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Q1

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Q2 **Cattaraugus Co Community Services Dept**

LGU:

Q3

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

- When basic needs (food, shelter) were not met, individuals could not attend to their mental health needs, especially when unemployment benefits were inaccessible and individuals exceeded limits for minutes and texting from cell phones (needed for Telehealth). People were running out of food or had no transportation to get to a Food Bank, so some agencies stepped up to deliver meals/food baskets to those individuals. Transportation is always a need in this rural area. PPE (Personal Protective Equipment) and some of the sanitization products were simply not available in the beginning of COVID, so it was difficult for agencies to provide services, at least at the onset. Some people/agencies are now stockpiling supplies so as not to be in that position again in the future, in the event Government enacts another "Pause" or another wave of COVID or similar pandemic occurs.
- Some individuals had no access to technology or internet access, so they were unable to attend meetings or appointments virtually or by videoconference. The local Warm Line assisted individuals, especially the elderly, with training to learn Zoom, GoToMeeting, Webex, and other virtual meeting platforms. Some schools in Cattaraugus County parked school buses around their community to provide internet access to individuals, but some members in those communities did not receive the information about the availability. Some workers also had difficulty accessing internet at home, which affected remote work productivity.
- If people did not know where to look for information, they did not take advantage of the options that were available. Perhaps when Public Health Nurses or Staff are visiting with individuals or families, they could share resource information – leave a brochure, training information, etc. when visiting people.
- Agencies scrambled to get things up and running, focusing on ways to get immediate access “at any cost,” to connect schools and families and consumers and provider agencies, while remaining cognizant of unemployment and social determinants of health.
- Reopening Plans did not include day camps or respite. Some families simply cannot afford the increased rate for programs that were able to reopen.
- There is clear need for budget help and educational opportunity, from virtual learning to changing the face-to-face environment for in-person learning. Through all of the changes, the LGU discovered that COVID brought out the very best and the very worst in agencies. Some agencies, providers, and workers stepped in immediately to help individuals in need, including stepping outside their comfort zone to assist and think outside the box to meet consumers’ needs. As an example, the Veteran's Office closed its van service during COVID but provided other emergency services, as needed. For example, the Dwyer Project provided Food-for-Vets program, where they worked with local restaurants that provided meals for vets, free or at reduced cost. The Food-for-Vets program served 1500 meals from mid-March until Mid-June, and the Dwyer Project issued a press release in the local newspaper and communicated the meal availability by word of mouth.
- STHCS (Southern Tier Health Care System) changed how they train for administration and distribution of NARCAN. STHCS also retrained EMTs regarding PPE use during COVID.
- CAReS (Council on Addiction Recovery Services, Inc.) provided Outpatient and Recovery Coach services via Telehealth with varying levels of success, and the return to the office looks different now than pre-COVID, e.g. with PPE, social distancing and restricted population density.
- Census dropped at CAReS, which seems directly related to changes due to COVID and lack of referrals from the criminal justice system. CAReS has not received referrals from individuals leaving incarceration.
- From a community standpoint, relapses were at an all-time high, especially with community support programs closing during the "Pause." Many elderly individuals, with 10+ years in recovery, could not navigate the technology and subsequently relapsed. Consumers ran out of phone minutes or changed phones repeatedly, which made engagement difficult. Funding was available to assist with phone minutes, but consumers did not receive any communication that free phones or minutes were available. Lack of broadband or internet access throughout the county has also been prohibitive to receiving recovery services. Government-issued phones did not permit Zoom and other virtual meeting platforms, which prevented consumers from attending self-help meetings. Fear of coming out of homes also prevented treatment or engagement. Some individuals refuse to comply with mask or other screening requirements, so those consumers continue with TeleHealth services rather than face-to-face services.
- Care Managers and the MTST (Mobile Transitional Support Team) increased contacts with members to once a week at minimum during the Pause. The MTST contacted consumers by phone, text, email, or post mail, as face-to-face contacts were not mandatory for billing purposes. Care Managers were able to maintain service delivery per member/per month

for billing purposes. Care Managers were able to maintain service delivery per member/per month.

