



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

Chenango County Community Srvs Board
September 5, 2019

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Planning Form	LGU/Provider/PRU	Status
Chenango County Community Srvs Board	70010	(LGU)
Executive Summary	Optional	Not Completed
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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
 Chenango County Community Srvs Board	 70010/70010	 (Provider)
Health Coordination Survey	Required	Certified
 Chenango Co Behavioral Health Srvs OP	 70010/70010/472	 (Treatment Program)
Clinical Supervision Contact Information Survey	Required	Certified
Program EHR and LGBTQ Survey	Required	Certified

Mental Hygiene Goals and Objectives Form
Chenango County Community Svcs Board (70010)
Certified: Ruth Roberts (5/30/19)

I. 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 complexity and acuity of needs has remained high. We are serving more individuals who have a more serious mental illness, individuals with dual diagnosis (mental health and intellectual/developmentally disabled) and individuals with co-occurring disorders (mental health and chemical dependency). This increase in complexity and acuity has required all local providers across the health and human services delivery system, housing, and social services to carefully consider. These individuals typically require more intensive efforts to maintain stability in the community.

The county operated outpatient clinic moved to OPEN ACCESS and expanded School-Based Behavioral Health Services in order to ease access to outpatient services and better meet the needs of individuals with a mental illness. The demand for these services has remained consistently high.

We have further expanded School-Based Behavioral Health Services into three (3) additional school districts in Chenango County.

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

The demand for outpatient mental health services continues to remain high. 2018 OPEN ACCESS numbers were above 2017 intake numbers and to date, 2019 is outpacing the previous year. Chenango County Behavioral Health is the only OMH licensed outpatient clinic operating in the county. We have increased our outreach and engagement efforts in the community which is a factor in the increased numbers we see in the county operated outpatient clinic. We are working closely with primary care providers to support referrals to the clinic for individuals with more complex psychiatric needs while also transferring individuals who can be managed in primary care settings to the primary care provider.

The acuity and complexity of needs continues to remain high.

Housing options and services for individuals with a mental illness continues to be a challenge.

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

The demand for MH services in 2018 and 2019 has been consistently above previous years. OPEN ACCESS to clinic services along with more outreach and engagement efforts may be factors, but we continue to struggle to meet the complex needs of individuals with a serious mental illness and/or co-occurring condition at the community level.

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**:

The opioid and heroin epidemic continues to present as a need in our small rural county. We are experiencing an uptick in the abuse of methamphetamine and cocaine. Alcohol abuse continues to be an identified need and has been overshadowed by the opioid crisis in terms of community focus. We lack detox resources in the community, crisis services and housing options for individuals with substance abuse needs. There is a large gap between inpatient options and outpatient options. We hope to have more access to inpatient detox services with the new OASAS facility in Broome County. Jail-based SUD services continues to be a need and will hopefully be addressed with some new state funding made available in the new state budget.

We have benefitted from the opening of a 50 bed Detox Center located in Broome County. It is now much easier to get individuals into detox which often eliminates a big barrier to getting admitted into inpatient treatment. Timely access is key to responding to an individual's decision to seek treatment.

Chenango County did receive notification of state aid to support SUD treatment services in the jail and will have a CASAC embedded in the local county jail to complete evaluations, provide individual and group SUD counseling and facilitate the transition to treatment and services once the individual leaves the county correctional setting.

We are moving to expand peer recovery services and recovery supports available in Chenango County.

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

We continue to struggle with an increase in abuse of methamphetamine and cocaine. From an outpatient treatment perspective, there are no clear guidelines for the treatment interventions for methamphetamine and this population remains very challenging to engage in treatment. Alcohol abuse continues to be a challenge in our small rural county where initiation and ongoing use is engrained in the culture of many families and communities.

We lack SUD prevention services. Our current level of state aid in comparison to surrounding counties is very low and only supports a small school-based prevention program. We are in need of strategic environmental strategies but to date have not secured funding.

We continue to struggle with the mere volume of individuals seeking treatment. The demand for services at the local level continues to

increase compared to the past 3 years. **OPEN ACCESS to clinic services along with more outreach and engagement efforts may be factors, but we continue to struggle to meet the complex needs of individuals with a serious mental illness and/or co-occurring condition at the community level.**

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

We lack clean and sober housing options for individuals who are working on Recovery. This continues to place many of our vulnerable individuals at risk.

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**:

In Chenango County we primarily rely on the voluntary providers, SpringBrook, Chenango ARC and Chenango County Catholic Charities, to provide programming for the ID/DD population. State operations have a smaller footprint in the county although the Developmental Disabilities Regional Office (DDRO) has been very helpful in terms of planning and problem solving. With the closure of Broome Developmental Center and with more individuals with ID/DD now living in the community and getting services in the community, there remain areas where there are shortages and gaps.

