive resources for individuals and families impacted by SUD. They also operate a helpline from 9am-9pm, 7 days a week, that is staffed by trained volunteers. Additional recovery groups that hold regular meetings in Columbia County include the National Alliance on Mental Illness (NAMI), Nar-Anon, Narcotics Anonymous, Alcoholics Anonymous, and Young People in Recovery.

Finally, extensive and expanding mental hygiene services are offered in the Columbia County jails and have been for many years. There has not been a way to track recidivism but beginning in 2019, this data will be expected of provider vendors in Columbia County.

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):
Recovery and support services are a focus within Columbia County. But as with many other focal points in the 2020 LGU plan, Columbia County views this as just one part of an overarching goal. We included recovery under the goal, "Enhance the continuum of care for individuals experiencing mental illness, substance use disorder, and/or intellectual/developmental disabilities." Care for individuals doesn't begin with recovery, so by including several different objectives under continuum of care, it allows for the county to create goals that touch on several steps of care instead of just one particular instance.

The objective relating to recovery and support is, "Increase the availability of recovery support including but not limited to recovery focused housing, pro-social activities and events, and recovery oriented organizations."

**Change Over Past 12 Months (Optional)**

As of spring of 2019, Columbia County began offering all inmates Narcan upon release.

OASAS awarded Twin County Recovery Services a grant for the State Targeted Response program. This grant has been combined with Greene County’s identical grant to create Greener Pathways, a mobile service to bring support, assistance and medications to those in remote areas.

Twin County Recovery Services is the only licensed provider of SUD outpatient treatment services in the region of Columbia and Greene counties. With a clinic located in both Hudson and Catskill, it serves two counties adequately with services including assessments, treatments, counseling, psycho-educational services and a 24-hour crisis hotline. These outpatient services assist residents in remaining local, with their families and support systems, and allow those close to SUD outpatients to learn more about the disease with a local way to receive further assistance.

**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):

Reducing stigma against those with SUD and SMI can be achieved with different methods. Because of this, we haven't included it as a goal or even as an objective under a specific goal. Instead the board's focus over the following year will be reducing stigma through actions already outlined within the plan. Some of these methods include:

- Increase access to medication assisted treatment so that those suffering from SUD will not need to be uprooted from their lives to get help
- Continue to add emergency beds to try and break the cycle of homelessness and possible SUD or SMI
- Provide education to individuals to prepare them to live in a self-sufficient way, allowing for individuals to better blend with the community
- Encourage peer-led supports to prevent relapses or crises

With every objective that Columbia County completes, it is the county's hope that it will assist the affected individuals in reintegrating with their community. When reintegration is coupled with providing the community education about why many stigmas are incorrect, it will hopefully allow for the community to learn more about SUD and SMI and what they can do to assist those around them who may be suffering.

**Change Over Past 12 Months (Optional)**

Over the past 12 months, several community forums were held. Each took place in a different town including Hudson, Kinderhook, Copake and Germantown.

**2j. SUD Outpatient Services - Background Information**

Twin County Recovery Services is the only licensed provider of SUD outpatient treatment services in the region of Columbia and Greene counties. With a clinic located in both Hudson and Catskill, it serves two counties adequately with services including assessments, treatments, counseling, psycho-educational services and a 24-hour crisis hotline. These outpatient services assist residents in remaining local, with their families and support systems, and allow those close to SUD outpatients to learn more about the disease with a local way to receive further assistance.

**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):

SUD services have been included in several parts of the plan, not specifically under one category. In regards to outpatient services, the main objectives are listed under the second goal, “Enhance the continuum of care for individuals experiencing mental illness, substance use disorder, and/or intellectual/developmental disabilities.”

The first objective is to increase local access to Medication Assisted Treatment (MAT), specifically Suboxone and Vivitrol. This form of treatment combines behavioral therapy and medications to treat substance use disorders. In Columbia County, there are only 6 prescribers who provide these services. 5 of the 6 provide suboxone, 5 provide vivitrol, and only 2 provide methadone. It is difficult to determine whether or not this capacity is sufficient for our county’s needs. However, anecdotal reports relay that we would benefit from increased local capacity for all three medication options. **According to the 2016 OASAS Medicaid Trend Detailed Recipient Summary Profile, in 2016 4,782 claims were submitted by Columbia County residents for methadone treatment by out-of-county providers. These residents are required to travel to a county**
that has methadone prescribers. If Columbia County was equipped to dispense methadone and had additional MAT treatment providers, it would allow more residents to access services.

Change Over Past 12 Months (Optional)

Albany County Department of Mental Health was awarded the Capital Regions' Open Access Engagement Program (CR-OAEP) award in 2018. It was anticipated to function as a "hub and spoke" model, with Columbia County serving as one of the "spokes." This will potentially allow Columbia County individuals ready to move towards recovery to receive 24/7 support by staff located in Albany. However, as suspected, the distance between the "hub" and Columbia County has prevented Columbia County residents from benefiting significantly. In the first quarter of 2019, CR-OAEP served 104 individuals, but only 6 from Columbia County.

During the Winter of 2018, OASAS informed the LGU that Berkshire Farm Center and Services for Children's was interested in having TCRS provide their on-campus OASAS licensed Substance Abuse Clinic for their OCFS Recovery Cottage program. Shortly after that was agreed upon, the LGU and TCRS were informed that no on-campus OASAS licensed Substance Abuse Clinic services would be offered, but an unknown model of OCFS substance abuse services would replace the OASAS model. OASAS was unable to provide the LGU a rationale for this change.

2k. SUD Residential Treatment Services - Background Information

As previously highlighted within 2A: Housing, the waitlist for residential programs for any population is long. In Columbia County, the only residential treatment service that focuses specifically on the SUD population is Twin County Recovery Service's men's residence. This facility currently houses 13 men going through treatment. A wait list for a bed at this facility has existed since it opened and is currently at 2 persons. Twin County Recovery Services has had approval to expand and relocate the men's residence (the "Red Door") for several years but has faced challenges doing so. In addition to NIMBY barriers, properties that had been identified by TCRS as available for purchase and potentially appropriate were unable to be secured by deposit, due to the delays of DASNY in conducting a feasibility study.

Do you have a Goal related to addressing this need?  

If "No", Please discuss any challenges that have precluded the development of a goal (e.g. external barriers):

Creating higher capacity and more encompassing SUD residential treatment service centers has been a goal of the county for several years. It is included within the plan, this time under the goal "Enhance the continuum of care for individuals experiencing mental illness, substance use disorder, and/or intellectual/developmental disabilities."

This year, the County will continue to assist (within the role of the LGU) Twin County Recovery Services in relocating and expanding the men’s residence in Columbia County from 13 to 18 beds. The plan also lists relocating and expanding the Greene County women’s residence from 12 to 18 beds. Both residences are frequently used by both Greene and Columbia County clients in recovery. The Columbia County LGU felt it was important to assist Twin County Recovery Services if needed for both of these services.

Change Over Past 12 Months (Optional)

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

Over the past several years, the heroin and opioid epidemic has been steadily getting worse. In Columbia County, it has been difficult to obtain funding to assist with the crisis outside of STR awards. According to the Healthcare Consortium presentation at the 2018 NYS Senate Heroin Task Force forum, many opportunities are awarded per Economic Development Zone (i.e. Open Access, and Medically Supervised Withdrawal Awards). This results in a large multi-county area receiving one grant for a mix of urban and rural counties. These awards often tend to favor larger, urban-situated and urban-centric organizations: recent OASAS funding opportunities have been prescriptive, requiring a level of service delivery that is both unwarranted and impossible to sustain in rural areas.

However the need for further funding is present. The New York State Department of Health's County Opioid Quarterly Report shows that, while administration of Nalaxone decreased in New York State from 2017-2018, administration by EMS personnel and by law enforcement increased in Columbia County for the same time period.

The New York State Department of Health's County Opioid Quarterly Report includes data up to September 2018. It shows that Columbia County regularly exceeds the averages for outpatient emergency department visits. The crude rate for outpatient emergency department visit for all opioid overdoses was 22.8 from July - September 2017, compared to 17 in the rest of NYS (excluding NYC). For the same months of 2018 (July - September), the crude rate was 34.4 for Columbia County, compared to 13.7 in the rest of NYS (51% increase). This same report shows that the rate of deaths involving opioid pain relievers decreased in NYS in the first nine months of 2018, but it doubled in Columbia County during the same time period. Additionally, SPARCS, BRFSS and County Rankings data reveal Columbia County to be in the worst quartile for opioid overdose hospitalization rate and opioid overdose mortality rate, with both numbers increasing significantly since 2010.

However gauging the crisis level for opioid overdoses has become increasingly more difficult as the numbers continue to rise. In an area with such a small population, crude rates can be skewed and not a true representation of the crisis. However, data with verified averages are released on average 3 to 4 years after the collection period. This results in county decisions being conducted off of crude rates or anecdotal data. There is a need not only for increased funding for the opioid crisis, but for data collection methods that can provide more up to date data for counties.

