2020
Local Services Plan
For Mental Hygiene Services

Monroe County Office of Mental Health
September 6, 2019
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2020 Mental Hygiene Executive Summary
Monroe County Office of Mental Health
Certified: Bonnie Smith (5/24/19)

Please see attached.

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<td>• Monroe County Executive Summary 2020.pdf - Monroe County Executive Summary 2020</td>
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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.

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

This year, there have been some improvements in the Monroe County mental health service system in the areas of crisis services, children and youth services, and services for adults with complex mental health needs via HARP. First, after nearly a year of planning, Rochester Regional Health System opened their Behavioral Health Access and Crisis Center (BHACC) in October of 2018. BHACC's urgent-care-like setting offers walk in services for mental health and substance use crises Monday through Friday during daytime and evening hours. Because BHACC's services are new, the community is evaluating the impact on emergency department visits. Second, early 2019 has been a time of great change for children and youth services. This transformation of the service system is positive because more services will be available to more children and youth. However, implementation has had some challenges. Lastly, HARP services have become more utilized in the community, based upon conversations at the bimonthly adult HCBS providers meeting. MCOMH attends this meeting, convened by a local provider, and has seen the group problem solve and come up with solutions over the last couple of years. This convening helps providers and therefore aids in community members accessing these new services. The success of this group gave MCOMH the idea to start a similar group for the new and emerging children's service array, which began in early 2019.

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

Much of the service system for mental health remained well utilized, as in previous years. While crisis services for adults continues to be a focus of service providers, less attention has been given to children and youth in crisis.

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

The provider community has been challenged with workforce recruitment and retention that has led to shortages in workers including direct care staff, peers, and psychiatrists among others. In addition, the service system for children and youth has undergone exciting changes and the transformation continues in 2019 and 2020. Providers have been challenged to learn how to thrive in the new system while providing services in alignment with the new service array. With the merger of several child and youth serving waivers into one, the introduction of the new state plan services, and the changing role of children's SPOA, it remains to be seen what the overall effect will bare out. Comprehensive crisis services for children and youth are sorely lacking in Monroe County and this is one focus area for 2020.

b) Indicate how the level of unmet substance use disorder (SUD) needs, overall, has changed over the past year:

Access to substance use services on the front end and in crisis related situations has improved over the last year. Nearly all outpatient programs have rapid access to appointments and/or walk in hours, access to Medication Assisted Treatment (MAT) has improved, 2 providers have started same day MAT induction, and the BHACC is serving people with SUD and connecting them to inpatient care often. The Open Access Clinic continues to operate 24/7 and saw over 1100 people in the last year and connecting 74% of them to care within 72 hours per their report.

The County's only inpatient detox provider added 15 beds. Another provider is slated to break ground this year on an 18 bed inpatient detox unit serving 16 years old and up, which is the first time that age group will have access to inpatient detox care in Monroe County.

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

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

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

Please describe any unmet SUD service needs that have worsened:

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

Workforce recruitment and retention continues to be challenging in the field despite many efforts in adapting to workforce needs and wants. The lack of a COLA over the last year has made offering competitive wages challenging and community based providers note that it is even more challenging for those programs not connected to a hospital system. Reimbursement rates remain low for all levels of care and most programs are operating in a deficit, which makes salaries less competitive, and workforce attrition more likely.
c) Indicate how the level of unmet needs of the developmentally disabled population, overall, has changed in the past year:  
- Improved ☐  
- Stayed the Same ☐  
- Worsened ☐  

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

DD Focus group participants discussed their hard won successes with the Self-Direction program in meeting the needs of their loved ones with I/DD. They were able to use the program to craft activities that enhance the lives of their loved ones.

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

There continues to be a shortage of housing for those who need it, although the exact numbers locally are unknown. This has not changed since last year.