- Clinics saw disparities in kept appointments for adults v. children.
- Respite Care services decreased while Warm Line use increased when in-home guest/respite services were not available. Warm Line usage has continued to increase, even with reopening and as guests return to Eagles Nest Respite House.
- The county developed a crisis response plan so that clients were contacted and assessed, either face-to-face or by phone. The intended result was the clients would not need to be assessed at the hospital for a mental health crisis, and this would decrease the number of people in the ED who were being seen for non-COVID issues. The local hospital and law enforcement agencies collaborated on this plan and informed DCS if they received a call from Dispatch or the Crisis Line that necessitated a contact. The assigned Crisis Person(s) would reach out. This resulted in a dramatic decrease in people being sent to the hospital for assessment.
- Many systems have been on pause or have provided limited services (i.e. court proceedings, cross system support services, and movement to appropriate residential settings in all systems).
- There has been a significant increase in crises involving individuals with cross system needs requiring a more enhanced need for collaboration, partnerships, and cross system services (i.e. Adult Protective Services (APS); Child Protective Services (CPS); school districts; and local hospitals). There is a limited ability to collaborate resources across service systems, and those resources are necessary for full support of individuals with complex needs.
- The impact of school closures and limited cross system direct services has resulted in an increase in family crisis, more psychiatric/complex behavioral emergencies, and more families leaving their loved ones in hospitals. This has created a burden on hospital supports and an increase in emergency need for residential services. It has also resulted in more admissions to skilled nursing facilities.
- There has been a strain on cross system resources (i.e. available resources to fully meet all needs; staffing resources; and fiscal resources).
- The COVID-19 pandemic has created necessary precautions that have influenced an ability to maintain a consistent and available workforce, which affects the ability to fully support all services across systems.
- People with developmental disabilities have been affected by isolation and depression, as they have been removed from the things they value: programs, school, and interactions with friends. With the lack of limited interaction they already had, this led to the isolation and depression we see now.
- The Native American population in Cattaraugus County was hit extremely hard during COVID; 4 of the deaths in Cattaraugus County were from the Native American population as of June 2020. Other factors might contribute to the disproportionate outcomes, including cultural diversity where Native American families tend to support each other physically, in person with larger gatherings, vs. maintaining remote contact.
- There has been a significant increase in requests for emergency children's residential beds and services prior to COVID, and it has become more pronounced during COVID. There has been an increase of children dropped off in the ER from overwhelmed parents with no discharge disposition. This most likely is attributed to lack of full educational, clinical, and cross system supports.
- The OLV Intensive Treatment Program (ITP) beds are now full and there are wait lists for admission.
- [Developmentally disabled] adults spent more time isolated alone, and kids lost their peer interaction and knowledge base from lack of education when schools closed.
- Regarding OPWDD Services:

- Consistent and ongoing face-to-face contact with individuals in their homes to directly assess their needs and well-being has been impacted.
- There has been an increase in hospitalizations, psychiatric destabilization, homelessness, mental health problems and those in need of crisis services.
- Insufficient cross system and community supports has increased the burden on working families and family dynamics.
- Schools not being open has created the hardship of virtual learning. Many I/DD individuals are not able to learn virtually or via telehealth. I/DD individuals require direct educational and clinical supports to be fully supported. Many individuals have not adjusted well. Families do not always have the resources physically, educationally and technologically to do this effectively.
- The need for direct services and support staff to meet the increasing demand for services has become more of a challenge to the service system.
- The impact in OPWDD appears to be consistent across all racial and ethnic groups.