Do you have a Goal related to addressing this need?  

If "No", Please discuss any challenges that have precluded the development of a goal (e.g. external barriers):

Though Heroin and Opioid Programs and Services are not specifically listed as a goal in the 2020 plan, the Community Services Board recognizes the scope of the crisis in Columbia County and will continue to address it through the goal of "Enhance the continuum of care for individuals experiencing mental illness, substance use disorder, and/or intellectual/developmental disabilities." One of the objectives that's been identified under this goal is to continue to increase access to medication assisted treatment, specifically Suboxone and Vivitrol. The Board has
also identified another objective that will indirectly have a positive effect on the heroin/opioid crisis in Columbia County: increase the availability of recovery support including but not limited to recovery focused housing, pro-social activities and events, and recovery-oriented organizations.

It should also be noted that the LGU is involved in several collaborative efforts in the County to combat the heroin/opioid problem. The LGU is an active founding member of the Columbia-Greene Addiction Coalition (CGAC) and is also part of the Prevention Subcommittee and the Media Workgroup associated with CGAC. The Columbia and Greene County LGUs, along with Twin County Recovery Services, also share supervision responsibilities of the newly-created Addiction Recovery Coordinator, who has been instrumental in coordinating the efforts of both Counties to combat the Heroin/Opioid problem in the twin counties. Finally, the LGU has played a primary role in the expanded use of ODMAP throughout the County.

Change Over Past 12 Months (Optional)

Over the past 12 months, the following progress has been made:

- Several community education forums were held, including hosting the New York State Senate Heroin Task Force at the local community college in February of 2018.
- A MAT service pilot project began to be considered by the Columbia County Mental Health Center.
- A medication drop box was installed at the Valatie Hannaford in the summer of 2018.
- 2 syringe drop boxes have been installed at the Hannafords in Livingston and Valatie.
- The Columbia County Board of Supervisors approved a resolution to join a class action lawsuit against Pharma, attempting to hold them responsible for dissemination of inaccurate information about the addictive nature of Oxycotin.
- A dedicated website is under development (and social media presence). Completion is anticipated during the Summer of 2019.
- A full time Addiction Recovery Coordinator was hired in October of 2018 serving both Columbia and Greene Counties.
- First responder use of the HIDTA ODMAP software has dramatically increased, permitting more timely data regarding fatal and non-fatal overdoses.

New:

- Twin County Recovery Services received funding from OASAS to provide SUD support to inmates post-release from the Columbia County jail. The Program is expected to begin in the Summer of 2019.
- Greener Pathways was established in 2018 to provide SUD support via peer services to Columbia County residents. Funding for Greener Pathways will continue under the SOR program.
- Twin County Recovery Services, Columbia Memorial Health, and the Greene County Rural Health Network are working with Ellenville Regional Hospital to support use of its SUD services. This initiative may continue if funding for an implementation grant is secured.
- Columbia and Greene Counties were 2 of 16 counties to be awarded National Institute of Drug Abuse funding for research and initiatives related to eradicating the opioid epidemic.
- The number of first responders entering data into the federal HIDTA ODMAP data base continues to increase. Hudson Police Department is now participating, in addition to the NYS Troopers and Sheriff's Department, and County EMS.

2a. Other Mental Health Outpatient Services (non-clinic) - Background Information

The Columbia County Department of Human Services received a waiver to provide Peer Support and Community Psychiatric Support and Treatment services. Staff have been trained and a billing mechanism is in place. Unfortunately, the clinic has not received any referrals for these services.

According to the 01/29/19 report from OMH, out of 451 HARP-eligible Columbia County residents, 64 of these individuals have been assessed for HCBS services and 62 of the 64 found eligible for HCBS services. The challenges in completing HARP assessments for individuals who are HARP eligible are not unique to Columbia County, but are creating an access obstacle for our 387 residents who are likely eligible and would benefit from these new services.

In Columbia County, the county along with several agencies are developing our adult HCBS waiver and 1115 waiver crisis integration benefit capacity. These agencies include the Columbia County Healthcare Consortium, Inc, the Columbia County Department of Human Services, the Mental Health Association of Columbia-Greene Counties, Northeast Parent and Child Society, and Parsons Child and Family Center.

In January 2019 current Medicaid waiver HCBS services began begin replaced by “Children and Family Treatment and Support Services” (CFTSS) services. The first three new services (replacing Medicaid Waiver and State Aid funded services) offered by numerous providers locally are now being introduced: “Community Psychiatric Treatment and Supports”, “Psychosocial Rehabilitation”, and “Other Licensed Practitioner”.

The county DCS and C-SPOA Coordinator have both been actively involved with a NYS CLMHD led initiative to standardized the C-SPOA across the state, including utilizing a single standardized form. Columbia is expecting to post this standardized application form and process on our county website by the Fall of 2019. Our C-SPOA and our MH Subcommittee of our CSB have also actively included CFTSS and Non-legacy Care Coordiantion partners in network wide education, planning and coordination of children's services.

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):

There is no goal or objective included in the plan to highlight these waiver changes. However, the mental health clinic continues to focus on this as we understand the importance of, and need for, these waivers.

Change Over Past 12 Months (Optional)

A new satellite clinic was established at Columbia-Greene Community College and one additional school district has expressed interest in having a satellite clinic at their district. With the addition of this school district, the Columbia County Mental Health Center will have satellite sites in all six Columbia County School Districts.

Aggressive initiation of Continuous Quality Improvement and Value Based Payment projects continue to be underway.

2s. Developmental Disability Student/Transition Services - Background Information
In Columbia County, the predominant agency helping those with developmental disabilities is the local ARC: COARC. Their services cover a large breadth of consumers, from children as young as 3 up to seniors. For students, the School to Work program provides students an internship at a local business that teaches employment skills and can build relationships, creating jobs after graduation.

OPWDD's children services' information states that, "Transition planning for students should begin at 15." With the School to Work program, students as young as 14 can join and are supported until they turn 22. This program provides more than the bare minimum listed in OPWDD's "Transition Planning: from school to adult life" which mainly recommends having a circle of support who can help a student plan their life goals and search for employment.

Using OPWDD County Data 2018, the number of consumers ranging from "Birth - 21" in "Pathway/Prevocational/Workshop" in 2017 was 5. In the same category for "Supported Employment" the figure was 2. A barrier with this data is understanding how to categorize specific services if they aren't titled exactly the same as OPWDD, and knowing when the students were counted. The latter is important as it shows any changes in enrollment from school year to school year.

**Do you have a Goal related to addressing this need?**

If "Yes", Please discuss any challenges that have precluded the development of a goal (e.g. external barriers):

Though our 2020 plan does not include a specific goal for Developmental Disability Student/Transition Services, it is included in two of our goals: Foster the independence of individuals with mental illness, substance use disorder, and/or intellectual disabilities, and enhance the continuum of care for individuals experiencing mental illness, substance use disorder, and/or intellectual/developmental disabilities. More specifically, the Board specified the following objectives to address the needs of developmentally disabled students and those who are transitioning out of the education system. They include:

- Researching the Ulster Greene ARC-implemented BIP transportation project (see 2B: Transportation). This program would allow students, after transitioning out of the school to work program, to have reliable transportation to work within the county at a job that may better suit their needs than one that is just a short walk away;
- Provide support, and continue to monitor activities, for individuals to prepare them to live in a self-sufficient way, for example:
  - How to access and navigate transportation
  - Employment training and support
  - Financial literacy
  - How to access and secure housing
  - Health and wellness literacy

**Change Over Past 12 Months (Optional)**

The Community Service Board and, more specifically the Intellectual/Developmental Disabilities Subcommittee, has strengthened their relationship with local school district CSE Chairs. In early 2019, the I/DD Subcommittee held a meeting with the district CSE Chairs to gather information on district needs. In addition, Intellectual/Developmental Disabilities Subcommittee recently requested data on exiting students from all six Columbia County school districts, as we have encountered barriers in obtaining this data from OPWDD. Three districts have provided the numbers for their district, which will allow the I/DD Subcommittee (and local providers) to better prepare for transitioning students.

**2. Developmental Disability Front Door - Background Information**

Following the implementation of OPWDD's Front Door program, data for local OPWDD services has become increasingly difficult to obtain. The data sets that are received are extensive, but as they encompass all counties in New York, they are not individualized. It is therefore difficult to use the Front Door system to anticipate upcoming community needs.

**Do you have a Goal related to addressing this need?**

If "Yes", Please discuss any challenges that have precluded the development of a goal (e.g. external barriers):

With the implementation of the Front Door system, data have become difficult to receive and utilize. Our goal is to work with local agencies in the county and OPWDD to find better ways to obtain and utilize the data.