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

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

Individuals and their families, as well as the provider network, identify significant unmet need related to workforce. Low rates of pay compared to high levels of responsibility for service providers yields high rates of staff turnover throughout the system. This trend interrupts continuity of care for individuals and results in fiscal challenges for providers in continual cost for recruitment, training, and support for new staff. Workforce issues within the OPWDD have been especially challenging over the last year, mostly due to changes from Medicaid Service Coordination to Care Coordination via CCO/HHs. During MCOMH's focus groups and from the DD Subcommittee, it was learned that there has been a lot of turnover within the Care Coordination system.

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

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

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

The form includes; goals based on local need; goals based on state initiatives and goals based in other areas:

2. Goals Based On Local Needs

<table>
<thead>
<tr>
<th>Issue Category</th>
<th>Applicable State Agency(ies)</th>
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</thead>
<tbody>
<tr>
<td>a) Housing</td>
<td>✓ OASAS ✓ OMH ✓ OPWDD</td>
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<tr>
<td>b) Transportation</td>
<td>✓ ✓ ✓</td>
</tr>
<tr>
<td>c) Crisis Services</td>
<td>✓ ✓ ✓</td>
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<tr>
<td>d) Workforce Recruitment and Retention (service system)</td>
<td>✓ ✓ ✓</td>
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<tr>
<td>e) Employment/ Job Opportunities (clients)</td>
<td>✓ ✓ ✓</td>
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<td>f) Prevention</td>
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<td>g) Inpatient Treatment Services</td>
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<td>h) Recovery and Support Services</td>
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<tr>
<td>i) Reducing Stigma</td>
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<tr>
<td>j) SUD Outpatient Services</td>
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<tr>
<td>k) SUD Residential Treatment Services</td>
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<tr>
<td>l) Heroin and Opioid Programs and Services</td>
<td>✓ ✓ ✓</td>
</tr>
<tr>
<td>m) Coordination/Integration with Other Systems for SUD clients</td>
<td></td>
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<tr>
<td>n) Mental Health Clinic</td>
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<tr>
<td>o) Other Mental Health Outpatient Services (non-clinic)</td>
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<tr>
<td>p) Mental Health Care Coordination</td>
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<tr>
<td>q) Developmental Disability Clinical Services</td>
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<td>Need</td>
<td>OMH</td>
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<tr>
<td>Developmental Disability Children Services</td>
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<td>Developmental Disability Student/Transition Services</td>
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<td>Developmental Disability Respite Services</td>
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<td>Developmental Disability Family Supports</td>
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<td>Developmental Disability Self-Directed Services</td>
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<td>Autism Services</td>
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<td>Developmental Disability Front Door</td>
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<td>Developmental Disability Care Coordination</td>
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<tr>
<td>Other Need 1 (Specify in Background Information)</td>
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<tr>
<td>Other Need 2 (Specify in Background Information) (NEW)</td>
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<td>Problem Gambling (NEW)</td>
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<td>Adverse Childhood Experiences (ACEs) (NEW)</td>
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(After a need issue category is selected, related follow-up questions will display below the table)

2a. Housing - Background Information

Monroe County is not unique when it comes to challenges around affordable, safe, and stable housing. This concern is especially acute in people with mental health disorders, substance use disorders, and intellectual and developmental disabilities. Our community has 617 MH housing beds with the shortest waitlist being about 3-6 months for a community residence and over 2 years now for supported housing level of care. Our SUD housing totals 367 beds between all levels of residential care and the shortest waitlists are 4-6 weeks with supportive living waitlists up to 3 or 4 months. The SUD consumer focus group conducted earlier this year elicited some clear demand for recovery housing, peer housing, and expansion and closer monitoring of our current housing array. The OPWDD focus group that MCOMH conducted with parents of consumers shared that housing for their family member is unresponsive, burdensome, and very challenging to navigate. The adult OPWDD housing waitlist can exceed 20 years in some cases. The strain put on these housing providers and lack of available options for families and consumers causes homelessness, inadequate and unsafe housing, and the members of our most vulnerable populations not being cared for. Additionally, homelessness is common among those with MH and SUD challenges. The primary cause of homelessness in 2017, according to the Monroe County Department of Human Services’ Housing and Homeless Services 2017 Annual report, continued to be eviction by the primary tenant. Individuals and families residing in the homes of relatives or friends are often asked to leave due to overcrowded conditions, substance use, domestic disputes, family breakups and strained relationships. This cause represented 60% of the total temporary housing assistance placements made in 2017. The Point in Time study for 2015 and 2016 reflected that homelessness in Monroe County has increased amongst those with severe mental illness and substance use disorder (Figure 1).