There are few dentists who are willing to provide care requiring individuals to travel great distances to be seen by a dentist. Psychiatric services available to the ID/DD population are severely limited and continue to be a challenge. Respite services, family supports and residential options are needed.

Problems with staff recruitment and retention in local OPWDD programs creates situations where individuals and the family is eligible for a service, providers are willing to provide but there are wait lists due to the lack of trained staff.

These situations place additional stress and strain on the overall system and too often ultimately lead to a crisis. Our region does not yet have a START program (currently in stages of development) and there are no crisis services specifically serving the I/DD population available in our region making a presentation at a local emergency room or CPEP much more likely.

The transition to care coordination through the OPWDD CCO structure and the elimination of MSC services is causing some stress among providers who have historically provided MSC services and also family members. Some local providers have already moved their staff into other positions within their organization leaving some concern about how smooth the transition will be for individuals with I/DD and their family members.

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

There continues to be a lack of medical providers in Chenango County for the I/DD population. Too often individuals with I/DD are required to travel great distance in order to see a dentist, primary care or specialty provider or behavioral health provider.

The region does not yet have a START program and based on feedback from other regions, there is little hope that a START program in OPWDD Region 2 will adequately meet the needs of individuals who have an I/DD and also have a significant mental illness. The lack of services designed to meet the dually diagnosed continues to be a challenge.

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

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 checked="" type="checkbox"/>
d) Workforce Recruitment and Retention (service system)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
e) Employment/ Job Opportunities (clients)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
f) Prevention	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
g) Inpatient Treatment Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) Recovery and Support Services	<input checked="" 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 checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

m) Coordination/Integration with Other Systems for SUD clients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n) Mental Health Clinic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o) Other Mental Health Outpatient Services (non-clinic)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p) Mental Health Care Coordination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
q) Developmental Disability Clinical Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
r) Developmental Disability Children Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
s) Developmental Disability Student/Transition Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
t) Developmental Disability Respite Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
u) Developmental Disability Family Supports	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" 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 checked="" type="checkbox"/>

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

2a. Housing - Background Information

The availability of safe and affordable housing to individuals across all three disabilities remains a serious challenge. In our small rural county housing options available are housing units built in the 1950's or earlier and due to the downturn in the economy and local real estate market, many have not been kept in good repair, thus limiting the options for the mentally disabled. There is very little new house construction and mobile homes are much more common but are located in more remote areas of the county, away from services and other resources.

Individuals who are serious about working on their recovery are too often placed in substandard housing paid by DSS and are often placed in motel rooms that are wrought with the sale and use of illegal substances. This places individuals who are transitioning out of our local county jail and those returning to the community from inpatient settings, at great risk of relapse.

Rural homelessness is on the rise.

For the general population in Chenango County it is reported that 43.25%* of households who rent are overburdened in Chenango County.

When you consider the additional barriers associated with having a mental disability, the overburden increases.

*Data derived from 2010 Census and 2014 5-Year American Community Survey.
1 Margin of Error: ± 4.4 percentage points.

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

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

Increase safe and affordable housing options in Chenango County for individuals with a mental illness and/or substance use disorder and/or developmental disability

Objective Statement

Objective 1: In partnership with the Chenango County Housing Council, pursue opportunities through state released RFPs to establish permanent and transitional housing in Chenango County.

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

Objective 2: In partnership with Catholic Charities of Chenango County, explore funding opportunities for multi-use housing center to serve individuals in need of emergency, transitional and permanent housing

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

Change Over Past 12 Months (Optional)

Catholic Charities of Chenango County has been notified that their RFP for the Empire State Supportive Housing Initiative Inter-Agency Service and Operating Funding Opportunity was not approved in the final round of awards. They remain ready and interested in applying again if the opportunity becomes available. They hope to provide permanent housing for individuals with mental disabilities, victims of domestic violence and the homeless and provide at least 30 housing units.

Achieve, Inc. opened an IRA that serves individuals with I/DD who have been previously been cared for by aging parents.

Additional options and development are needed at the local level.

2b. Transportation - Background Information

There is a public transportation system in Chenango County that's very limited due to cuts in funding. The bus system has in the recent years reduced several routes. Chenango County is geographically vast and very rural. There are 20 small towns and villages with only one city, Norwich, that make up Chenango County. Individuals often identify lack of transportation as a barrier to accessing healthcare including primary care, preventive care and behavioral health. Lack of transportation also impacts the ability to access healthy food and recreational activities. Chenango County has the highest rate of obesity in the state for children and is second highest for adults. Lack of access to fresh food, opportunities to exercise and unhealthy lifestyle choices contribute to the high obesity rates. This is further complicated by low socioeconomic status of many of the Chenango County residents.