**Change Over Past 12 Months (Optional)**

**2. Developmental Disability Care Coordination - Background Information**

The NYS DOH Medication Managed Care Initiative for the I/DD population begins with the 07/01/2018 change from using a specific agency’s Medicaid Service Coordinator (MSC) to using a Care Coordination Organization (CCO). This has been closely monitored by Columbia County. In the Taconic DDSO Region, three CCOS have been approved to offer care coordination to the residents. These three agencies are LIFEPan, Tri-County Care and Care Design NY. InFlight and Devereux are affiliated with LIFEPan, and COARC is affiliated with Care Design NY.

This new model has brought up workforce sustainability concerns. Some anecdotal reports suggest that MSCs were not accepting care coordination positions with the CCO, possibly creating a shortage of coordinators. In Columbia County, COARC, Devereux and In Flight have been present and vocal at monthly Intellectual and/or Developmental Disabilities Subcommittee Meetings. They have stated their MSCs are generally making arrangements to begin working with the CCOS in a specific amount of time, dependent on the agency. However, agencies have expressed concern over data sharing. According to OPWDD’s website regarding the transition to CCOS, CCOS will “provide a more robust, integrated system of care management” that “brings together medical, behavioral health services and other long term support and services.” Local agencies have noticed that the new system OPWDD is requiring to be used does not allow for simple data sharing. Instead, these agencies may have to use more resources to input details into both the agency’s system and OPWDD’s.

**Do you have a Goal related to addressing this need?**

If "No", Please discuss any challenges that have precluded the development of a goal (e.g. external barriers):
As the change from MSCs to CCOs is still in process as of this plan’s creation and much is contingent on directives from CMS, NYS DOH and NYS OPWDD, it was decided that this could not support being a goal on its own. However, the Board is committed to supporting local agencies that serve individuals with intellectual and developmental disabilities.

Change Over Past 12 Months (Optional)

A self-advocacy spokesperson has informed the county of different OPWDD events explaining the change from MSCs to CCOs. Additionally, agencies are explaining to all individuals and families the changes that will take place.

In Flight Inc.’s I-SAIL (In-Flight Success Academy for Independent Living) program encourages and assists individuals with developmental disabilities to self-manage and develop social skills needed for community and employment integration. They are located within Greene County (Catskill, NY) but provide services to individuals in Columbia County.

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<th>Attachments</th>
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<tr>
<td>• CG BH Crisis Plan Draft.pdf - Columbia Greene Behavioral Health Mobile Crisis System</td>
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<td>• 2019 Annual CSB Plan.pdf</td>
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The following survey is intended to promote alignment with the NYS Prevention Agenda for 2019-2024 as part of local services plan development.  
All inquiries regarding this survey should be directed to oasasplanning@oasas.ny.gov.

**Background**
The New York State Prevention Agenda for 2019-2024 aims to make New York State the Healthiest State in the Nation for People of All Ages. The Prevention Agenda's overarching strategy is to implement public health approaches that improve the health and well-being of entire populations and eliminate health inequities. This strategy includes an emphasis on social determinants of health - the social, cultural and environmental factors that influence health status, and are root causes of poor health and adverse outcomes. An agenda that focuses on social determinants necessitates cross-cutting policy development and support for local implementation.

As part of the Prevention Agenda, counties are required to submit Community Health Assessment and Community Health Improvement Plans to the Department of Health. LGUs responsible for mental hygiene services have often been active partners in the development and implementation of these plans that align with the statewide prevention agenda. The 2019-2024 Prevention Agenda includes goals and interventions specific to behavioral health, and overall health and well-being. Within the Prevention Agenda, available here, please review the Healthy Women, Infants, and Children Action Plan (pgs. 97-153) and the Promote Well-Being and Prevent Mental and Substance Use Disorders Action Plan (pgs. 154-171).

To reach the statewide prevention goals, future local service planning should include implementation of identified or other evidence-based interventions. Localities will need to create or identify metrics and data collection methods to determine impact. In some cases, data or metrics may not exist. Therefore, data collection will need to occur at the county/provider levels. These activities will require the support of all stakeholders.

**Questions**

1. Has your LGU developed a plan that aligns with the Statewide Prevention Agenda?
   - [ ] No
   - [ ] Yes, please explain:  
     The first goal in the 2020 plan relates to Housing. Specifically, the goal states "Increase the availability of housing, including emergency, transitional and permanent for individuals experiencing mental illness, substance use disorder, and/or intellectual/developmental disabilities." This goal aligns with NYS Prevention Agenda Priority Area: Promote Well-Being, Goal 1.1 Strengthen opportunities to build well-being and resilience across the lifespan.

2. Each of the eight goals in the "Promote Well-Being" focus area and "Prevent Mental and Substance Use Disorders" focus area, have an associated intervention. Please select which of the following interventions you have begun or will begin implementing:

   **Focus Area 1: Promote Well-Being**
   **Goal 1.1: Strengthen opportunities to build well-being and resilience across the lifespan**
   - [ ] 1.1 a) Build community wealth
   - [ ] 1.1 b) Support housing improvement, affordability and stability through approaches such as housing improvement, community land trusts and using a "whole person" approach in medical care
   - [ ] 1.1 c) Create and sustain inclusive, healthy public spaces
   - [ ] 1.1 d) Integrate social and emotional approaches across the lifespan and establish support programs that establish caring and trusting relationships with older people. Examples include the Village Model, Intergenerational Community, Integrating social emotional learning in schools, Community Schools, parenting education.
   - [ ] 1.1 e) Enable resilience for people living with chronic illness by increasing protective factors such as independence, social support, positive explanatory styles, self-care, self-esteem, and reduced anxiety.
   - [ ] 1.1 f) Implement evidence-based home visiting programs
   - [ ] 1.1 g) Other

   **Goal 1.2 Facilitate supportive environments that promote respect and dignity for people of all ages**
   - [ ] 1.2 a) Implement Mental Health First Aid
   - [ ] 1.2 b) Implement policy and program interventions that promote inclusion, integration and competence
   - [ ] 1.2 c) Use thoughtful messaging on mental illness and substance use
   - [ ] 1.2 d) Other

   **Focus Area 2: Mental and Substance Use Disorders Prevention**
   **Goal 2.1: Prevent underage drinking and excessive alcohol consumption by adults**
   - [ ] 2.1 a) Implement environmental approaches, including reducing alcohol access, implementing responsible beverage services, reducing risk of drinking and driving, and underage alcohol access
   - [ ] 2.1 b) Implement/Expand School-Based Prevention and School-Based Prevention Services
   - [ ] 2.1 c) Implement Screening, Brief Intervention, and Referral to Treatment (SBIRT) using electronic screening and brief interventions (e-SBI) with electronic devices (e.g., computers, telephones, or mobile devices) to facilitate delivery of key elements of traditional SBI
LGU's DCS Co-Chairs the Columbia Greene Addiction Coalition which has focused on (among other things) practice guidelines.

The OASAS support and those that still do, do so with modest in-kind supports. This funding decrease we are told by district superintendents is OASAS prevention funding was cut from Columbia's allocation. This severely cutailed our efforts to serve the community and multiple Counties is our sole provider of OASAS funded prevention services in our schools. Funding has been flat since ~2011, when ~$200k/yr of underage drinking. The LGU has financed billboard ads with SUD services. The LGU has financed development of a website and social media community behavioral health leadership to reinforce this need. 2.1a- The LGU works closely with the local DOH which aggressively prevent related to mental health and suicide messaging. Multiple public speaking events, radio and television interviews have been conducted by

MHACG has been contracted by DSS to provide on-site wrap around services. Both of these housing initiatives have access to care coordination mid peer services. 1.1e- The OMH funded Recovery Center-"Apogee Center " and the OASAS funded Youth Clubhouse have offered services to individuals with SMI and SUD with an emphasis on well being and resilience. 1.1b- MHACG's Greenport Gardens Apartments opened its doors in 2018 and used an innovative combination of financing sources. The Columbia County Department of Social Services is leasing a motel for its to serve as the counties' first congregate homeless shelter.