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

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

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

Objective Statement

Objective 1: Advocate for safe, sustainable and stable housing options in the community.

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

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

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

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

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

Change Over Past 12 Months (Optional)

2b. Transportation - Background Information

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

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

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

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

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

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

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

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

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

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

Change Over Past 12 Months (Optional)

2c. Crisis Services - Background Information

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

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

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

Do you have a Goal related to addressing this need?  

Yes  No

Goal Statement- Is this Goal a priority goal (Maximum 5 Objectives per goal)?  

Yes  No

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

Objective Statement

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

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

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

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

Objective 3: Improve access to a continuum of care for people in crisis in order to proactively reduce the likelihood of future crises. Services may include, but not be limited to, peer support, community mentoring and connections, andpatient and outpatient care, housing, etc.

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

Objective 4: Strategize with providers to build awareness of local options for people in crisis beyond the emergency room.

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

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

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

Change Over Past 12 Months (Optional)

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

Based on OASAS Treatment Program staffing surveys from 2018, Monroe County providers experience an average of 12.5 weeks to fill vacant positions with some reporting up to one year to fill medical staff vacancies. Participants in the DD focus groups identified that support staff have a tenure of less than 6 months and wait times to fill those positions can take well past one year. MH providers struggle with recruitment and retention as well. Of providers surveyed in 2018, 90% report extreme difficulty in recruiting a psychiatrist and 100% of providers found it somewhat or very difficult to recruit nurse practitioners. Retention is a significant concern with 56% reporting it difficult to retain all positions. Salary levels are identified as the being the most common contributor to challenges in retention. Per FLPPS 2017 Data (Figures 4a and 4b), the Finger Lakes region ranks high amongst those communities most challenged by high vacancy rates in multiple position types and that challenge is felt acutely at the service provider level. In 2018, MCOMH began convening providers around the issues related to workforce recruitment and retention. MCOMH is in the process of developing action steps from the following priorities that were identified: supply and demand for qualified workers (connecting with job fairs/colleges, investing in training, etc.), recruitment and retention of people of color and diverse workers at all levels, affordable health insurance, and health and wellness (or "creating an environment for longevity").
Do you have a Goal related to addressing this need? Yes No

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

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

**Objective Statement**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2f. Prevention - Background Information

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

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

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

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

**Objective Statement**

Objective 1: Leverage collaborative efforts to ensure that community members have access to resources that they need.

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

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

Applicable State Agency: (check all that apply): OASAS OMH OPWDD
Objective 3: Actively address social-emotional health and trauma-informed care practices through proposals, quality assurance measures and multi-disciplinary community planning.

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

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

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

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

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

Change Over Past 12 Months (Optional)

2g. Inpatient Treatment Services - Background Information

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

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

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

Change Over Past 12 Months (Optional)

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

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

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

Goal Statement- Is this Goal a priority goal (Maximum 5 Objectives per goal)? ☐ Yes ☐ No
Enhance the county-wide, cross-sector response to the overdose epidemic by increasing access to appropriate levels of care, including Medication Assisted Treatment

Objective Statement

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

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

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

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

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

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

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

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

Change Over Past 12 Months (Optional)
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<td>- Monroe County Executive Summary 2020.pdf - Monroe County Appendix 2020</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?
   - [ ] Yes
   - [ ] No
   - [ ] Yes, please explain:

   The 2019-2024 Prevention Agenda from NYS has a strong focus on behavioral health and wellness. MCOMH staff members have met with the Monroe County Department of Public Health (MCDPH) leading up to when MCDPH needs to submit their community plan to the State. MCOMH has given input into their choices of priority goals. Because a portion of the the Prevention Agenda focuses on behavioral health and wellness, some of our work falls under the priorities naturally. MCOMH looks forward to continuing to meet with MCDPH to collaborate on their Prevention Agenda work in the community.

