



Office of
Mental Health

Office of Alcoholism and
Substance Abuse Services

Office for People With
Developmental Disabilities

2020
Local Services Plan
For Mental Hygiene Services

Chemung County Mental Health
September 5, 2019

Table of Contents

| Planning Form | LGU/Provider/PRU | Status |
|--|-------------------------|------------------|
| Chemung County Mental Health | 70190 | (LGU) |
| Executive Summary | Optional | Certified |
| Goals and Objectives Form | Required | Certified |
| New York State Prevention Agenda Survey | Required | Certified |
| Office of Mental Health Agency Planning (VBP) Survey | Required | Certified |
| Community Services Board Roster | Required | Certified |
| Alcoholism and Substance Abuse Subcommittee Roster | Required | Certified |
| Mental Health Subcommittee Roster | Required | Certified |
| Developmental Disabilities Subcommittee Roster | Required | Certified |
| Mental Hygiene Local Planning Assurance | Required | Certified |

2020 Mental Hygiene Executive Summary

Chemung County Mental Health

Certified: Brian Hart (7/25/19)

Our Developmental Disability Committee, with the full support of the Community Services Support recommended that that we provide brief comment on a significant barrier with regard to the ongoing housing issue. While we are realistic, and recognize that for OPWDD, housing is often a lifetime commitment,, the eligible individuals from that system in need of such services are in desperate need of access. However, local planning is in fact not local, but regional at best. In the Finger Lakes region their are approximately 600 emergent and/or urgent individuals based on the priority ranking system. However, most of those are from Monroe County, some 1 1/2 hours away, and we have to wait for declinations, which is a laborious process before we can finally consider any local needs. We would ask that this process be evaluated, and that local availability be able to be utilized locally utilizing the prioritized individuals in the the community.

In addition, we are seeking regulatory reform from OPWDD in a parallel process to that of telemedicine that they have approved in the Article 16 clinics to extend to CCO organizations for use on periodic require "face to face" visits, especially in the rural communities where the workforce demands are so limited and travel time decreases the availability of direct care time.

With those recommendations out of the way, you will note that our plan once again addresses the continuing need for housing across all three disability systems.

This time, for the first time in the 15 years that I have been in this role, we are formally addressing workforce as a goal in that it has become virtually impossible to find, and sustain staff at every level, in all systems regardless of if they work for the state, county, or for local not-for-profit agencies. This is not unique to Chemung, and we recognize that fact, but if we don't address it, we will continue to have individuals seeking services that can't be met.

Mental Hygiene Goals and Objectives Form
Chemung County Mental Health (70190)
Certified: Brian Hart (4/24/19)

1. Overall Needs Assessment by Population (Required)

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

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

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

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

The demand for children and youth acute care beds has risen, which historically wouldn't have been as noticeable, but since the closure of St. James the region has been dramatically impacted. For example, in 2017, the Elmira Psychiatric Center processed approximately 1,000 requests for adolescent admissions from the region, and admitted approximately 125.

It has been helpful to have the RCE/Long Stay beds between Catholic Charities and Arbor Development in support of our housing continuum that includes a homeless shelter, OMH licensed community residence for youth, group for adults, supported and supportive housing. However, we struggle having any movement in the RCE/Long Stay beds as the guidance from OMH is contradictory. Some believe that individuals should never lose these supports, and others believe that as part of recovery we should be encouraging them to stay in the apartment of their choice, but remove housing supports entirely or replace them with health home care management.

The Elmira Psychiatric Center and Family Services have both added Nurse Practitioner services in support of former long term stay patients now residing in regional skilled nursing facilities within the region. They do this in a collaborative manner with one another, the MIT team and the nursing facilities medical staff. This service ended in December of 2018 after all parties agreeing that we should convert this to a billable service between the skilled nursing facilities and Family Services. Unfortunately, at the end of 2018, this program closed after realizing that this program should be converted to a billing service. The funds have been reappropriate to a service to address individuals who are in crisis, but don't meet the need for a psychiatric admission, and still have some unmet needs. IN these cases where a few hours of additional supports in their home could benefit them if a peer specialist spent time with them, or they could utilize a adult respite location for up to 7 days assuming they have a place to return to, then they can be referred to the **Brief Respite in your own Environment And Temporary Help with live stressors (BREATH) program.**

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

Fast forward to 2019, and the demand has not changed. Children continue to often spend days at a time on an ER gurney and far too often end up being discharged after the symptoms have dissipated over time. Clearly NOT ideal mental health treatment, as they truly don't receive treatment during their stay in a non-CPEP licensed ER.