Goal 2.2 Prevent opioid overdose deaths

☐ 2.2 a) Increase availability of/access and linkages to medication-assisted treatment (MAT) including Buprenorphine
☐ 2.2 b) Increase availability of/access to overdose reversal (Naloxone) trainings to prescribers, pharmacists and consumers.
☐ 2.2 c) Promote and encourage prescriber education and familiarity with opioid prescribing guidelines and limits as imposed by NYS statutes and regulations.
☐ 2.2 d) Build support systems to care for opioid users or those at risk of an overdose
☐ 2.2 e) Establish additional permanent safe disposal sites for prescription drugs and organized take-back days
☐ 2.2 f) Integrate trauma informed approaches in training staff and implementing program and policy

Goal 2.3 Prevent and address adverse childhood experiences (ACES)

☐ 2.3 a) Address Adverse Childhood Experiences and other types of trauma in the primary care setting
☐ 2.3 b) Grow resilient communities through education, engagement, activation/mobilization and celebration
☐ 2.3 c) Implement evidence-based home visiting programs

Goal 2.4 Reduce the prevalence of major depressive disorders

☐ 2.4 a) Strengthen resources for families and caregivers
☐ 2.4 b) Implement an evidence-based cognitive behavioral approach such as Peter Lewinsohn's Coping with Depression course, Gregory Clarke's Cognitive-Behavioral Intervention Prevention
☐ 2.4 c) Implement the Combined Parent-Child Cognitive-Behavioral Therapy (CPC_CBT)

Goal 2.5 Prevent suicides

☐ 2.5 a) Strengthen economic supports: strengthen household financial security, and policies that stabilize housing
☐ 2.5 b) Strengthen access and delivery of suicide care â€“ Zero Suicide (a commitment to comprehensive suicide safer care in health and behavioral health care systems)
☐ 2.5 c) Create protective environments: reduce access to lethal means among persons at risk of suicide; integrate trauma informed approaches; reduce excessive alcohol use
☐ 2.5 d) Promote connectedness, coping and problem-solving skills: social emotional learning, parenting and family relationship programs, peer norm program

Goal 2.6 Reduce the mortality gap between those living with serious mental illnesses and the general population

☐ 2.6 a) Implement a multilevel intervention model that focuses at the individual, health systems, community and policy-levels. This model describes a comprehensive framework that may be useful for designing, implementing and evaluating interventions and programs to reduce excess mortality in persons with SMD.
☐ 2.6 b) Implement integrated treatment including concurrent therapy for mental illness and nicotine addiction
☐ 2.6 c) Support and strengthen licensing requirement to include improved screening and treatment of tobacco dependence by mental health providers

Please describe your efforts implementing the interventions selected above (if any). Also, if you selected an "other" category from any set of interventions above, please describe it here:

1.1b- MHACG&aposs Greenport Gardens Apartments opened its doors in 2018 and used an innovative combination of financing sources. The Columbia County Department of Social Services is leasing a motel for its to serve as the counties&aposs; first congregate homeless shelter. MHACG has been contracted by DSS to provide on-site wrap around services. Both of these housing initiatives have access to care coordination mid peer services. 1.1e- The OMH funded Recovery Center-"Apogee Center " and the OASAS funded Youth Clubhouse have offered services to individuals with SMI and SUD with an emphasis on well being and resilience. 1.2b The Columbia "Think Differently" initiative promotes cultural humility and inclusion. The Apogee Center , the Youth Clubhouse promote inculcation and integration. 1.2c- The Columbia Greene Addictions Coalition is working on a guidance document to be distributed to media outlets to encourage respect and dignity for all medical conditions,especially SUD. The Columbia Greene Suicide Prevention Coalition has distributed similar guidance documents to local media outlets related to mental health and suicide messaging. Multiple public speaking events, radio and television interviews have been conducted by community behavioral health leadership to reinforce this need. 2.1a- The LGU works closely with the local DOH which aggressively prevent underage drinking. The LGU has financed billboard ads with SUD services. The LGU has financed development of a website and social media presence for our addiction coalition which contain (among other things) prevention material 2.1b - Catholic Charities of Columbia and Greene Counties is our sole provider of OASAS funded prevention services in our schools. Funding has been flat since ~2011, when ~$200k/yr of OASAS prevention funding was cut from Columbia&aposs; allocation. This severely cutailed our efforts to erve the community and multiple advocacy efforts to OASAS for expanded funding have been unsuccessful. Unfortunately during the same time period , fewer school are matching the OASAS support and those that still do, do so with modest in-kind supports. This funding decrease we are told by district superintendents is due to their own severe district level budgetary constraints. Co-Ser funding through QUESTAR III/ BOCES is being actively pursued 2.2c - The LGU&aposs; DCS Co-Chairs the Columbia Greene Addiction Coalition which has focused on (among other things) practice guidelines.
Distribution about free or low cost relevant prescriber education is distributed. Medical and Mental Organizations have begun to mandate select training related to opioid prescribing. Non-acute/non-palliative pain prescriptions of Opioids have reduced. 2.2.6: The LGU has worked with the DOH and Law Enforcement to establish a few permanent safe disposal site and promote the drug take-back days. The volume (weight?) of drug disposal has increased significantly over the past few years. 2.2.7: Multiple trauma informed care trainings have been provided for mental hygiene staff in public and voluntary provider agencies. Increasing use of ACE screening for initial assessment has been reported system wide.

2.2.4-Columbia Counties: first responder community has largely embraced use of the HIDTA ODMAP software (NYS Police, County Sheriff, Hudson PD, EMS, 911, and a few village PDs). 2.2.5- Several events have been organized by: the Apogee Center, our SUD Youth Clubhouse, the REACH Center, CAC, DOH, CCPR and our CG Addiction Coalition to promote wellness, resiliency and recovery. This has been done in the form of tabling at community events and public forums. 2.3d: MHACG provides innovative non Health Home Case Management, Family support and respite services to support families as they endure a variety of challenges related to mental hygiene issues and others. 2.4a-Seesl 2.3d 2.4d: PHQ-9 screenings are now routinely being conducted at CMH primary care sites. Upper Hudson Planned Parenthood as of March 2019 began operating NYS Medicaid Collaborative Care Depression Program which offers depression screening and brief counseling for individuals screening positive for depression. 2.5b-The Columbia Greene Suicide Prevention Coalition (CGSPC) continues to meet and schedules activities which promote: public education of the risks and protective factors related to suicide, stigma reduction, and access to and use of screening, treatment and self-help. Radio interviews, tabling at community events, movable public display boards and the annual "Out of Darkness" walk (AFSP) are some of the activities. 2.5c- The LGU and CGSPC have supported the DOHs expansion of unused medication disposal receptacles. Gun lock (obtained through the VA) distribution has begun. See above for information related to trauma informed care promotion and alcohol abuse awareness activities. 2.5d- The LGU and CGSPC have supported the VAs Prevention Initiatives and facilitate scheduling of Safe Talk, Assist and Mental Health First Aid training for the public and professionals. 2.6b- Both the OMH licensed mental health clinic and the OMH PROS program have aggressively promoted tobacco reduction/cessation initiative with their high risk population with that dual diagnosis. At least two community mental health providers obtained certification. The proliferation of vaping and myths surrounding its "safety" have compounded this challenge, as has the medical marijuana initiative and the prospect for adult recreational use. 2.6c-all licensed OMH and OASAS incorporate nicotine dependence screening in their intake protocol and either have on-site services to refer to or have access to community providers.

3. Have you engaged any local or regional partners in implementing actions related to the New York State Prevention Agenda (e.g., Local Health Department, hospital or hospital system, substance use disorder prevention coalition)?
   - No
   - Yes, please explain:
     Local Health Departments, CMH, BHNNY, CBHN, CGAC

4. As data and metrics related to the Prevention Agenda's behavioral health interventions may not exist, has your LGU considered how to track progress of implementation?
   - No
   - Yes, please explain:
     PSYCKES HIXNY data (once we begin to have access)

5. Has your LGU identified statewide policies that assist or impede implementation of Prevention Agenda interventions?
   - No
   - Yes, please explain:
     Funding for: 1) affordable housing 2) transportation 3) Behavioral Health Education 4) Regulatory rigidity reduction

6. Is your LGU planning for Prevention Agenda alignment by Article 31 and 32 clinics via implementation of evidence-based practices? If so, please describe, and include relevant details on any LGU support of data protocols that would assist clinics in determining outcomes?
   - No
   - Yes, please explain:

7. Are the Prevention Agenda's cross-cutting goals and priorities (e.g., environmental concerns, chronic illness reduction) addressed in your health department's Community Health Assessment and Community Health Improvement Plan? If so, how will your LGU support these cross-cutting goals and priorities?
   - No
   - Yes, please explain:
     1) Obesity 2) Nicotine Use Reduction 3) Diabetes at Mental Health Clinic

8. DSRIP funding has advanced many projects related to the overall improvement of behavioral health and well-being. Of these projects supported by DSRIP, are there local prevention opportunities that your LGU could build upon and sustain?
   - No
   - Yes, please explain:
     BHNNY recently respond to a request by our outpatient mental health clinic to have access to training for therapists related to the most frequently and lethal chronic co-occurring medical conditions. As a first step CMH has agree to have their diabetes specialist offer this training which will enhance the knowledge of the medical condition and enhance the therapist ability to evaluation readiness to address the condition, the impact on mental well-being and how to incorporate goals and objectives into a treatment plan, so that billable health monitoring services can provided to those interested and in need.

9. Aside from Prevention Agenda activities, please identify any of the following social determinants of mental health that you are addressing in your community:
   - Un/Underemployment and Job Insecurity
   - Poor Education
[Checkboxes are filled for Food Insecurity, Adverse Early Life Experiences, Housing Instability or Poor Housing Quality, and Other.]