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
2.1 d) Integrate trauma-informed approaches into prevention programs by training staff, developing protocols and engaging in cross-system collaboration

2.1 c) Other

### 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
- 2.2 g) Other

### 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
- 2.3 d) Other

### 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
- 2.4 c) Implement the Combined Parent-Child Cognitive-Behavioral Therapy (CPC_CBT)
- 2.4 d) Other

### 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 e) Promote connectedness, coping and problem-solving skills: social emotional learning, parenting and family relationship programs, peer norm program
- 2.5 f) Other

### 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
- 2.6 d) Other

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:

**Goal 1.1:** Many of the services promoted by MCOMH strengthen opportunities to build well-being and resilience across the lifespan. MCOMH contracts with agencies to provide services to people to improve their resiliency at home and in the community. Contracted services include peer services, employment services, housing services, crisis services, and many others. MCOMH also regularly convenes providers to share victories and challenges as they do their work. This gives the providers the opportunity to problem-solve about issues and come up with collective solutions to improve care. Goal 1.2: During the past year, four staff members of MCOMH were certified to teach different types of Mental Health First Aid. One was trained to teach Adult Mental Health First Aid and does so for Law enforcement, in partnership with a local law enforcement agency. Three were trained in Youth Mental Health First Aid and have already begun providing training in the community. Additionally, thoughtful messaging is something MCOMH is always looking at as a way to reduce stigma and promote acceptance of people with various life challenges. Over the past year, we have been working on updating our website with appropriate language and in meetings we use care to speak using terms that will empower others. Goal 2.3: Within Monroe County, resiliency has been integrated into existing efforts and activities that the community is developing and implementing. Over the last five years, MCOMH has collaborated with the County Department of Public Health to revise the Youth Risk Behavior Survey (YRBS) to include 11 ACEs questions as well as asset questions to gain further insight of the needs of students in our community. The data collected from the YRBS reflected a need for further collaboration between school districts and community providers. The Resiliency Learning Collaborative was created as an effort to foster connections for school systems and community providers working with students and families. Monroe County continues to convene a multi stakeholder meeting including schools, hospitals and clinics. This meeting allows for systems directly involved to collaborate around the needs of children and youth in the community. Additionally, Monroe County continues to offer Youth Mental Health First Aid at no cost to the community to build capacity around how to recognize and assist a youth in mental distress. Goal 2.5: Partners For Suicide Prevention (PSP), a community wide coalition, now has a website, quarterly informative and
collaborative meetings for the community, and has become a program of NAMI Rochester to ensure sustainability. The PSP has local AFSP chapter leaders who work with the coalition on trainings such as “Talk Saves Lives” for all sectors of the community. Monroe County has added four Youth Mental Health First Aid trainers that are on staff within MCOMH, only adding to the robust number of trainers within the community. Monroe County also boasts a number of Mental Health First Aid trainers and the two largest hospital systems are exploring training personnel in MHFA. Countless forums around suicide prevention continue to take place within schools and the community throughout the year and Kevin Hines (an internationally renowned speaker) has been brought to the area 3 times in the last 2 years. MCOMH continues to analyze the Youth Risk Behavior Survey to look for trends, risks, and protective factors to ensure efforts are reaching those in the greatest need. The Consortium on Trauma Illness and Grief (TIG) works with all schools in the region to help promote resilience and respond to tragedy affecting the school populations. In the last year, 110 school personnel have been trained with the TIG model and five new schools were added.

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:

MCOMH staff members were included in the local Community Health Improvement workgroup convened by the MCDPH as they were working on their plan for the most recent Prevention Agenda. This workgroup also included both local hospital systems and will continue as they implement the interventions associated with their plan. At this time, the goals MCDPH plans to address in relationship to the Prevention Agenda are strengthening opportunities to build well-being and resilience across the lifespan and facilitating supportive environments that promote respect and dignity of all people. MCOMH staff members plan to continue being a part of the MCDPH workgroup.