Movement in our adult housing remains slow, and therefore, admissions into the apartment programs has been somewhat limited over time. In 2018, there were 6 admission to the RCE and Transiional beds out of 41 referrals with 13 discharges averaging 15 1/2 month stays, with 16 individuals awaiting placement as of the February 2019 report. Our Long Term Stay/MRT housing saw 2 admissons and 3 discharges for the 10 beds in 2018. The supportive housing program had 11 admissons and 13 discharges in that year. The majority of the movemnet that typically services approximtely 100 mentally ill adultes was the supported housing program in 2018, which had 39 admissions and 37 discharges, and 18 awaiting housing based on the February report..

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

The availability of professional staff is at an all time worst to the point that some agencies have considered closing down programs and/or have been out of compliance with expectations such as clinical staff assessing mental health needs in the jail after hours as some of our crisis team are MSWs waiting to take their license.

Acces to state intermidate care has become extremely difficult, as it is now required to have a Treatment Over Objection (TOO) order for all cases and they want them "satbilized" prior to transfer, and the latter of which eems to defy the logic of the need for transfer. The TOO requiremen tis also palcign an increased finacial burdenon the 9.39 hosptial system.

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

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

Trinity's youth clubhouse is up and operational with enrollment of approximately 275 youth and daily attendance of 20-25 members who make up their advisory council. Youth are reporting tremendous benefit from having this option in their life, and have embraced period joint events with family members as well with minimal resistance. The number of youth using the progrma at least once a month in 2018 has averaged 95, clearly challenging the staffing model of three.

In response to the Heroin/Opioid epidemic, we created a regional coalition referred to as the Substance Abuse Regional Alliance (SARA). Participation has been tremendous and it focuses on treatment access, social determinants as barriers to success, and public messaging as well as the development of a phone application. The commrcials have been compleetd and are being shared with other commnities as well as being prepared for local airing. The FREE phone application is planned for relaese later this eyar.

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

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

We had hoped to open a recovery school in a collaborative arrangement between BOCES and Trinity, but the local school districts were not supportive.

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**:

The new Care Coordination Organizations (CCO) are up and running in place of the former Medicaid Service Coordination (MSC). However, as we heard directly from CCO representatives when having them recently join our Developmental Disability Committee, there a multitude of problems. They reported having issues where people were unable to get ahold of their care coordinators. They have been doing a good job of working through all the issues and OPWDD is extending deadlines. They are worrying that families are getting turned off with having to do too many assessments and the consumers will have assessment fatigue. Life plans have started, but they can't enter anything in the system because it's not set up. There is no clear guidance, and waiver providers are having a hard time working on the differences. Everyone is learning and working together so services are not interrupted. When this new system started, they were never provided with cell phone numbers or emails to providers, so they could be contacted. OPWDD had a different guidance than the waiver program. They need to sit at the table and all hear the same information on the rules. OPWDD is having forums across the state and providers can attend these forums, but are not allowed to speak at them. There were some technical issues but it was found that mediskid was the route of those problems. Care Coordinators are often left out of the loop. When they are involved, there have been lost emails and phone numbers. It took time to make those connections. While consumers are waiting they are assigned a care coordinator, but no services are being provided because they would have to pay for them. They can attend play groups/dances/adult group/tween group which are 1 day a week. They are just a handful of programs they can access while waiting. One thing that they were worried about is families having to deal with all the changes and having a different care coordinator, but they didn't have to change.

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

This statement from last year, continues to be true...."far too often children find themselves in need of services, but they don't meet OPWDD criteria, and/or aren't eligible for special education services as determined by either the Committee on Pre-school Special Education (CPSE) or the Committee on Special Education (CSE). As a result, families are left with trying to pay for clinical services out-of-pocket, or opting to have their child not receive services entirely."

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

See what **needs improvement** above.

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

2. Goals Based On Local Needs

| Issue Category | Applicable State Agenc(ies) | | |
|--|-------------------------------------|-------------------------------------|-------------------------------------|
| | OASAS | OMH | OPWDD |
| a) Housing | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| b) Transportation | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| c) Crisis Services | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d) Workforce Recruitment and Retention (service system) | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| e) Employment/ Job Opportunities (clients) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f) Prevention | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| g) Inpatient Treatment Services | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| h) Recovery and Support Services | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| i) Reducing Stigma | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| j) SUD Outpatient Services | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| k) SUD Residential Treatment Services | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| l) Heroin and Opioid Programs and Services | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| m) Coordination/Integration with Other Systems for SUD clients | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| n) Mental Health Clinic | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| o) Other Mental Health Outpatient Services (non-clinic) | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| p) Mental Health Care Coordination | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| q) Developmental Disability Clinical Services | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| r) Developmental Disability Children Services | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

| | | | |
|---|--------------------------|--------------------------|--------------------------|
| s) Developmental Disability Student/Transition Services | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| t) Developmental Disability Respite Services | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| u) Developmental Disability Family Supports | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| v) Developmental Disability Self-Directed Services | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| w) Autism Services | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| x) Developmental Disability Front Door | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| y) Developmental Disability Care Coordination | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| z) Other Need 1(Specify in Background Information) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| aa) Other Need 2 (Specify in Background Information) (NEW) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| ab) Problem Gambling (NEW) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| ac) Adverse Childhood Experiences (ACEs) (NEW) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