Lack of transportation is considered a major factor when considering health disparities. Many efforts through the Chenango Health Network, Rural Health Network of the Southern Tier, HealthLinkNY (Population Health Improvement Plan, PHIP) and the Southern Tier Regional Consortium (RPC) are working toward increasing transportation options available however it remains a major barrier to achieving positive health outcomes.

- <http://www.rhnsny.org/programs/mmscny>
- <http://www.chenangohealth.org/>
- <http://www.healthlinkny.com/population-health-pg.html>
- http://www.clmhd.org/rpc/Southern-Tier_204_pg.htm

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

Expand existing public transportation system and pursue the development of new transportation options in Chenango County

Objective Statement

Objective 1: Work with County Officials and other county department heads to advocate for additional dollars to support transportation throughout the county.

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

Objective 2: Partner with the Rural Health Network, Chenango Health Network, HealthLinkNY and the Southern Tier Regional Planning Consortium to develop additional transportation options.

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

Objective 3: Explore the development of a peer operated transportation.

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

Objective 4: Through the Southern Tier RPC, continue to address transportation challenges with MAS / DOH

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

Change Over Past 12 Months (Optional)

Medicaid transportation in Chenango County is too often unresponsive to urgent needs and has not kept pace with changes in the larger healthcare / service system where greater focus is on timely, often same day access. It also falls short when it doesn't provide transportation to preventative appointments, pharmacy and the grocery store - all important to achieving good health outcomes. This remains an area that is being addressed in the Southern Tier Regional Planning Consortium.

The county is not in a position to provide any funding for transportation although this remains a topic of discussion at the local level as it impacts the local economy.

First Transit, the only public transportation available in Chenango County, continues to reduce routes making it virtually impossible to arrange transportation from rural parts of the county.

The Southern Tier Rural Health Network does provide limited transportation but does not have the resources to provide regular transportation such as regular appointments at the outpatient behavioral health clinic or other healthcare facilities.

While we do not have a formal peer operated transportation system, there is now an informal group that provides transportation for individuals in need. Additionally, RSS peers have access to a vehicle that can be used to provide transportation to individuals and families. Peer supported transportation options should be further explored.

Uber is a new option available on a limited basis but may potentially provide additional transportation options.

Through the RPC, discussions are underway with DOH regarding access to treatment / services and the barriers Medicaid transportation too often creates.

2c. Crisis Services - Background Information

We currently have 24/7 crisis services available in the county serving Chenango County citizens. These services are funded through OMH and include outreach and engagement services along with in-home stabilization peer services. Crisis services are also provided in the county operated Article 31 clinic during regular business hours. Still the resources are stretched due to the vast geographical area of the county.

OASAS does not fund crisis services in Chenango County although a high percentage of individuals accessing crisis services or presenting at the

nearest CPEP have substance use or abuse issues.

There is a lack of respite services and family supports for individuals with I/DD and served by the OPWDD or for those individuals where OPWDD eligibility has not yet been determined. This shortage contributes to the increase likelihood that when a crisis does occur, it will require more intense and more costly response.

We are the last region scheduled to have OPWDD implement Systemic, Therapeutic Assessment, Resources and Treatment (START). There are no crisis services available to individuals who have an intellectual / developmental disability and/or a mental health condition in Chenango County. Often these individuals are served by the existing crisis services however most often individuals require a trip to the ER or CPEP. Often these situations create a great strain on the overall healthcare system and are extremely frustrating for the individual with I/DD and their family.

Mobile Crisis and Assessment Team (MCAT) provides crisis services and receives funding from OMH to provide regional services. Due to difficulty recruiting and retaining qualified staff, we continue to experience a shortage of these services.

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

In collaboration with OMH, OASAS, OPWDD and local partners, improve the response to crisis in effort to prevent and intervene at the community level in effort to avoid unnecessary ER/CPEP visits, inpatient level of care or involvement with the criminal justice system.

Objective Statement

Objective 1: Collaborate with regional CPEP to better divert and manage referrals.

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

Objective 2: Collaborate with regional OPWDD office in the implementation plan of START

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

Objective 3: Continue to work with community stakeholders on the implementation of sequential intercept mapping

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

Change Over Past 12 Months (Optional)

Chenango County, along with Otsego, Delaware and Schoharie Counties, contracts with the Neighborhood Center Inc. for a Mobile Crisis Assessment Team (MCAT). We review data on a regular basis. **In 2018, 90% of adult individuals and 95.7% of children served by MCAT were successfully diverted from inpatient or emergency psychiatric care.**

START is scheduled to be implemented some time in 2018 however there is concern that one START team serving the entire Region 2 will not adequately meet the crisis needs of individuals with I/DD who also have a behavioral health condition. **At this point in time, there is question about the future development of START in Region 2.**

As more individuals with I/DD chose Self-Direction, and experience increased independence, there is the need to have crisis services available to address any events that might threaten their stability in the community.