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:
The data/metrics of MCOMH's work related to the Prevention Agenda are captured in a contracting system, via the Behavioral Health Community Database, and via spreadsheets. MCOMH does not currently track goals in relationship to the Prevention Agenda. Rather, goals and objectives are tracked as part of a Local Services Planning process via a spreadsheet.

5. Has your LGU identified statewide policies that assist or impede implementation of Prevention Agenda interventions?

☐ No
☐ Yes, please explain:

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:

MCDPH is also concentrating on maternal and child health and will use our collaborative work in incorporating ACEs into the Youth Risk behavior survey as a basis and driver of their work. ACEs will also be used in the work on the well being goal. Another intervention that MCDPH will be considering is training more people in Mental Health First Aid, which would speak to the prevention cross-cutting principle and MCOMH would be a close collaborator.

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:

There are many projects and efforts within DSRIP’s purview for which MCOMH will be looking at sustainability. Here are some examples: MCOMH will discuss work that has been done with Tele-Mental Health and the elderly population and work on sustainability. Also, there are potential opportunities to have a more integrated system of care, between our 2 large hospital/provider systems. MCOMH will continue to work with the two hospitals concerning this issue. Access to MAT that is occurring within hospitals and PCPs is something that MCOMH will also work to make sure is an important and sustained support in our community. Finally, there is an effort to provide and/or improve care in homeless shelters in collaboration with local providers and MCOMH will work to ensure these efforts continue.

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
☐ Food Insecurity
☐ Adverse Features of the Built Environment
☐ Housing Instability or Poor Housing Quality
☐ Poor Education
☐ Poverty/Income Inequality
☐ Adverse Early Life Experiences
☐ Poor Access to Transportation
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): Trauma-informed Care, Youth Mental Health First Aid, High Fidelity WRAP Trauma, Illness and Grief in Schools (TIG)

How many hours: Varies

Target audience for training: Staff members at agencies (all staff), school personnel

Estimate number trained in one year: unknown

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:

MCOMH works collaboratively with our local Office for the Aging (MCOFA) to look for areas of mutual impact. For example, we recently conducted a Narcan training at a senior center in collaboration with the MCOFA. There are more Narcan trainings planned for the future. We also have 2 programs that are funded through our office that impact the aging population. First, there is a program that assesses older people for mental health symptoms and connects them to applicable services. Second, MCOMH funds a program that connects people with I/DD with supports to attend senior centers in the Rochester area.
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:
      MCOMH sent out a survey to the Monroe County provider community based upon the survey that was sent out by the MHPC. 80% of the 20 respondents to the provider survey said that the PPS was supportive (n=9) or somewhat supportive (n=7). Of those that commented, it was noted by providers that most of the funding and initiatives supported the work of our large hospital systems, leaving less funding and support for community-based providers in their successful preparation for VBP. It was also noted by one provider that the Developmental Disability community was not included in much of this effort, thus creating an even deeper rift between the service systems.

2. Has your LGU planned for PPS project sustainability beyond March 31, 2020?
   a) Yes No
   b) Please explain:
      MCOMH (as the LGU) meets with the local PPS (FLPPS) monthly to stay updated on potential collaborations and overlapping efforts. From discussions with FLPPS, some projects may be more easily sustained than others. Per the contact at FLPPS, the system transformation projects have changed workflows and processes, such that the systems that were touched by these projects (BH, PCP, Nursing homes, Homeless, etc.) will benefit in an ongoing way. For the clinical improvement projects, where integrated care across systems is involved, state intervention will be required to make sure that there is a regulatory/billing mechanism that will make sense to providers to continue that work. For population health and prevention, it remains to be seen what projects will require sustainability efforts from the LGU after DSRIP.

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):
      Of those surveyed, 8 out of 20 respondents said they are in various stages of VBP arrangements. Some steps providers have taken include...
formation of BHCCs, negotiating with Managed Care, and some providers are pursuing Medical VBP arrangements first. Of the two local hospital systems, one said they are working on medical VBP and the other said they are working on it through Accountable Health Partners.