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

2a. Housing - Background Information

Supply vs. demand continues to be a huge barrier to structured housing options when considering licensed housing across all three disability populations. While we appreciate efforts by all three state agencies in the past couple of years to increase community housing options, major gaps remain.

We are tremendously appreciative of the addition of more long stay beds from OMH and the newest funded project by OASAS allowing for CASA of Livingston (dba: Trinity of Chemung) to build a 20-bed Part 816.7 Medically Supervised Withdrawal and Stabilization facility in collaboration with Glad Tidings Christian Life Church (dba: The Journey Center), who operates two unlicensed family care look alike homes for adults with substance abuse issues.

As noted above there is little to no movement in much of the OMH licensed housing options.

Other than the planned mandatory conversion of ICF's to IRA's for OPWDD licensed housing providers, development of housing has been minimal. The unbundling of clinical services in these residential options presents significant challenges.

AIM is in the development of an approved mixed housing projects that will slightly increase the capacity for the IDD population.

The ARC of Chemung has been approved to open a four plus one (respite) IRA for young adolescents. In addition, Housing Visions is completing a project with 45 unlicensed apartments and seven of which will be set aside for ARC referrals.

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

Develop new housing options that are either licensed by one of the three state agencies, or utilize an unlicensed approach for individuals with mental health, substance abuse and/or developmental disability diagnosis including but not limited to mixed use options.

Objective Statement

Objective 1: Assist with any and all necessary components required to move individuals who meet the criteria and/or self-identify as being prepared for transitioning to a less restrictive environment.

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

Objective 2: Develop more congregate care housing as well as community based affordable housing options.

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

Objective 3: Expand upon respite options.

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

Objective 4: Develop supported housing including but not limited to mixed use options.

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

Objective 5: Need more support from the state to address the need of additional supervised housing.

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

Change Over Past 12 Months (Optional)

Objective #1- These discussions continue, but as noted above there is mixed guidance from OMH, but the discussion should be re-visited form a recovery focus with an emphasis on identifying financial supports to enable the consumer to stay int heir apartment, but remove the staffing supports. The ICF's are being converted to IRA's as noted, but more pork continues on the rate structure.

Objective #2- This needs to be revisited with current leadership of the half-way house.

Objective #3- We have added the BREATH program for adults with mental illness, but it is not fully operational yet. We need a respite/sobering

up station option for individuals with substance abuse issues.

Objective #4- Funding has been approved for a facility within the county for several projects, but more are needed in the next few years.

Objective #5- Intent is to consider a Family Care like model, and/or revisit a concept from previous local plan of encouraging providers to become landlords with pushed in multi-agency case/care management services to an unlicesecened apartment building. At least one of these locations needs to take into consideration the need for ADL skill development for those moving an apartment for the first time.

2b. Transportation - Background Information

Changes in the public transportation system have made it difficult for many consumers to make their appointments in a timely manner, and for those individuals who have a disability, but have a work schedule in the evenings and/or weekends, transportation is next to impossible or non-existent. Changes continues, as the previous problems were related to fewer routes, now they have moved to the soon to be implemented SMART TAP bus card that is dependent on the need for the consumer to have an e-mail, and this has created a multtitude of issues yet to be resolved.

In additon, one the local 9.39 Emergency Room will be closing, and all emergency services will be re-directed to its sister ER 2 miles across town. This will likely create a significant transportation issue, as many empoverished individuals live in and around the ER that is closing this year.

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

Develop or join an existing a coalition of local human service agencies as well as those involved in the provision of public transportation to determine the scope of the problem and develop a strategic plan for any possible recommendations. This could include such options as the development and implementation of a robust volunteer driver program to assist in filling the gaps in the current transportation menu of options. The rural nature of our area combined with the low incomes of those with disabilities and the elderly make a volunteer driver option a good alternative for those who are currently under served.

Objective Statement

Objective 1: Assemble or join an existing a coalition/task force.

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

Objective 2: Track scope of the problem throughout the year.

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

Objective 3: Evaluate and implement alternative options.

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

Objective 4: Add tracking of barriers/problems with use of new SmartTap card system as standing item to all committee agendas.

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

Change Over Past 12 Months (Optional)

NEW

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

For the first time in over 15 years, not just one, but all three committees identified the lack of workforce as a significant issue.