Q4

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

- Reduced face-to-face contacts resulted in mixed outcomes for Care Management. These mixed outcomes were especially noticeable when trying to engage very young children and the elderly population via phone, text, or virtual meeting.
- During each of their weekly contacts with consumers, Care Managers and Mobile Transitional Support Team reviewed symptoms, shared education, and directed the clients to appropriate resources with issues related to COVID-19, in addition to their regular duties.
- Care Managers and Mobile Transitional Support Team assisted in coordinating access to basic needs such as food and housing in addition to working to get members access to services by getting phone cards and problem solving. Care Managers were able to use connections to WRAP funds and resources to assist in access to needed supplies for home schooling, for example a printer.
- Children's and Adult SPOA Committees continued to meet as scheduled via virtual meetings. Each SPOA Committee continues to receive and process referrals, and then assign those referrals to appropriate agencies.
- During the Pause, Care Management agencies were not permitted to discharge clients, but rather put them in a pended status to assist in continued stabilization.
- During the Pause, the Olean General Hospital-Health Home Care Management Project was suspended due to COVID-19 related safety concerns, so agencies and staff were not able to enter the hospital ED or units in efforts to connect individuals to services.
- The county-operated clinics offered an option of face-to-face or Telehealth service but saw a decline in the number of appointments kept. This may be in part due to lack of technology or due to the lack of engagement or due to consumers prioritizing day-to-day needs over their mental health needs. The Clinics publicized ongoing access and availability to services was still in place, but the numbers of services provided continued to decline. Since OMH authorized Telehealth during the pandemic, the counseling centers provided Telehealth services to 70% of clients, with only 30% of clients opting for face-to-face sessions.

Q5

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

- STHCS (Southern Tier Health Care System) changed processes to provide virtual NARCAN training, with ability to mail the kits to trainees, as needed. STHCS is concerned about youth, with no oversight or follow-through for prevention services when youth are not in school.
- Seneca Nation saw increased anxiety with mental health and increased overdoses, with 8-9 deaths in just 2 months related to drugs/alcohol or medical complications that escalated due to the pandemic "Pause."
- OASAS designated population is the "criminal justice" population, which has not had the typical pass-through connection to obtain services mandated by courts.
- Rural population and high levels of poverty, combined with lack of technical means to engage in treatment during closures, have prevented many consumers from obtaining appropriate levels of care.
- Domestic Violence calls also increased, where CAReS staff could actually hear the physical beatings in the background during one incident. CAReS staff requested police intervention at least 4 times during first 3 months of the "Pause," and in one instance, the police could not even locate the woman (reported victim).
- Reports to Children's Protective Services increased, at least 7-8 per week, mostly alcohol related.
- CAReS received two new referrals for problem gambling, although the casinos were closed during the Pause.

Q6

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

- Individuals are receiving primary program services in residential settings, via telehealth, altered service duration or had services on “Pause.” Face-to-face and/or on-site programming is increasing gradually.
- Children whose school and clinical supports are on Pause or who cannot benefit from remote learning require additional cross system supports.
- I/DD children and adults that require consistent routines and/or who have highly complex needs have had a strain on their available resources (family and residential setting).
- Individuals living independently and with families have been impacted by the limited capacity of available cross system resources and necessary precautions for in-home supports.
- The newly eligible developmental disability population cannot access services at this time. With the closure of Article 16 clinics and testing places they cannot receive OPWDD eligibility to gain access to services at this time. This puts both adults and kids in a holding pattern until these places and schools open back up. Even then, the backlog will be so big, appointments will take a long time in an already bogged down system.

Q7

a. Mental Health providers

DOH/Health Homes and OMH/Forensic Services increased the frequency of trainings and webinars done virtually to address the ongoing changes. For example, during the Pause, Health Homes of Upstate New York (HHUNY) changed their HUB meetings from once every three months to biweekly. Guidance continually changed and was sometimes disjointed and inconsistent. It became difficult to determine application to specific agencies/populations. Training guidance was not available until more COVID information became available. Some agencies might have benefited from more accurate and timely information. CDC guidance changed as scientific information changed. Social Media played a large role in conflicting information, including from various other states.

Q8

b. SUD and problem gambling service providers:

Need for technical training to ensure individuals and providers can appropriately engage and treat individuals in the future.

Q9

c. Developmental disability service providers:

The Governor’s Executive Order and OPWDD guidance provided abbreviated/refresher training and recertification to address the COVID-19 emergency response. Abbreviated training formats and alternate delivery methods for training, such as webinars, video recording and self-certification documentation (“read and sign”) was encouraged in accordance with meeting all training requirements.