Please describe your efforts in addressing the selections above:
Information regarding food pantries, farmers markets and the like are disseminated LGU community advocacy for affordable, safe supportive housing occurs regularly. Community Mental Hygiene programs provide Section 8 list applications as they become available to all clients. See 2.3 above for information related to ACE screening and Trauma Informed Care LGU community advocacy for improved access to affordable public transportation occurs regularly. Schedules and routes of existing limited transportation options are provided to clients in need.

10. In your county, do you or your partners offer training related to strengthening resilience, trauma-informed or trauma-sensitive approaches?
   a) No  Yes
   b) If yes, please list
      Title of training(s): Not tracked
      How many hours:
      Target audience for training:
      Estimate number trained in one year:

11. New to the 2019-2024 cycle of the Prevention Agenda is the incorporation of a Health-Across-all-Policies approach, initiated by New York State in 2017, which calls on all State agencies to identify and strengthen the ways that their policies and programs can have a positive impact on health. As part of this effort, New York State was designated as the first Age-Friendly State in the nation by the American Association of Retired Persons (AARP).

Does your LGU have policies and procedures in place to support the positive environmental, economic, and social factors that influence the health and well-being of all residents, especially older adults?
   No
   Yes, please provide examples:
The purpose of this survey is to promote continued and improved access to quality mental health services in Medicaid Reform (DSRIP/Value Based Payment). All questions regarding this survey should be directed to Melissa Staats, MA MSW, at 518-408-8533, or Melissa.Staats@omh.ny.gov

Background
On April 14, 2014, New York received a waiver from the federal government that allowed the state to reinvest $8 billion in federal savings generated by Medicaid Redesign Team (MRT) reforms and support the redesign of the health care delivery system. Of this, $6.42 billion is used to support Delivery System Reform Incentive Payments (DSRIP). The DSRIP program promotes community-level collaborations and focus on system reform, specifically a goal to achieve a 25 percent reduction in avoidable hospital use over five years. DSRIP projects focus on system transformation, clinical improvement and population health improvement. All DSRIP funds are based on performance linked to achievement of project milestones.

DSRIP serves as a bridge to value-based payment in New York State.

DOH website

DSRIP Performing Provider Systems (PPS)
Organizations responsible for implementing DSRIP goals via Project Plans are called Performing Provider Systems. Many counties report the value PPS brings to communities as they provide resources that support efforts currently not funded by Medicaid.

DSRIP Project Lists
New York State Delivery System Reform Incentive Payment Program Project Toolkit
DSRIP Performing Provider Systems (PPS Statewide)

Value Based Payment (VBP) - Reduce Costs/Improve Quality
The New York State Medicaid managed care system is transforming from one that pays for service volume to one that rewards value, as defined by the intersection of cost and quality. This transformation is detailed in the NYS VBP Roadmap for Medicaid Payment Reform.

New York State VBP Roadmap
Further details regarding VBP readiness and implementation can be found at: DSRIP - Value Based Payment Reform (VBP) and VBP for Providers

NYS Behavioral Health (BH) Value Based Payment (VBP) Readiness Program
The BH VBP Readiness Program provides funding over 3 years to selected BH provider networks that have formed a Behavioral Health Care Collaborative (BHCC), beginning in 2017. There are 19 BHCCs across the state receiving this funding.

A BHCC is a network of providers delivering the entire spectrum of behavioral health services available in a natural service area. The BHCC includes, but is not limited to, all licensed/certified/designated OMH/OASAS/Adult BH HCBS programs and service types. The Readiness Program is designed to achieve two overarching goals:

1. Prepare behavioral health providers to engage in VBP arrangements by facilitating shared infrastructure and administrative capacity, collective quality management, and increased cost-effectiveness; and
2. Encourage VBP payors, including but not limited to MCOs, hospitals, and primary care practices, to work with BH providers who demonstrate their value as part of an integrated care system.

Value Based Payment Readiness for Behavioral Health Providers
New York State Behavioral Health Value Based Payment Readiness Program Overview
New York State's goal is to have the vast majority of total managed care payments tied to VBP arrangements by 2020. DSRIP funding to support BHCCs and PPS projects ends March 31, 2020.

Questions

1. Have the PPS supported your LGU and community? For example, support for efforts such as: addressing gaps in services, promoting evidence based and best practices, and facilitating clinical integration.
   a) Yes ❌ No
   b) Please provide more information:

   Better Health Northeastern New York (BHNNY) has supported our community in several ways. 1) BHNNY has acknowledged that, though we are one PPS, Columbia and Greene Counties have a unique set of rural and single-hospital catchment needs and are not served by any other PPS. For these reasons, several “Southern Hub” (Columbia and Greene County) collaborative initiatives have been recognized by BHNYY. 2) BHNYY provided partial financing to the Southern Hub’s Mobile Crisis Assessment Team (MCAT) operated by the Mental Health Association of Columbia and Greene Counties for the purpose of expanding capacity. 3) BHNYY has supported the Counties’ OP mental health clinic in its effort to embed a mental health professional in one of Columbia Memorial Health’s (CMH) Urgent Care/Family Practice Centers. The county clinic was unable to obtain an operating certificate from OMH HRFO to bill for services at that site, so that initiative was discontinued. BHNYY also supported CMH in embedding some of their psychiatric staff in ambulatory settings. 4) BHNYY has funded a planning project for the Southern Hub (utilizing CCSI) for enhanced service integration and data exchange for community wide mental hygiene and physical care services at all levels of care acuity. 4) It is the LGU’s understanding (the LGU is not privy to BHNYY’s contracting details) that: the Columbia County Department of Human Services, Twin County Recovery Services, Mental Health Association of Columbia-Greene Counties, Inc., the Healthcare Consortium, Catholic Charities of Columbia and Greene Counties, Inc., and Coarc all have had BHNYY contracts in one or more of the phases.

2. Has your LGU planned for PPS project sustainability beyond March 31, 2020?
   a) Yes ❌ No
   b) Please explain:

   Our LGU is encouraging its provider Boards to consider partnering with one or more IPAs with similar or complementary services, missions and outcome priorities. The Capital Behavioral Health Network (CBHN) is the Capital District region’s Behavioral Health Care Collaborative and providers have also been encouraged to affiliate with or without risk with this emerging group. The CBHN is likely to be the single most significant PPS project sustainability vehicle. A small degree of sustainability will be achieved through adult HCBS and CFTSS Medicaid billing.
3. Are there any behavioral health providers in your county in VBP arrangements?
   a) Yes ☐ No ☐
   b) Please explain (if "yes" include steps providers have taken to execute contracts):
      It is the LGU’s understanding (the LGU is not privy to CBHN’s contracting details) that Mental Health Association of Columbia-Greene Counties, Inc. and Twin County Recovery Services, Inc. have entered into risk bearing arrangements with CBHN.

4. Is the LGU aware of the ways in which managed care organizations and mental health providers plan to leverage VBP resources to implement evidence and best practices like, but not limited to, Collaborative Care Model (CCM), Dual Diagnosis Integration, or Self-Help and Peer Support Services?
   a) Yes ☐ No ☐
   b) Please explain:
      CDPHP has partnered with Mental Health Association of Columbia-Greene Counties, Inc. for targeted Mobile Crisis Assessment Team (MCAT) use and with Columbia Memorial Health for support for a high acuity dual diagnosis quasi-partial hospitalization utilizing the "In-Lieu Of" mechanism.

5. Is the LGU aware of the development of In-Lieu of proposals?
   a) Yes ☐ No ☐
   b) Please explain:
      See above

6. Can your LGU support the BHCC planning process?
   a) Yes ☐ No ☐
   b) Please explain:
      Our LGU attends CBHN meeting, participates in Committee work, and has affiliated as a non-risk bearing member of CBHN.