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

Pursue options for proactively linking to high schools and colleges to promote the field of healthcare. Develop approaches for enticing new staff and sustaining existing employees.

Objective Statement

Objective 1: Develop videos with use of staff from multiple agencies to promote healthcare field, and report vacancies to NYS Dept. of Labor..

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

Objective 2: Promote the healthcare filed through career day events, engaging local high schools and colleges.

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

Objective 3: Develop career track document to define path for achieving employment in the field, and advocate enhanced wages and benefits for all staff in the field.

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

Objective 4: Evaluate loan forgiveness programs, shared staffing models and other incentive options for all employers.

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

Objective 5: Explore options of reimbursement for college in exchange for commitment to continued employment with their agency.

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

Change Over Past 12 Months (Optional)

NEW

2g. Inpatient Treatment Services - Background Information

So many of the 1000+ plus admissions to the psychiatric unit at St. Joseph' hospital psychiatric unit, and their 350+ admission to their substance abuse rehab unit are dually diagnosed, but are rarely transferred form one department to the other. Likewise, in absence of a dual diagnosis program, they don't receive concurrent treatment during their hospitalization.

Far too often children and adolescent sit for days on ER gurneys awaiting psychiatric placement, and when that doesn't occur, they are eventually determined to no longer meet medical necessity for psychiatric admission .

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

Develop and implement a psychiatric assessment training program for staff in both Emergency Rooms, the Behavioral Health Assessment Team (BHAT).

Continue to enhance use of crisis and peer services especially following overdoses to connect individuals to treatment and avoid unnecessary ER visits.

Cross train staff on the Behavioral Sciences Unit (BSU) and on New Dawn to be able to provide dual recovery treatment at either and/or both locations.

Address the need of children and adolescents presenting with psychaitric presentations in the emergency room.

Trinity of Chemung will connect with individuals while receiving acute substance abuse treatment, and work collaboratively with staff to assure that all available community based needs are met at discharge including but not limited to social determinants of health such as housing, ability to obtain medications, and addressing treatment and support needs such as health home care management and peer services if offered in the respective discharge community.

Objective Statement

Objective 1: Explore options for alternatives to Emergency Department visits and behavioral health hospitalizations including but not limited to enhanced utilization of the mobile crisis team.

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

Objective 2: Train all ER, BHAT staff to provide a comprehensive emergency psychiatric assessment, and to utilize of a community resource guide.

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

Objective 3: Explore options for opening an additional children and youth acute unit to complement the existing service at the Elmira Psychiatric Center.

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

Objective 4: Assure that all staff on New Dawn rehab are cross trained with FIT modules, and initiate Dual Recovery groups.

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

Change Over Past 12 Months (Optional)

Objective #1- As a part of the DSRIP efforts, a greta deal of effort has been palced on enahcing communication about ER visists, and follow up post ER visists. In addition, an RFP has been approved by OMH, OASAS and DOH to merge assest of the two local hosptials allowing them to be consiered one, laying the gorund work for all 9.39 oresentations to start occurring at Arnot Hospital's ER at some poitin in 2019, while keeping the psychaitric inpatient and acute rehab soem two miles away at St. Joe's hospital.

Objective #2- Considering Objective #1, this has made Objective #2 that much more critical. To that end, the residents rogram has been beneficial, by nto only having a precences, but by hiring a psychiatrist assigned to the ER service, who amongst other things is sperheading the efforts of assuring competency amongst staff.

Objective #3- New

Objective #4- New

2j. SUD Outpatient Services - Background Information

Historically off-site clinical services were not permitted, so outpatient clinical services were limited to the locations of the local clinics. In the past few years, CASA of Livingston dba: Trinity of Chemung took over the clinical services from ADRC and St. Joseph's Hospital, and now

provides outpatient clinical services to approximately 500 unduplicated individuals a month. In 2018 they were providing services at the county jail and in a primary care office, but not through a formal satellite licensure process. Therefore, their productivity numbers are down and could result in the need for a corrective action plan. However, limited funding has been awarded to Trinity for jail based funding starting in 2019.

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

Address use of jail based of services funds to the best of our ability allows, and space is limited in the jail.

Integrated care has been challenging based on the design presented by NYSDOH, as article 28 clinics are actually prohibited from co-locating with article 31 or article 32 clinics without some major concessions. Therefore, locally we have had to become quite creative in dressing these needs, by using private practice providers with article 28 clinics, and/or having article 31/32 clinics in close proximity without co-locating.

Objective Statement

Objective 1: Utilize funding in the jail to its fullest capability.

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

Objective 2: Open satellite clinics in close proximity to primary care and mental health clinic settings.