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:
From our survey, 8 out of 20 respondents say they are doing this. Most providers report already exploring and/or using Evidence-Based practices to meet the needs of their clients. The providers noted that they were using these practices prior to the implementation of VBP. Many providers are using peer services and nearly all are exploring peer services implementation. One provider stated that they have this as part of their strategic plan for the next 18 months.

5. Is the LGU aware of the development of In-Lieu of proposals?

a) Yes ☐ No ☐

b) Please explain:
One agency noted on their survey response that they are in the beginning stages of proposing volunteer mentoring as an approach to sustaining skill-acquisition in other billable services. Another agency noted on their survey response that they are not developing any proposals currently, but they plan to. A third agency that is primarily based in Syracuse said they are developing proposals, but did not elaborate on what the proposal is.

6. Can your LGU support the BHCC planning process?

a) Yes ☐ No ☐

b) Please explain:
Monroe County LGU works closely with the lead agencies for the two local BHCCs. Because of our close collaboration with CCSI, which is a supporting agency for one of the two local BHCCs, MCOMH staff members have been able to become and stay informed on how best to support the BHCC planning process. At this time, it is unclear to us how MCOMH can best be involved in the effort.

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:
MCOMH has a data team that can work with our data in the Behavioral Health Community Database and also PSYCKEs to assist providers with preparing for VBP. MCOMH does not provide direct services as a county, but is involved in a fair amount of information and referral work. As such, MCOMH is in the process of gathering information about our needs for a unified internal data system. Within our provider network, providers are using RHIO, UniteUs platform, and many other organizations have internal electronic medical/client records. Several SUD providers have a shared Electronic record via Recovery Net. FLPPS is also working with Chess to create an e-intervention platform to assist with smoother referrals and transition to care.
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<td>Mendoza, Michael, M.D., MPH, MS</td>
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<td>Carrasquillo, Carmen</td>
<td>Community Place of Greater Rochester</td>
<td>12/2020</td>
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<tr>
<td>Fu, Annabel, M.D.</td>
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<td>LiButti, Daniel, Ph.D.</td>
<td>Public</td>
<td>12/2021</td>
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Indicate the number of mental health CSB members who are or were consumers of mental health services: 1

Indicate the number of mental health CSB members who are parents or relatives of persons with mental illness: 1
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<td>Craig Johnson</td>
<td>Yes No</td>
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<tr>
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<tr>
<td>Annabel Fu</td>
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<tr>
<td>Carly Constantino-Gallagher</td>
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<td><a href="mailto:cconstantino@libertymgt.com">cconstantino@libertymgt.com</a></td>
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### Mental Health Subcommittee Roster

**Monroe County Office of Mental Health (70560)**

**Certified: Jason Teller (5/20/19)**

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**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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<th>Name</th>
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<th>Represents</th>
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<tr>
<td>Annabel Fu</td>
<td>Yes</td>
<td>URMC Psychiatry</td>
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<tr>
<td>Kelly Wimot</td>
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<td>Jennifer Storch</td>
<td>Yes</td>
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<td><a href="mailto:jennifer_storch@yahoo.com">jennifer_storch@yahoo.com</a></td>
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<tr>
<td>Mariella Diaz</td>
<td>Yes</td>
<td>Family</td>
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Indicate the number of mental health subcommittee members who are or were consumers of mental health services: **1**

Indicate the number of mental health subcommittee members who are parents or relatives of persons with mental illness: **1**
## Developmental Disabilities Subcommittee Roster

Monroe County Office of Mental Health (70560)
Certified: Jason Teller (5/13/19)