7. Does your county have access to data and IT systems that will support further transformation to VBP and outcomes management?
   a) Yes ☐ No ☐
   b) Please explain:
      Our LGU utilizes PSYCKES data, clinic EHR data and Power BI to manage clinic outcomes. Consideration will be given during the 2020 state aid pass-through contracting process to create performance based contracts with relevant HEDIS/QUAR metric tracking.
**Community Service Board Roster**  
Columbia County Dept of Human Services (70140)  
Certified: Michael Cole (5/7/19)

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Represents</th>
<th>Term Expires</th>
<th>Email Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beth Schuster</td>
<td>Physician, Psychologist</td>
<td>Twin County Recovery Services, Inc</td>
<td>12/2020</td>
<td><a href="mailto:beth@twincountyrecoveryservices.org">beth@twincountyrecoveryservices.org</a></td>
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<tr>
<td>Nancy Hoag</td>
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<tr>
<td>Amanda Pierro</td>
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<tr>
<td>Theresa Lux</td>
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<tr>
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<tr>
<td>James Haskin</td>
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<td><a href="mailto:jhaskin@mhaclg.org">jhaskin@mhaclg.org</a></td>
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<tr>
<td>Julie Valliere</td>
<td>Physician, Psychologist</td>
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<td><a href="mailto:jvalliere@cmh-net.org">jvalliere@cmh-net.org</a></td>
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<tr>
<td>Kristy Frederick</td>
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</tr>
<tr>
<td>Leitha Pierro</td>
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</tr>
<tr>
<td>Claire Parde</td>
<td>Physician, Psychologist</td>
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<td>12/2022</td>
<td><a href="mailto:cparde@columbiahealthnet.org">cparde@columbiahealthnet.org</a></td>
</tr>
</tbody>
</table>

**Note:** There must be 15 board members (counties under 100,000 population may opt for a 9-member board). Indicate if member is a licensed physician or certified psychologist. Under item labeled "Represents", enter the name of the member's organization or enter "Consumer", "Family", "Public Representative", etc. to indicate the particular community interest being represented. Members shall serve four-year staggered terms.
Name: Rebecca Crast

- Physician
- Psychologist

Represents: InFlight, Inc

Term Expires: 12/2022

Email Address: bcrast@inflightinc.org

Name: Jeffrey Rovitz

- Physician
- Psychologist

Represents: Mental Health Association of Columbia-Greene Counties, Inc

Term Expires: 12/2020

Email Address: jrovitz@mhaacg.org

Indicate the number of mental health CSB members who are or were consumers of mental health services: 2

Indicate the number of mental health CSB members who are parents or relatives of persons with mental illness: 3
**Note:** The subcommittee shall have no more than nine members. Three subcommittee members must be members of the board; those members should be identified here. Under item labeled "Represents", enter the name of the member's organization or enter "Consumer", "Family", "Public Representative", etc. to indicate the perspective the member brings to the subcommittee.

<table>
<thead>
<tr>
<th>Name</th>
<th>CSB Member:</th>
<th>Represents:</th>
<th>Email Address:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claire Parde</td>
<td>Yes</td>
<td>Columbia County Community Health Care Consortium, Inc.</td>
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<tr>
<td>Peter Volkmann</td>
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</tr>
<tr>
<td>Ellen Forman, Ph.D.</td>
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<tr>
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</tr>
<tr>
<td>Laurie Scott</td>
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<td>Yes</td>
<td>Twin County Recovery Services, Inc.</td>
<td>bethstwincountyrecoveryservices.org</td>
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</table>
Mental Health Subcommittee Roster
Columbia County Dept of Human Services (70140)
Certified: Michael Cole (5/7/19)

Note:

- The subcommittee shall have no more than eleven members. Three subcommittee members must be members of the board; those members should be identified here.

New York State Mental Hygiene Law requires that "each subcommittee for mental health shall include at least two members who are or were consumers of mental health services, and at least two members who are parents or relatives of persons with mental illness."

Under item labeled "Represents", enter the name of the member's organization or enter "Consumer", "Family", "Public Representative", etc. to indicate the perspective the member brings to the subcommittee.

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<tr>
<td>William Hughes</td>
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<tr>
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<tr>
<td>Katherine Oldakowski</td>
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<tr>
<td>Tim Smith</td>
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<tr>
<td>Carol Novack</td>
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<tr>
<td>Amanda Pierro</td>
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<td>Julie Valliere</td>
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<td>James Haskin</td>
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</tbody>
</table>

Indicate the number of mental health subcommittee members who are or were consumers of mental health services: 4

Indicate the number of mental health subcommittee members who are parents or relatives of persons with mental illness: 3
### Developmental Disabilities Subcommittee Roster

**Columbia County Dept of Human Services (70140)**

Certified: Melissa Scheriff (3/29/19)

<table>
<thead>
<tr>
<th>Name</th>
<th>CSB Member</th>
<th>Represents</th>
<th>Email Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Christina Fish Acker</td>
<td>Yes</td>
<td>Public Representative</td>
<td><a href="mailto:mcffa@verizon.net">mcffa@verizon.net</a></td>
</tr>
<tr>
<td>Carolynn Anklam</td>
<td>No</td>
<td>Coarc</td>
<td><a href="mailto:carolynna@coarc.org">carolynna@coarc.org</a></td>
</tr>
<tr>
<td>Lee Jamison</td>
<td>Yes</td>
<td>Public Representative</td>
<td><a href="mailto:ber02244@berk.com">ber02244@berk.com</a></td>
</tr>
<tr>
<td>William Furse</td>
<td>Yes</td>
<td>Consumer</td>
<td><a href="mailto:fursephoto@verizon.net">fursephoto@verizon.net</a></td>
</tr>
<tr>
<td>Maureen Hotaling</td>
<td>No</td>
<td>Family</td>
<td><a href="mailto:moeford35@yahoo.com">moeford35@yahoo.com</a></td>
</tr>
<tr>
<td>Anna Papadakis</td>
<td>Yes</td>
<td>Columbia County Early Intervention</td>
<td><a href="mailto:anna.papadakis@columbiacountyny.com">anna.papadakis@columbiacountyny.com</a></td>
</tr>
<tr>
<td>Nathan McLaughlin</td>
<td>No</td>
<td>Camphill Hudson</td>
<td><a href="mailto:nathan@camphillhudson.org">nathan@camphillhudson.org</a></td>
</tr>
<tr>
<td>Rebecca Crast</td>
<td>No</td>
<td>InFlight, Inc</td>
<td><a href="mailto:bcrast@inflightinc.org">bcrast@inflightinc.org</a></td>
</tr>
<tr>
<td>Elena Mosley</td>
<td>Yes</td>
<td>Operation Unite</td>
<td><a href="mailto:elena@operationuniteyny.org">elena@operationuniteyny.org</a></td>
</tr>
</tbody>
</table>

**Note:**

The subcommittee shall have no more than nine members. Three subcommittee members must be members of the board; those members should be identified here. Under item labeled "Represents", enter the name of the member's organization or enter "Consumer", "Family", "Public Representative", etc. to indicate the perspective the member brings to the subcommittee.
Pursuant to Article 41 of the Mental Hygiene Law, we assure and certify that:

Representatives of facilities of the offices of the department; directors of district developmental services offices; directors of hospital-based mental health services; directors of community mental health centers, voluntary agencies; persons and families who receive services and advocates; other providers of services have been formally invited to participate in, and provide information for, the local planning process relative to the development of the Local Services Plan;

The Community Services Board and the Subcommittees for Alcoholism and Substance Abuse, Mental Health, and Developmental Disabilities have provided advice to the Director of Community Services and have participated in the development of the Local Services Plan. The full Board and the Subcommittees have had an opportunity to review and comment on the contents of the plan and have received the completed document. Any disputes which may have arisen, as part of the local planning process regarding elements of the plan, have been or will be addressed in accordance with procedures outlined in Mental Hygiene Law Section 41.16(c);

The Community Services Board and the Subcommittees for Alcoholism and Substance Abuse, Mental Health, and Developmental Disabilities meet regularly during the year, and the Board has established bylaws for its operation, has defined the number of officers and members that will comprise a quorum, and has membership which is broadly representative of the age, sex, race, and other ethnic characteristics of the area served. The Board has established procedures to ensure that all meetings are conducted in accordance with the Open Meetings Law, which requires that meetings of public bodies be open to the general public, that advance public notice of meetings be given, and that minutes be taken of all meetings and be available to the public.

OASAS, OMH and OPWDD accept the certified 2020 Local Services Planning Assurance form in the Online County Planning System as the official LGU assurance that the above conditions have been met for the 2020 Local Services planning process.
Columbia and Greene County
Behavioral Health Mobile Crisis System
and
Implementation Plan

1. Describe your current system and/or vision for the development and delivery of Behavioral Health mobile crisis services in your county for children and adults. This should include information about how new benefit will be used to enhance the existing system overall.

Current system

See chart below. MHACG’s Mobile Crisis Assessment Team provides children and adults 12 hour/day- 7 days/week phone and mobile response capacity for both Columbia and Greene Counties.

The Columbia and Greene County Behavioral Health Crisis System is comprised of an interconnected patchwork of Adult and Child, MH and SUD, hotlines, warmlines, information lines and helplines which have variety of hours of operation. Both OMH out-patient clinics operate 24 /7 warmlines staffed by licensed professionals. Both OASAS clinics provide 24/7 hotline access.

Recently, two volunteer organizations assist with SUD information and referral for detox and rehab transportation services especially for Columbia County: Columbia County Pathways to Recovery and Chatham Cares for You (a “Police Assisted Addiction Recovery Initiative” aka PAARI-like model).

Columbia County RIV Article 28/31 receives funding for 9 months/year of 1 hospital diversion bed for SMI diagnosed adults and funding for SED children’s overnight respite services. Greene County RIV Article 28/31 receives funding 12 months/year 1 hospital diversion bed for SMI diagnosed adults and funding for SED children’s overnight respite services. These services are known to and utilized by our crisis service network providers.

Apogee Recovery Center, peers, adult CMA’s and MCAT all offer limited crisis in-reach at Columbia Memorial Health’s –Emergency Department to divert hospitalizations and at the Psychiatric Unit to prevent re-hospitalizations.