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

Change Over Past 12 Months (Optional)

Objective #1- New

Objective #2- In discussions with Arnot and Family Services.

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

There is concern about a pattern amongst some of the chronic mentally ill population with regard to not following their medication regime, resulting in decompensation, and repeated unnecessary hospitalizations.

With regard to the provision of substance abuse services, families are rarely actively engaged in the support of their loved ones in treatment, despite the benefits from such.

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 a respectful manner of engaging the chronic mentally ill to choose to become compliant with their medication regime as prescribed without pursuing AOT orders.

Objective Statement

Objective 1: Utilize the Mobile Integration Team as Transition Coordinators between inpatient and outpatient

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

Objective 2: Encourage prescribers to consider more long acting injectable medications, and utilization of home visiting nursing services.

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

Change Over Past 12 Months (Optional)

The goal and objectives are new.

2r. Developmental Disability Children Services - Background Information

Far too often children find themselves in need of services, but they don't meet OPWDD criteria, and/or aren't eligible for special education services as determined by either the Committee on Pre-school Special Education (CPSE) or the Committee on Special Education (CSE). As a result, families are left with trying to pay for clinical services out-of-pocket, or opting to have their child not receive services entirely.

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

Identify the scope of the problem, and determine barriers that need to be addressed including but not limited to, accuracy of information being provided to decision making bodies, addressing workforce issues, and identifying alternative funding....

Objective Statement

Objective 1: Gather data indicating the frequency of youth not meeting criteria with OPWDD, CPSE and/or CSE committees.

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

Objective 2: Determine what if any barriers exist for approval of services, and develop strategic plan to address sustainable solutions.

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

Objective 3: Formulate a cross systems stakeholders meeting to consider use of alternative supports such as Family Support Services, Unified Children's waiver and OMH SPOA services for Early Intervention age Youth that are too young to meet OPWDD criteria, but have unmet needs.

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

Change Over Past 12 Months (Optional)

No progress has been made on Objectives 1 and 2.

Objective #3- New

New York State Prevention Agenda Survey
Chemung County Mental Health (70190)
Certified: Brian Hart (4/24/19)

The following survey is intended to promote alignment with the NYS Prevention Agenda for 2019-2024 as part of local services plan development.

All inquiries regarding this survey should be directed to oasasplanning@oasas.ny.gov.

Background

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

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

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

Questions

1. Has your LGU developed a plan that aligns with the Statewide Prevention Agenda?

- No
- Yes, please explain:

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 e) 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 Prevention 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 – 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:

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:

The DCS is a Board member of FLPPS, HHUNY and the S2AY Rural Health Network, in addition to facilitating a regional/multi-state coalition known as the Substance Abuse Regional Alliance (SARA).

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 DCS has a long history of tracking local data since 2014 by obtaining monthly data directly from providers about all 80 programs that he oversees. In addition, he has kept maintained a timely data system on suicide attempts and completions, as well as opioid overdoses and fatalities. The latter has allowed us to recognize a trend away from heroin and a significant decrease in fatalities starting mid 2017, long before other counties in the region were reporting any ability to notice these trends even if they were using ODMAP, which many hadn't started using by that point.

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

No

Yes, please explain:

As reported in the region and to the "O" agencies as well as DOH, one of the barriers to the prevention agenda is that it isn't coordinated with 5.07 planning, and in fact, DOH predetermines what categories the prevention agenda should address as if those are the only areas needing attention across the state, and limit the localities to how many they can choose. Other than this document, there is no integration of the 5.07 planning process with the local prevention agenda. At the state level, do you bring the plans together? Recently, I sat through our Prevention Agenda planning process, and the large group (approximately 30) of participants, despite much discussions to the contrary, decided that mental health and substance abuse are the top two agenda needs utilizing the less than scientific method of rating information based on the knowledge of those doing completing the rating form without background data as to what the needs actually are. As a result the local DOH isn't sure how to proceed, and has asked to have a follow-up meeting with the LGU.

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:

Unable to answer at this point.

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:

Unable to answer at this point.

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:

Integrated care was a fantastic concept in theory, if DOH had actually worked harder with CMS to allow for true integration of article 28 and 31/32 clinics. This is a huge missed opportunity for our shared consumers! LGU could continue to support expand methods of interoperable methods of communication amongst providers to minimize redundancy, treatment no shows and cancellations and unnecessary ER visits.