### Note:

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>Lawana Jones</td>
<td>Yes</td>
<td>Consumer/Family</td>
<td><a href="mailto:lawana@theautismcouncil.org">lawana@theautismcouncil.org</a></td>
</tr>
<tr>
<td>Fran Dubester-Vick</td>
<td>Yes</td>
<td>community member</td>
<td><a href="mailto:franvick@gmail.com">franvick@gmail.com</a></td>
</tr>
<tr>
<td>Ginny Giesow</td>
<td>Yes</td>
<td>community member</td>
<td><a href="mailto:gieg26@yahoo.com">gieg26@yahoo.com</a></td>
</tr>
<tr>
<td>Bonnie Smith</td>
<td>Yes</td>
<td>Staff Liaison</td>
<td><a href="mailto:bonniesmith@monroecounty.gov">bonniesmith@monroecounty.gov</a></td>
</tr>
<tr>
<td>Jennifer Foley</td>
<td>Yes</td>
<td>Independent Start Up/advocacy</td>
<td><a href="mailto:jtfoley11@gmail.com">jtfoley11@gmail.com</a></td>
</tr>
<tr>
<td>Dalton Letta</td>
<td>Yes</td>
<td>Person receiving services</td>
<td><a href="mailto:daltonletta@yahoo.com">daltonletta@yahoo.com</a></td>
</tr>
<tr>
<td>Krysie Letta</td>
<td>Yes</td>
<td>Family Member</td>
<td><a href="mailto:krysieletta@yahoo.com">krysieletta@yahoo.com</a></td>
</tr>
<tr>
<td>Daniel Libutti, PhD</td>
<td>Yes</td>
<td>public representative</td>
<td><a href="mailto:djl6269@aol.com">djl6269@aol.com</a></td>
</tr>
<tr>
<td>Valerie Smith</td>
<td>Yes</td>
<td>URMC</td>
<td><a href="mailto:valerie_smith@urmc.rochester.edu">valerie_smith@urmc.rochester.edu</a></td>
</tr>
</tbody>
</table>
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.
As DSRIP enters into its final phases, OASAS residential redesign is well underway, and OPWDD is moving closer to managed care, New York continues to progress with the restructure and reform of the Behavioral Health Service System. The Monroe County Office of Mental Health (MCOMH) remains committed to ensuring quality in the local service system concurrent to executing State and Federal initiatives. While navigating a shifting healthcare landscape throughout these transformative efforts, and in our ongoing commitment to serve the people of Monroe County, MCOMH operates with the following priorities:

i. Ensure individuals with the highest need are identified, prioritized and linked with services responsive to their identified needs.

ii. Increase the availability of, access to, and coordination and/or integration of services/supports for individuals whose needs cross systems.

iii. Identify gaps in the availability of a full range of prevention, treatment and recovery services to meet community need, leveraging resources to reduce gaps where identified.

iv. Ensure a robust provider network exists within Monroe County to adequately meet the behavioral health (mental health, substance abuse, and developmental disability) needs of community residents.

v. Ensure that delivery models are person-centered, strength-based and recovery-oriented.

vi. Incorporate prevention/education, awareness, early identification and intervention approaches related to mental health, chemical dependence and developmental disabilities into systems of care.

As a result of evaluating the success of these priorities and informing the development of the 2020 Local Services Plan, MCOMH has continued to increase lines of communication with system stakeholders. Most importantly, over the last two years, MCOMH improved direct feedback from consumers and family members. MCOMH offered focus groups for consumers and family members in each disability area, as well as offering online surveys. Additional information was gleaned from providers, Monroe County Agency Executives, and the Community Services Board, through review of state and local data, and quality assurance activities. This collaborative, data-driven process has identified and highlighted key areas of impact for 2020 that are reflected in the Local Services Plan. These goals and the related objectives will be closely monitored for progress to continue to drive quality, achieve MCOMH priorities, inform future planning, and maintain LGU accountability to Monroe County residents.

2020 Priority Goals include:

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

Through the focus provided by these goals and their related objectives, MCOMH is confident that there will be a significant impact on improving care, decreasing cost, and improving health outcomes for Monroe County residents across the three disability areas. Executing and evaluating these target areas will accomplish the progress necessary in 2020, setting the foundation for future growth in Monroe County that is responsive to the needs of our residents and achieves the vision established by State and Federal initiatives.
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