Q10

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

INPATIENT (State PC, Article 28/31 Inpatient, Residential Treatment Facilities)	**No Change**
OUTPATIENT (Clinic, ACT, Day Treatment, PROS, Continuing Day Treatment, Partial Hospitalization)	**No Change**
RESIDENTIAL (Support, Treatment, Unlicensed Housing)	**No Change**
EMERGENCY (Comprehensive Psychiatric Emergency Programs, Crisis Programs)	**No Change**
SUPPORT (Care Coordination, Education, Forensic, General, Self-Help, Vocational)	**No Change**

Q11

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

No changes were seen in the demand for support type services.

Q12

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

INPATIENT (State PC, Article 28/31 Inpatient, Residential Treatment Facilities)	**No Change**
OUTPATIENT (Clinic, ACT, Day Treatment, PROS, Continuing Day Treatment, Partial Hospitalization)	**No Change**
RESIDENTIAL (Support, Treatment, Unlicensed Housing)	**Decreased**
EMERGENCY (Comprehensive Psychiatric Emergency Programs, Crisis Programs)	**No Change**
SUPPORT (Care Coordination, Education, Forensic, General, Self-Help, Vocational)	**Decreased**

Q13

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

A decrease was seen in the access to support type services with courts being put on hold or held virtually. Respite and HCBS services were either put on hold (respite) or done virtually (CFTSS/HCBS). It was also more difficult to connect individuals with placements (RTF's or CR, for example). Access was available through Telehealth, but disjointed approaches to sharing information and lack of information initially made it difficult for clients to know that access remained the same.

Q14

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

2

Q15

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

Two mental health programs limited operations due to COVID-19. In addition, one of those agencies restructured staff and combined programs due to COVID-19.

Q16

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

0

Q17

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

Some agencies provided services via TeleHealth, but some requested face-to-face visits, depending on circumstances or need for clarity of assessment, especially for new intakes or crisis situations.

Q18 **Yes**

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

Q19

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

The county-operated mental health clinics continued to provide services, a hybrid of both face-to-face and Telehealth. 70% of Clinic clients opted for Telehealth services during the pandemic. The county-operated Foundations for Change PROS Program continued to provide face-to-face services, as well as Telehealth; however, census decreased for group sessions during the COVID Pause for social distancing and consumer density compliance.

Q20 **No**

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

Q21

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

Respondent skipped this question

Q22

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

No

Q23

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

Respondent skipped this question

Q24

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

Yes (please describe):
Case Management and MTST (Mobile Transitional Support Team) used coordination and collaboration with treating providers to engage clients. Care Managers were able to participate in support of treatment during three-way calls and virtual Telehealth. In addition to this, providers were also willing to allow clients to use their internet access or phones in the event that a client did not have access to complete core services. Telehealth continues for the near future, as authorized by OMH. Agencies shared staff to provide services e.g. Meals on Wheels. Thrift Stores closed, so Cattaraugus Community Action could not provide clothing/household vouchers to obtain necessities. CCA obtained grant funds for phones and phone cards; Directions obtained grant funds to purchase tablets for consumers to use, as outlined below. Directions in Independent Living, Cattaraugus Community Action, Housing Options Made Easy, and Health Homes of Upstate New York each provided extra services to meet the needs of individuals under age 60, including food/meal delivery and assistance in obtaining technical means for virtual support. Directions in Independent Living secured grant funds to provide smart phones to 8 individuals and 46 pre-paid phone cards so that consumers had access to Telehealth and other services. Cattaraugus Community Action provided 2 phones and 5 unlimited phone cards to 3 clients, and they provided phone cards to 10 additional clients. Some school districts set up portable WiFi in various parts of communities for access to internet. Meals offered at schools, and some schools delivered meals directly door-to-door for families. Directions in Independent Living also obtained grant funds to provide 12 tablets to consumers. Cattaraugus County Department of Aging received additional funds to provide 14,500 meals each month through June to individuals aged 60 and over. Even after New York State began to reopen, Dept. of Aging delivered 14,200 meals to individuals in July. Cattaraugus Community Action also partnered with local restaurants to deliver prepared frozen meals to individuals in need.

Q25

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

No

Q26

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

8

Q27

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

All of the mental health providers in Cattaraugus County continued to provide services during the COVID Pause. The intervention changed from face-to-face to Telehealth, including telephone, texting, and videoconferencing, with the exception of injections (which remained face-to-face) and crises where the person needed to be seen face-to-face. All of these face-to-face instances included use of appropriate PPE, supplied by the Cattaraugus County Emergency Operations Center (OEM).