9. Aside from Prevention Agenda activities, please identify any of the following social determinants of mental health that you are addressing in your community:

- | | |
|---|---|
| <input type="checkbox"/> Un/Underemployment and Job Insecurity | <input type="checkbox"/> Poor Education |
| <input type="checkbox"/> Food Insecurity | <input type="checkbox"/> Poverty/Income Inequality |
| <input type="checkbox"/> Adverse Features of the Built Environment | <input type="checkbox"/> Adverse Early Life Experiences |
| <input checked="" type="checkbox"/> Housing Instability or Poor Housing Quality | <input checked="" type="checkbox"/> Poor Access to Transportation |
| <input type="checkbox"/> Discrimination/Social Exclusion | <input type="checkbox"/> Other |

Please describe your efforts in addressing the selections above:
See efforts defined in more detail within the Goals and Objectives section of the plan.

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): We just started to work with Southern Tier Kids on Track to show, Resilience: The Biology of Stress the Science of Hope, followed by a facilitated discussion.

How many hours: 2

Target audience for training: DSS and Human Service agencies in general

Estimate number trained in one year: 5

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:

We have an embedded staff person from the mental health clinic in the Office for Aging and Long Term Care. In addition, the mental Health clinic

provides a specific track of services for the geriatric population and reports out on this program to the county on a monthly basis.

Office of Mental Health Agency Planning (VBP) Survey
Chemung County Mental Health (70190)
Certified: Brian Hart (4/4/19)

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:

Most of the support has gone to the healthcare system in town, and the primary outpatient mental health clinic. It hasn't necessarily successfully addressed gaps such as post hospital visits within 7 or 30 days, for example, as those numbers are still very poor in the community. For example, only an average of 64% were seen within 30 days in 2018.

2. Has your LGU planned for PPS project sustainability beyond March 31, 2020?

a) Yes No

b) Please explain:

In some cases we have done so via collaborative arrangements that will outlive PPS funding and guidance, such as locating article 28 and article 31 in the same building, but on different floors to enhance access for consumers, or addressing this integrated approach by bringing private practitioners into article 28 locations.

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):

Two Agencies are participating members with FLIPA and FLST BHCC. FLIPA is in VBP negotiation as a provider network with Fidelis Care and Excellus. As part of FLIPA and FLST BHCC-related activities funded through funding agreements with FLPPS, they both participate in DSRIP Initiative Projects (e.g., DY5 JOG, Health Engagement, and OES) aimed at closing healthcare indicator gaps (using PSYCKES and CCSI consultants) in preparation for VBP contracting. The Mental health clinic has incentive-based contract arrangements with Fidelis Care and I-Circle related to Clinical Healthcare Outcomes (7-day/30-day FUMH post Inpatient Discharge Home Visit Care and MLTSS) as precursors to VBP contracting. FLST BHCC is in the process of becoming an IPA. Separately, the mental health clinic has also received FLPPS System

Transformation Funding for its own VBP Readiness activities focus on EHR and HIT-HIE development, with consultation provided by HMA.

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:

FLPPS funded a Peer Network Project—with Catholic Charities of Chemung and Schuylar County as the lead agency and participation by multiple other community partners—aimed at recruitment and certification of 12 Peer Empowerment Support Specialists for placement with community agencies over a three year period. A local mental health clinic is working with a different Care Compass Network, another regional PPS funded project headed by Trinity of Chemung, Inc., aimed at closing the healthcare indicator gap for dually diagnosed individuals with two or more BH ED and/or Inpatient Stays in the last twelve months.

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

a) Yes No

b) Please explain:

Most of the agencies are not even familiar with what an ILS is.

6. Can your LGU support the BHCC planning process?

a) Yes No

b) Please explain:

Not invited to the table as we don't provide any direct services.

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:

Minimally in that the county has been putting outcome sin provider contracts for years. Each month the providers report out in an Excel spreadsheet on the various programs across all three disability areas for nearly 80 programs to the LGU. Any with state aid absolutely have outcomes, and our QA Department audits the program annually with the agency and demands a plan of corrective action to address any deficiencies in obtaining the outcomes. As the LGU, I have been trying to prepare the community based organization for several years by making sure they have electronic record keeping systems, and encouraging them to assure that those systems have the flexibility to add measurement of new outcomes fairly quickly and at minimal expense to keep up with the demand of MCOs, or they will not be prepared sufficiently for VBP, and will likely loss money and/or close their agencies.