Columbia County 24/7 Coordinated Behavioral Health Crisis Options (Draft)

<table>
<thead>
<tr>
<th>Service/Agency</th>
<th>Columbia County Department of Human Services</th>
<th>Twin County Recovery Services</th>
<th>Twin County Recovery Services</th>
<th>Greene County Mental Health</th>
<th>Mental Health Association of Columbia and</th>
<th>Columbia Pathways to Recovery</th>
<th>911</th>
<th>NYS Bridge Authority</th>
<th>Columbia Memorial Health</th>
</tr>
</thead>
</table>


<table>
<thead>
<tr>
<th>Name of Service</th>
<th>Greene Counties</th>
<th>Mental Health or Substance Use Related Service</th>
<th>Service Type</th>
<th>Hours of Operation</th>
<th>Service Access</th>
<th>Ages Served</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Center On-Call</td>
<td>TCRS On-Call</td>
<td>STR-COTI</td>
<td>Mental Health Center On-Call</td>
<td>Mobile Crisis Assessment Team (MCAT)</td>
<td>CPR Helpline</td>
<td>911</td>
</tr>
<tr>
<td>Both</td>
<td>Both</td>
<td>Both</td>
<td>Both</td>
<td>Both</td>
<td>Both</td>
<td>Both</td>
</tr>
<tr>
<td>Counseling, support, information, referral and follow-up by phone with a licensed behavioral health professional</td>
<td>Counseling, support, information, referral and follow-up by phone with a licensed behavioral health professional</td>
<td>Counseling, support, information, referral and follow-up by phone with a licensed behavioral health professional</td>
<td>Screening, Assessment Crisis prevention, intervention and follow-up services</td>
<td>Information, Resources and Referrals</td>
<td>Dispatch for Emergency Services</td>
<td>Counseling, support, information, referral and follow-up by phone with a licensed behavioral health professional</td>
</tr>
<tr>
<td>Warmline/Phone capacity</td>
<td>Hotline/Phone capacity</td>
<td>Warmline/Phone capacity</td>
<td>Hotline/Answering Service/Mobile and Phone capacity</td>
<td>Hotline/Phone capacity</td>
<td>Hotline</td>
<td>Hotline</td>
</tr>
<tr>
<td>24/7</td>
<td>24/7</td>
<td>24/7</td>
<td>8am-10pm</td>
<td>9am-9pm</td>
<td>24/7/365</td>
<td>24/7/365</td>
</tr>
<tr>
<td>365 days a year</td>
<td>365 days a year</td>
<td>365 days a year</td>
<td>365 days a year</td>
<td>365 days a year</td>
<td>365 days a year</td>
<td>365 days a year</td>
</tr>
<tr>
<td>518-828-9446</td>
<td>518</td>
<td>518-622-9163 after hours 518-622-3548</td>
<td>518-943-5555</td>
<td>877-467-3365 (877-HOPE-365)</td>
<td>911</td>
<td>Pick up phone</td>
</tr>
<tr>
<td>all</td>
<td>14+</td>
<td>all</td>
<td>all</td>
<td>all</td>
<td>all</td>
<td>all</td>
</tr>
</tbody>
</table>
Vision  It is our hope to expand the hours and non-Medicaid funding for MHACGs MCAT services to permit them to function 24/7/365 for both counties. It is also being considered for MHACG’s MCAT to serve as our two counties’ single overarching 24/7/365 Triage and Referral hotline for both counties.

In Columbia County, an emerging 100% peer volunteer information and transportation SUD crisis service provider; Columbia County Pathways to Recovery has recently strengthened the counties’ crisis response continuum. It is our hope to obtain state aid to permit funding for a paid employee to oversee the network of volunteers. This peer type organization does not exist in Greene Co.

The Medicaid reimbursable Crisis benefit will have limited impact on our ability to create a financially sustainable service model. However, having access to another financing revenue stream will be helpful. There are limited scenarios whereby a provider can routinely obtain the necessary minimum demographic information for service documentation and billing, while simultaneously maintaining sensitivity and clinically appropriate priority focus on client safety.

2. Describe the infrastructure currently utilized or the infrastructure needed to implement and maintain mobile crisis services in your county for each of the following services:

  - Telephonic Triage and Response
  - Mobile Crisis Response
  - Telephonic Follow-Up
  - Mobile Follow-Up

Current system

All providers offer person-centered, trauma informed, culturally and linguistically competent services. Mobile and Telephonic Crisis Response Services is available 14 hours per day, seven days per week, and 365 days per year. Mobile Crisis Response currently provides in-person intervention within 3 hours of determination of need (depending upon demand). Services are provided upon the recipient’s presentation for the service, face to face or telephonically by a variety of providers offering a partial patchwork of warm-line, hotline and information lines services. Mobile and Telephonic Crisis Response Services are integrated with local emergency systems (e.g., 911, local crisis hotlines) and law enforcement, up to and including co-response, to be able to provide the safest and best-coordinated crisis response. Mobile and phone follow up services are currently available by MCAT and on a more limited basis by MH clinic warmline services. MCAT currently has a contract with CDPHP (MMCO) for follow up of their members post psychiatric hospitalization.

Vision
It is our hope to expand the hours and non-Medicaid funding for MHACGs MCAT services to permit them to function 24/7/365 for both counties. It is also being considered for MHACG's MCAT to serve an additional function; as our two counties' single overarching 24/7/365 Crisis Network Triage and Referral hotline for both counties.

In Columbia County, an emerging 100% peer volunteer information and transportation SUD crisis service provider; Columbia County Pathways to Recovery has recently strengthened the counties' crisis response continuum. It is our hope to obtain state aid to permit funding for a paid employee to oversee the network of volunteers.

We anticipate that significant support at the federal and state levels will be needed to maintain a viable workforce. Recruitment and retention for professionals and peers alike is a challenge. Current adult MH clinic "Open Access" initial evaluation models contribute to a system of care that is more responsive to crisis. It is our hope that MH children's clinic service access and SUD clinic access for both children and adults will convert to an Open Access model in the near future.

The MCAT CDPHP contract model has the potential to be expanded to other MMCOs, permitting limited relief from state aid dependence. The Medicaid reimbursable Crisis benefit will have limited impact on our ability to create a financially sustainable service model. However, having access to another financing revenue stream will be helpful. There are limited scenarios whereby a provider can routinely obtain the necessary minimum demographic information for service documentation and billing, while simultaneously maintaining sensitivity and clinically appropriate priority focus on client safety.
Columbia Greene Proposed "HOPELINE" Call Response Flow

Mental health, substance abuse and intellectual disability related crisis response (front door)

Mental Health Association of Columbia and Greene Counties
24/7 Live BH Crisis Central Dispatch, Triage, Information and Referral Function

- Imminent Threat to Life
  - Connect caller to 911

- Intellectual Disability related concern
  - Connect with Coarc, In-Flight, UGARC, other agencies, OPWDD Region 3 START Team
  - Mobile support

- Mental Health related concern
  - Non-Mobile support
  - Mobile support
  - County of Residence
  - MHACG MCAT

- Substance Abuse related concern
  - Non-Mobile Support
  - Mobile support
  - Informatio n and referral to detox
  - Twin County Recovery Services On-Call

  - CCPR
  - MHACG MCAT

  - CC4U

Back Door Direct Access to Specialty Services
3. Provide descriptions of how your mobile crisis services will support the population need, including the following if known:
   - Populations served, regardless of age and ability to pay;
   - Policies and procedures for triage and response, for example PSYCKES mobile app;
   - Use of protocols and assessment tools;
   - Training plan;
   - SUD response and protocols
   - Mobile response time

Current System

Our network of crisis responders provides services regardless of age or ability to pay. Due to the crisis nature of the intervention, often insurance payer and age are not known. The Columbia County crisis on-call service offers approximately 700 telephonic calls yearly and it is estimated that 80% of those callers are Medicaid insured. Greene County crisis on-call service offers approx. 600 calls yearly and it is estimated that 60% of those callers are Medicaid insured. Our MHAGC MCAT provider estimates that for calendar year 2017, 695 of the 1,312 individuals served were provided face-to-face services (53%). Of those seen face-to-face, 67% (or 465 of the 695) were Medicaid insured.

Each crisis provider has its own triage and response protocols and assessment tools, training plan, MH, SUD and I/DD referral and telephonic and mobile (if applicable) response time. PSYCKES mobile app is not currently used by any crisis provider.