Q28

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

0

Q29

Respondent skipped this question

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

Q30

Both

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

Q31

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

The OEM and LGU assisted in obtaining PPE and other supplies so that the mental health providers could continue operations. The OEM and LGU also provided updates to the mental health providers, as information became available.

Q32

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

Program-level Guidance,

Telemental Health Guidance,

Infection Control Guidance,

FAQs,

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

OMH and CLMHD (Conference of Local Mental Hygiene Directors) provided daily guidance, but those documents were sometimes repetitive of DOH guidance. NYS expectations changed, which made it difficult for all three of the Oversight Agencies to put guidance and plans in place. OMH does not extend Telehealth until the very last second, so it's always a last-minute scramble to ensure patient engagement, even if face-to-face service is available. The State followed CDC Guidance, which was also available to providers through DOH. Even though Fiscal and Contract Guidance was available, the State puts a political agenda ahead of the pandemic response for adequately meeting the needs of the people we serve. The flood of information from all levels of state oversight precluded any FAQs; an answer one minute was quickly changed or updated the following day as new information and data became available.

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Q33

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

Prevention services are primarily school-based, and schools closed since March. Even community-based services, e.g. YMCA, are not available because facilities remain closed. With limited information about schools reopening or what will happen if another outbreak occurs, it is difficult to plan. Recovery Coach Services are also limited, and the majority of Telehealth was really safety checks. Safety checks were more successful because individuals could connect by Zoom and "tell providers whatever they wanted."

Q34

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

Prevention services were affected in both delivery and demand due to schools being closed. CAReS Director of Prevention, Rachel Linderman, continues to contact schools about delivery of prevention services. Schools are already worried about face-to-face "seat" time, so there may not be extra time available for prevention education in schools. CAReS staff are also prevented from going into the Jail, so those cases were closed and individuals will be readmitted if the Jail allows treatment in the future and the individuals are still in need.

Q35

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

Two individuals were referred to CAReS for gambling. Recovery efforts were limited to "check-in" and keeping spirits elevated because Coaches could not meet with individuals in person. Zoom meetings were not successful for individuals with little technical knowledge.

Q36

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

Two individuals were referred to CAReS for gambling, but CAReS had no gambling treatment services in place.

Q37

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

INPATIENT	**N/A**
OUTPATIENT	**Decreased**
OTP	**No Change**
RESIDENTIAL	**N/A**
CRISIS	**Increased**

Q38

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

Other Counties refused to accept patients from Cattaraugus County, but there was no increase in demand or need for inpatient. Seneca Nation noted OTP Suboxone was tricky in beginning because urine screens were needed – they continued to do COVID screens, everyone wore masks, and then continued to provide Suboxone in MAT. No escalation in requests or people "falling off" but services continued, "as is." When urine screens began again at CAReS, there was some pushback but individuals complied.

Q39

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

INPATIENT	**No Change**
OUTPATIENT	**No Change**
OTP	**No Change**
RESIDENTIAL	**No Change**
CRISIS	**No Change**

Q40

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

OASAS distributed a letter in December 2019 that agencies already approved for Telehealth could do separate policy & procedures to maintain Telehealth. CAReS will continue to offer Telehealth. OASAS Guides still indicate that Telehealth should still be the primary mode of engagement, but most providers are meeting face-to-face. CAReS Executive Director met with other providers from across the state and noted that most did not do well with Telehealth – initially the numbers of participation was high but then decreased as time went on. CAReS also just opened up a new Group menu that is limited to 10 people per group, so more groups are being offered to accommodate the need but to maintain just 10 individuals in a group limits accessibility. Seneca Nation Health Care reported their census doubled when they offered services via Telehealth.

Q41

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

Yes (please describe):
Seneca Nation implemented technology that will be used post-COVID, including TeleHealth, as long as permitted. Seneca Nation also enhanced technology to access people directly through medical records - to heighten patent access to care. CAReS also merged their EMR programs to include patient access, similar to Seneca Nation. Both agencies are providing more community-based services – looking to expand and reach out to other organizations that might want face-to-face services in community, as opposed to coming into the office – an expansion of mobile services.