Community Service Board Roster
Chemung County Mental Health (70190)
Certified: Brian Hart (4/24/19)

Note:

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

| | | | | |
|---------------------------------|---|--|---------------------------------|--|
| Name: David Andrienne | <input type="checkbox"/> Physician <input type="checkbox"/> Psychologist | Represents: CIDS | Term Expires: 12/2020 | Email Address: davida@cidsfamilies.com |
| Name: Rosemary Anthony | <input type="checkbox"/> Physician <input type="checkbox"/> Psychologist | Represents: CCC | Term Expires: 12/2019 | Email Address: rosemary.anthony.ra@gmail.com |
| Name: Joe Cevette | <input type="checkbox"/> Physician <input type="checkbox"/> Psychologist | Represents: Pathways | Term Expires: 12/2019 | Email Address: jcevette@pathwaysforyou.org |
| Name: Rene Snyder | <input type="checkbox"/> Physician <input type="checkbox"/> Psychologist | Represents: AIM | Term Expires: 12/2020 | Email Address: rene@aimcil.com |
| Name: Jennifer Emery | <input type="checkbox"/> Physician <input type="checkbox"/> Psychologist | Represents: Family Services of Chemung | Term Expires: 12/2020 | Email Address: jemery@familyservices.cc |
| Name: Michelle Pavillard | <input checked="" type="checkbox"/> Physician <input type="checkbox"/> Psychologist | Represents: Private Practice | Term Expires: 12/2021 | Email Address: mpavillard@stny.rr.com |
| Name: John Alves | <input checked="" type="checkbox"/> Physician <input type="checkbox"/> Psychologist | Represents: Arnot Healthcare | Term Expires: 12/2021 | Email Address: jalves@ah.arnothealth.org |
| Name: Ellen Topping | <input type="checkbox"/> Physician <input type="checkbox"/> Psychologist | Represents: Catholic Charities | Term Expires: 12/2023 | Email Address: ellen.topping@dor.org |
| Name: Lisa Alger | <input type="checkbox"/> Physician <input type="checkbox"/> Psychologist | Represents: Able 2 | Term Expires: 12/2020 | Email Address: algerl@able-2.org |
| Name: Tara Fethers | <input type="checkbox"/> Physician <input type="checkbox"/> Psychologist | Represents: Trinity of Chemung | Term Expires: 12/2023 | Email Address: tfethers@casa-trinity.org |
| Name: Heather Hargraves | <input type="checkbox"/> Physician <input type="checkbox"/> Psychologist | Represents: Arbor Development | Term Expires: 12/2021 | Email Address: hhargraves@arbordevelopment.org |
| Name: Michelle Johnson | <input type="checkbox"/> Physician <input type="checkbox"/> Psychologist | Represents: YWCA | Term Expires: 12/2021 | Email Address: michelej@ywcaelmira.org |
| Name: Lori Murphy | <input type="checkbox"/> Physician <input type="checkbox"/> Psychologist | Represents: Elmira Psychiatric Center | Term Expires: 12/2020 | Email Address: lori.murphy@omh.ny.gov |
| Name: Sean Eagan | <input type="checkbox"/> Physician <input type="checkbox"/> Psychologist | Represents: ARC of Chemung | Term Expires: 12/2022 | Email Address: EagenS@arcofchemung.org |

Name: Alan Yeck

Physician

Psychologist

Represents:
Corning
Community
College

Term Expires:

Email Address:
ayeck@corningcc.edu

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

Indicate the number of mental health CSB members who are parents or relatives of persons with mental illness:

Alcoholism and Substance Abuse Subcommittee Roster
Chemung County Mental Health (70190)
Certified: Brian Hart (4/3/19)

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.

| | | | |
|------------------------------------|--|---|--|
| Name: Jennifer Emery | CSB Member: <input checked="" type="radio"/> Yes <input type="radio"/> No | Represents: Family Services of Chemung | Email Address: jemery@familyservices.cc |
| Name: Tara Fethers | CSB Member: <input checked="" type="radio"/> Yes <input type="radio"/> No | Represents: Trinity of Chemung | Email Address: tfethers@casa-trinity.org |
| Name: Lisa Wilson | CSB Member: <input checked="" type="radio"/> Yes <input type="radio"/> No | Represents: Salvation Army | Email Address: lisa.willson@use.salvationarmy.org |
| Name: Glenn Jarvis | CSB Member: <input checked="" type="radio"/> Yes <input type="radio"/> No | Represents: St. Joe's-New Dawn | Email Address: GJarvis@arnohealth.org |
| Name: Linda Gabrielli-Waite | CSB Member: <input checked="" type="radio"/> Yes <input type="radio"/> No | Represents: Retired | Email Address: lgwaite@stny.rr.com |
| Name: Ellen Topping | CSB Member: <input checked="" type="radio"/> Yes <input type="radio"/> No | Represents: Catholic Charities | Email Address: ellen.topping@dor.org |
| Name: Nick Moffe | CSB Member: <input checked="" type="radio"/> Yes <input type="radio"/> No | Represents: AIM | Email Address: nmoffe@aimcil.com |
| Name: Dr. John Alves | CSB Member: <input checked="" type="radio"/> Yes <input type="radio"/> No | Represents: Arnot Healthcare | Email Address: jalves@ah.arnohealth.org |
| Name: Desiree Rogers | CSB Member: <input checked="" type="radio"/> Yes <input type="radio"/> No | Represents: NYS Drug Court | Email Address: dsrogers@nycourts.gov |