Vision

Uniform network policies and procedures must be developed and maintained by both Columbia and Greene LGUs in tandem (with state aid funding for consultant support) in conjunction with OMH, OASAS, OPWDD, DOH and MMCOs. These policies and procedures would encompass the topics of:

- workforce training
- triage
- HIE/PSYCKES admission, discharge notification,
- sub-population triage
- screening competency
- LOCD tools, and
- response type and time standards
- LGU reporting and system CQI
- Uniform data collection fields (volume by type and payer, warmline call back and mobile response time, diversion/hospital status, post crisis outpatient care engagement percentage and timeline
4. Describe County protocols for oversight of the crisis plan that will be used to monitor implementation and to provide updates regarding progress, strengths and/or need to address gaps. Measures should be developed to determine outcomes. Measures may include but are not limited to:

- The number of calls received/responded (include time of day, population served and services provided);
- Hospital diversions;
- Access to community services; and
- Time from crisis to engagement in community based services.

**Current System**

Reports are requested and provided to the LGU by some crisis responding organizations at present. OMH HRFO Art 28/31 RIV funding reports are submitted monthly. Frequent CSB discussions identify gaps, redundancies, referral volume, diversion stats, response and follow up. Columbia and Greene County LGU requests some data collection for RIV Article 28/31 projects.

**Vision**

Uniform network policies and procedures must be developed and maintained by both Columbia and Greene LGUs in tandem (with state aid funding for consultant support) in conjunction with OMH, OASAS, OPWDD, DOH and MMCOs. These policies and procedures would encompass the topics of:

- workforce training
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- sub-population triage
- screening competency
- LOCD tools, and
- response type and time standards
- LGU reporting and system CQI
- Uniform data collection fields (volume by type and payer, warmline call back and mobile response time, diversion/ hospital status, post crisis outpatient care engagement percentage and timeline

Refinement and/or creation of performance based contracting by LGUs for state aid funded services will be needed to maximize oversight. Creation of Columbia and Greene PSYCKES data dashboards for salient data fields would enhance our oversight and crisis system CQI. Once the Medicaid crisis benefit is being used, PSYCKES tracking can be done, cross referencing service provision with preventable ED and re-hospitalization rate reduction. Non Medicaid reimbursable services, MMCO’s and PPS data must also be requested by LGUs to enhance comprehensive local and sub-regional crisis system
performance. In lieu of service data tracking may also need to be implemented- to the extent that Columbia or Greene providers have submitted crisis related proposals and these have been approved and utilized.

5. Describe Budget and Fiscal considerations:

Submit your budget to support your plan including the following:
• What is the anticipated volume of Medicaid Managed Care crisis service recipients per year? From that, estimate potential revenue that will be generated, if known;
• Current funding sources and budget allocations for existing and expanded crisis services; and
• How existing funding sources will be utilized to complement any revenues that may be realized by the Crisis Intervention benefit.

Current System

Our network of crisis responders provides services regardless of age or ability to pay. The Columbia County MH clinic crisis on-call service offers approximately 700 telephonic calls yearly and it is estimated that 80% of those callers are Medicaid insured. The Greene County MH clinic crisis on-call service offers approximately 600 telephonic calls yearly and it is estimated that 60% of those callers are Medicaid insured. The volume and payer type of those individuals utilizing our SUD clinic provider crisis service is unknown. The volume and payer type of those individuals utilizing Columbia Counties’ Columbia County Pathways to Recovery/Chatham Cares for You crisis service is unknown. Our MHACG MCAT provider estimates that for calendar year 2017, 695 of the 1,312 individuals served were provided face-to-face services (53%). Of those seen face-to-face, 67% (or 465 of the 695) were Medicaid insured.
Vision

STATE AID-

1) Expansion of funding for MCAT from a variety of sources to achieve vision will be needed. Depending upon the level of service expansion the annual additional funding required would be in the $100,000- $400,000 range (for two counties combined).

2) Columbia County Pathways to Recovery’s SUD detoxification and rehabilitation information, referral and transportation service funding estimated to be needed from OASAS would be an additional $150,000 annually (for two counties combined).

3) Consultant funding from OMH, OASAS and OPWDD for development and implementation of system wide: policies and procedures, training, data collection and analysis is estimated to be $150,000.

4) OASAS STR State Aid amount is unknown and short term. Meeting the OASAS expectation of conversion of funding from state aid to Medicaid reimbursement is difficult to determine as the project is just getting underway and because of the low volume rural area constraints.

5) Technical Assistance support would be required to permit efficient and medically necessary service delivery and billing for recipients of state aid expected to transition revenue for services delivered from state aid to Crisis benefit reimbursable services.

NON STATE AID-

MCAT
If we estimate that 879 (67%) of 1312 individuals served in some capacity annually had Medicaid insurance and we estimated that those 879 individuals received two services each, and we estimated that 10% (176) of those 1758 services were billable, then the annual estimated reimbursement for the crisis benefit for MCAT (upstate H2011 and S9485 rates) would be 176 times $100 = $17,600.

Other Partners
Technical Assistance support would be required to permit efficient and medically necessary service delivery and billing for non-Medicaid billing current providers expected to transition revenue for services delivered from state aid to Crisis benefit reimbursable services.
6. Identify providers approved by the County eligible to bill for Medicaid reimbursable services and that are willing to enter into contracts with Medicaid Managed Care Organizations.

Current System

Columbia County Department of Human Services
Greene County Mental Health
Mental Health Association of Columbia and Greene Counties
Twin County Recovery Services

Vision
Columbia County Pathways to Recovery
## 2019 Community Services Board Annual Plan - Summary

<table>
<thead>
<tr>
<th>Priority Goals</th>
<th>Objective Statements</th>
<th>Status Update as of __________</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Increase the availability of housing, including emergency, transitional and permanent, for individuals experiencing mental illness, substance use disorder, and/or intellectual/developmental disabilities</td>
<td>A. Add 20+ emergency units to serve the homeless Columbia County population</td>
<td></td>
</tr>
<tr>
<td></td>
<td>B. Explore new funding sources for IRA and supportive housing beds</td>
<td></td>
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<tr>
<td></td>
<td>C. Explore collaboration with new and existing partners to develop and increase affordable housing</td>
<td></td>
</tr>
<tr>
<td>2. Enhance the continuum of care for individuals experiencing mental illness, substance use disorder, and/or intellectual/developmental disabilities</td>
<td>A. Relocation and expansion of capacity of Twin County Recovery Services’ residence</td>
<td></td>
</tr>
<tr>
<td></td>
<td>a. Men’s residence: 13 to 18 beds</td>
<td></td>
</tr>
<tr>
<td></td>
<td>b. Women’s residence: 12 to 18 beds</td>
<td></td>
</tr>
<tr>
<td></td>
<td>B. Increase local access to medication assisted treatment (MAT)</td>
<td></td>
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<tr>
<td></td>
<td>C. Expand school and community based prevention programming and intervention counseling</td>
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<tr>
<td></td>
<td>D. Increase the availability of recovery support including but not limited to recovery focused housing, pro-social activities and events, and recovery oriented organizations</td>
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<tr>
<td></td>
<td>E. Explore the possibility of ambulatory detox</td>
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<tr>
<td></td>
<td>F. Monitor the transition from MSC to CCO and address any consumer concerns or inquiries</td>
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<tr>
<td>Priority Goals</td>
<td>Objective Statements</td>
<td>Status Update as of __________</td>
</tr>
<tr>
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</tr>
<tr>
<td>3. Foster the independence of individuals with mental illness, substance use</td>
<td>A. I/DD</td>
<td></td>
</tr>
<tr>
<td>disorder, and/or intellectual/ developmental disabilities</td>
<td>1. Plan presentation by UGARC for the Health and Medical Services Committee regarding the implementation of a BIP transportation project, similar to Greene County’s</td>
<td></td>
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<tr>
<td></td>
<td>2. Meet with pupil personnel directors regarding all 8 school districts’ current CSE practices for 14-21 year olds regarding employment preparation for students</td>
<td></td>
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<tr>
<td></td>
<td>3. Co-sponsor an Employer Recognition event with the Chamber of Commerce to highlight successful partnerships and educate other local businesses about hiring I/DD consumers</td>
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<tr>
<td></td>
<td>B. Provide direct education for individuals to prepare them to live in a self-sufficient way, for example:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. How to access and navigate transportation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Employment training and support</td>
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<td></td>
<td>3. Financial literacy</td>
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<td></td>
<td>4. How to access and secure housing</td>
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<td></td>
<td>5. Health and wellness literacy</td>
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<td></td>
<td>C. Encourage the use of peer-led supports to increase connections to community resources</td>
<td></td>
</tr>
<tr>
<td>4. Increase the capacity, awareness and utilization of local crisis services</td>
<td>A. Explore development of crisis stabilization center</td>
<td></td>
</tr>
<tr>
<td></td>
<td>B. Advocate for and support expansion of MCAT</td>
<td></td>
</tr>
<tr>
<td></td>
<td>C. Inventory existing crisis services and identify gaps and opportunities</td>
<td></td>
</tr>
<tr>
<td></td>
<td>D. Deliver community education about existing crisis services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>E. Pursue crisis training for law enforcement, first responders and other target groups in regards to cases involving the MH, ASA and I/DD communities</td>
<td></td>
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</tbody>
</table>