Q42

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

Yes (please describe):
Seneca Nation partnered with Inpatient Reflections out of Buffalo – using them more because out-of-county inpatient facilities would not accept Cattaraugus County patients (with exception of Bradford MICA). CAReS also contacted WNY Council of Problem Gambling, as CAReS cannot provide that service on its OASAS license. That Williamsville, NY, provider might come to Olean to meet needs of two clients referred for help; however, CAReS may also need to transport those individuals out to their Williamsville site; will depend on what OASAS will permit.

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Q43

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

Yes (please explain):
1. Cattaraugus County has not conducted an analysis of the impact of COVID related to IDD services. It would be difficult to conduct an analysis on services that have basically halted, as noted in the below statements. Eligibility determinations are basically at a stand-still and will be delayed well into 2021, which ultimately impacts every other service delivery. Most other services remain in “Pause” or have restarted at reduced census or capacity.

Q44

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

Newly enrolled developmental disability population cannot access services at this time. With the closure of Article 16 clinics and testing places, they cannot receive OPWDD eligibility to gain access to services at this time. This puts both adults and kids in a holding pattern until these places and schools open back up. Even then, the backlog will be so big appointments will take a long time in an already bogged down system.
Community-Habilitation was not provided during the “Pause.” Community-Hab has restarted on a very limited basis, and some consumers are struggling with lack of face-to-face. Respite is also a concern due to lack of respite/providers during the past few months. Family Support Funding is now being used for Respite. Social Security meeting is scheduled in Buffalo to train for virtual hearings to determine eligibility. Admin Law Judges have difficulty determining eligibility with only telephone contact, so advocates have to request reconsideration for those cases. Clinics are not open to see people face-to-face and complete evaluations, so people going through OPWDD eligibility are at a “stand-still” statewide. Strong Memorial and Buffalo Hearing/Speech and Oishei Children’s Hospital and Robert Warner Clinics are all on extended wait time for assessments and appointments.
Care Coordinators are seeing consumers on a case-by-case basis, based on specific need to do face-to-face visits. Person Centered Services must approve face-to-face visits, and their Regional Director is approving those visits only for extreme needs. Prime Care’s Clinical Team is also approving face-to-face visits, requiring a COVID screening assessment before permitting any visit. Directions in Independent Living is also providing face-to-face on very limited basis, for some com-hab. Lack of technology and access to technology (computer, phones, etc.) is barrier to Telehealth. FRP moneys are being used for Respite. FSS Funds are also being used for recreational needs, as well as some tech assistance through the e-mod funding, which is matched 50% with fed funds. E-Mod process is significantly longer than the FSS process, but IDD may get more money through e-Mod.
Special Education Services at Schools remains a concern with the start of the 2020/21 school year. BOCES is providing a 5-day school week with self-contained classes, and most regular ed classes are a hybrid model. There are cases where IEP cannot be met 100% because a 10-minute cleaning break is needed between special therapy sessions. Kids need consistency, and sending them home mid-week for remote learning is an extra struggle, so parents are welcome to transport their children to the school on their scheduled “remote” days to ensure face-to-face learning. Some students have not participated in any way since March 16, 2020; so there is significant regression in those children. The virtual learning process significantly affects brain development and eye health. There may be long-term effects of trauma related disorders related to some home environments, having to wear masks and having limited public/social contact. Social/emotional support may supersede educational support in coming months. Union Contracts are also prohibiting progress to do best service for kids. One positive outcome from remote learning is that aide support is not needed to such a great extent in general education because class sizes are much smaller, and aides are then able to support other students with more flexibility based on level of need.
The clinic at Suburban Adult Services, Inc. (SASi) is operating with more in-person since day programs opened on a limited basis. Families can return to work when I/DD family members can return to programs. Consumers do not want to wear the mask, so they are participating outdoors as often as possible. As noted by other agencies, changes in PPE requirements also financially burden SASi and their I/DD consumers. If any staff has any symptoms, even if not tested positive for COVID, the staff is required to quarantine for 14 days, along with any individuals they have contacted directly, which puts another burden on service delivery. About 170 individuals are back in programs among the 8 SASi sites as of 09/10/2020. Supported workers lost their jobs at the onset of COVID, and OPWDD is not comfortable with them getting new jobs – OPWDD is only permitting “discovery” rather than “getting the new job,” which is frustrating for the individuals. SASi is also struggling to hire new staff – minimal direct support professionals are applying for openings. In-Home Respite was not being approved (staff actually going into and staying in the home), so those staff are providing a “Day-Hab” service in the home as a means to work through the system to provide adequate support to families/individuals.
Eligibility testing results are outdated, sometimes by 5-6 months, and OPWDD will not accept outdated results for Eligibility Criteria, even if only outdated by 1 day or week. Many families are waiting for psych evaluations and assessments, which means they are not getting any services. OPWDD is sticking strictly to testing requirements, not recognizing that clinics are not open or appointments are backed up 6 months. A large number of families cannot even access the “Front Door.” In one instance, OPWDD denied an individual’s assessment because it was 1 week older than the time limit, and the individual cannot get another test for at least 5-6 months. When things finally start to open up, there were will be a flood of people who need services. The Cattaraugus County Developmental Disabilities Subcommittee suggested OPWDD establish a “provisional eligibility,” using the assessments and evaluations available at this time and requiring updated assessments before a provisional deadline, perhaps 18 or 24 months from the date of “provisional eligibility.” Even if the assessments are outdated (and not accepted), they do support evidence of need. If people cannot get eligibility,