Mental Health Subcommittee Roster
 Chemung County Mental Health (70190)
 Certified: Brian Hart (4/3/19)

Note:

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

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

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

| | | | |
|------------------------------------|--|---|--|
| Name: Lori Murphy | CSB Member: <input checked="" type="radio"/> Yes <input type="radio"/> No | Represents: Children's Integrated Services | Email Address: lori.murphy@omh.ny.gov |
| Name: Rebecca Robertshaw | CSB Member: <input checked="" type="radio"/> Yes <input type="radio"/> No | Represents: St. Joseph's Hospital | Email Address: robertshaw@arnothhealth.org |
| Name: Tarry Jochem | CSB Member: <input checked="" type="radio"/> Yes <input type="radio"/> No | Represents: Family/Consumer/Peer | Email Address: gramma2tlj@gmail.com |
| Name: Kellie traugott-Knoll | CSB Member: <input checked="" type="radio"/> Yes <input type="radio"/> No | Represents: Children's Integrated Services | Email Address: KTraugott-Knoll@chemungcountyny.gov |
| Name: Tiffany Bloss | CSB Member: <input checked="" type="radio"/> Yes <input type="radio"/> No | Represents: AspireHope NY | Email Address: tbloss@flpn.org |
| Name: Kelli Vaughn | CSB Member: <input checked="" type="radio"/> Yes <input type="radio"/> No | Represents: Social Connection | Email Address: Kelli.Vaughn@omh.ny.gov |
| Name: Lois Bocchicchio | CSB Member: <input checked="" type="radio"/> Yes <input type="radio"/> No | Represents: Glove House | Email Address: lbocchicchio@glovehouse.org |
| Name: Ellen Topping | CSB Member: <input checked="" type="radio"/> Yes <input type="radio"/> No | Represents: Catholic Charities | Email Address: etopping@dor.org |
| Name: Laurie Wert | CSB Member: <input checked="" type="radio"/> Yes <input type="radio"/> No | Represents: Capabilities | Email Address: Lauriew@capabilities.org |
| Name: David Andreine | CSB Member: <input checked="" type="radio"/> Yes <input type="radio"/> No | Represents: CIDS | Email Address: davida@cidsfamilies.com |
| Name: Jennifer Emery | CSB Member: <input checked="" type="radio"/> Yes <input type="radio"/> No | Represents: Family Services of Chemung | Email Address: jemery@familyservices.cc |

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

Indicate the number of mental health subcommittee members who are parents or relatives of persons with mental illness:

Developmental Disabilities Subcommittee Roster

Chemung County Mental Health (70190)

Certified: Brian Hart (4/3/19)

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.

| | | | |
|------------------------------------|--|---|--|
| Name: Sean Eagan | CSB Member: <input checked="" type="radio"/> Yes <input type="radio"/> No | Represents: ARC of Chemung | Email Address: EagenS@arcofchemung.org |
| Name: David Andreine | CSB Member: <input checked="" type="radio"/> Yes <input type="radio"/> No | Represents: CIDS | Email Address: davida@cidsfamilies.com |
| Name: Leisa Alger | CSB Member: <input checked="" type="radio"/> Yes <input type="radio"/> No | Represents: Able 2 | Email Address: algerl@able-2.org |
| Name: Renee Snyder | CSB Member: <input checked="" type="radio"/> Yes <input type="radio"/> No | Represents: AIM | Email Address: rene@aimcil.com |
| Name: Aj Kircher | CSB Member: <input type="radio"/> Yes <input checked="" type="radio"/> No | Represents: Capabilities | Email Address: ajk@capabilities.org |
| Name: Craig Menning | CSB Member: <input type="radio"/> Yes <input checked="" type="radio"/> No | Represents: Person Centered Services | Email Address: cmennig@personcenteredservices.com |
| Name: Ed Lukumski | CSB Member: <input type="radio"/> Yes <input checked="" type="radio"/> No | Represents: Pathways | Email Address: elukumski@pathwaysforyou.org |
| Name: Kellie Traugott-Knoll | CSB Member: <input type="radio"/> Yes <input checked="" type="radio"/> No | Represents: Children's Integrated Services | Email Address: KTraugott-Knoll@chemungcountyny.gov |
| Name: Carey Peters | CSB Member: <input type="radio"/> Yes <input checked="" type="radio"/> No | Represents: Southern Tier Connects | Email Address: PetersC@SouthernTierConnect.org |

2020 Mental Hygiene Local Planning Assurance
Chemung County Mental Health (70190)
Certified: Brian Hart (4/24/19)

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.