they continue to stay at home without services. It is a statewide problem, and Care Coordinators noted that some larger school districts simply do not answer the phone anymore to provide assessment information because none of the information is updated or acceptable to OPWDD. Olean City Schools CSE Chair noted they are also trying to catch up on all the assessments that would have been due in March, April, May, and June 2020. Now that the new school year has started, the 2021 assessments will also be due. Additionally, Cattaraugus County and the entire Western New York region must face the following challenges in the coming months:
- Residential screening and placements were paused initially and have resumed gradually as OPWDD and all providers continue to maintain necessary COVID precautionary measures.
- Day services were initially paused with the onset of the pandemic. Providers were flexible in delivering day services such as on-site in residential setting and via telehealth. OPWDD agencies were provided with site-based day services re-opening guidance compliant with all necessary COVID-19 precautions (social distancing, PPE, disinfecting/cleaning, signage, etc.). Agencies are gradually implementing site-based day program re-opening plans.
- OPWDD respite services were limited with the onset of COVID-19 and the need for necessary precautions. Various types of in-home or on-site respite services are gradually becoming more available.
- There has been an increase in requests for Family Support Services (FSS) respite reimbursement to meet the needs of individuals residing with families and to meet the needs of children (re: unable to attend school).
- As noted, OPWDD has seen an increase in hospitalizations, psychiatric destabilization, homelessness, mental health problems, and in the need for crisis services. Insufficient cross system and community supports has increased the burden on working families, family dynamics, and with fully meeting the needs of individuals with highly complex medical, psychiatric and behavioral needs.
- OPWDD provided guidance to Care Coordination providers to assist with safely delivering services during the pandemic (both face-to-face and via Telehealth) to ensure individual's service needs were met and to ensure emergency needs were identified and addressed.
- OPWDD provided guidance to providers to ensure individuals can be safely transported to critical services and to accommodate the reopening of day services.
- OPWDD does not provide personal care aide/assistance support.
- It will be necessary to maintain all COVID-19 precautions and flexibility in service delivery for the duration of the pandemic. The impact noted above will continue be prevalent for I/DD individuals and their families. Continued efforts of providing cross system services and supports will be critical to I/DD individuals and their families.

Q45

Respondent skipped this question

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

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Q46

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

Unfunded mandates are out of control, including DOH changes in PPE allowances and requirements. Agencies make decisions one day to ensure compliance with safety requirements, and the regulations and guidance changes the following day, so there is a huge amount of waste. For example, schools obtained gator-type masks for students based on reopening plans submitted and approved by the State, but then Department of Health stipulated, after schools purchased the masks, that they were no longer appropriate PPE and not permitted for student use. "Building the plane in the air" does not give agencies the opportunity to balance budgets, which ultimately affects the provision of quality services.