With the opening of an OASAS 50 bed detox facility in Broome County we hope to be able to increase the detox options to Chenango County residents. **During 2018, Helio Health opened a crisis detox center located in Broome County and this has improved regional access to detox services.**

The Chenango County Behavioral Health Services outpatient clinic has worked closely with MCAT and UHS CPEP to identify high risk / high need individuals and make every attempt to engage these individuals in outpatient clinic services and community linkage. **During 2018, MCAT added a peer recovery coach to the MCAT team.**

During 2018, Care Compass Network hosted a Sequential Intercept Mapping (SIM) event where several community stakeholders came together to consider community resources to improve response when individuals with a mental disability come into contact with law enforcement, courts, local county jail and transitional services.

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

In Chenango County, there are severe shortages and challenges in recruiting and retaining qualified health professionals specifically, social workers, psychologists, registered nurses, nurse practitioners and psychiatrists. The availability of psychiatrists, particularly child and adolescent psychiatrist is extremely limited in our county and region.

Physical health providers express the same challenges and there is currently a shortage of primary care practitioners.

OPWDD providers struggle to recruit and retain the required professional staff (dental and psychiatric remain critically low) and direct care providers. This has created stress and strain for local providers in assuring regulatory staffing requirements. Additionally, the Justice Center investigations have created additional staffing challenges.

State operated programs report they have experienced a high number of retirements and it takes a very long time to refill positions.

Direct care positions remain difficult to recruit and retain. Often the workforce is made up of individuals who the working poor, have unreliable transportation and multiple stressors in their life that prevent them from performing in their job.

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

If "No", Please discuss any challenges that have precluded the development of a goal (e.g. external barriers):
This problem is a state and national problem and is not one that Chenango County or the region has been able to successfully address over the past several years. This will require greater efforts at the state and national level to address.

Telemedicine and Telepsychiatry does hold promise but to date, has not offered relief.

Change Over Past 12 Months (Optional)

No Changes. The region is now experiencing a more serious shortage of clinical social workers.

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

Employment / Volunteerism / Educational opportunities are critical components in the path of recovery and community integration. In Chenango County there is a shortage of opportunities for individuals with a mental disability. Despite the US Bureau of Labor of Statistics reporting a decline in the unemployment rate in Chenango County over the past 7 years, there are still barriers for individuals who have a mental disability in achieving their employment goals.

According to the New York Work Pays (NYWP) project which used data from the American Community Survey (ACS) for the time period of 2008-2010, the employment rate for working-age people with disabilities in Chenango County is 28.2%, compared to 75.6% for people without disabilities, a gap of 47.4%. Further, 32.2% of working-age people with disabilities live below the federal poverty level which is more than 3 times the poverty rate for people without disabilities.

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

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

Increase employment / volunteerism / educational opportunities for individuals with a mental disability.

Objective Statement

Objective 1: Engage local employers, stakeholders and the state agencies to create new opportunities.

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

Change Over Past 12 Months (Optional)

We continue to make small progress toward this goal. There is a group that meets regularly that considers the needs of the employers in the county and develops strategies to develop a workforce. Employers report difficulty recruiting and retaining a qualified workforce. Often transportation, substance abuse and a culture of generational poverty creates barriers. This group is interested in developing employment opportunities for individuals with disabilities.

Additionally, there is a local businessman who has partnered with one of the school districts where Chenango County Behavioral Health has a school-based outpatient clinic. This partnership provides experiential learning opportunities to high risk youth and focuses on work skill development to match the needed skill set reported by regional manufacturing employers.

The LGU continues to meet with local officials, superintendents and BOCES to discuss building a stronger school to work pathway for students, with a particular focus on students with who are at risk or have a mental disability.

Additionally, the LGU has had preliminary discussions with local employers to explore alternatives when an employee tests positive for substance use on the job to allow employees to remain employed and also to protect the time and investment the employer has made to train the employee.

I/DD providers report an increase in request for Pathway to Employment opportunities and a movement away from the sheltered workshop model. Integrated employment is now the norm and as self - direction increases, more individuals with I/DD are wanting to seek employment opportunities.

Chenango Health Network and PHIP are hosting community events to increase employment opportunities for individuals who have a SUD.

The United Way has recently brought community partners together to consider the needs of the ALICE population (Asset Limited, Income Constrained, Employed) which consists of underemployed or the working poor families. This group is looking to increase the awareness of the vulnerabilities of this population and develop community strategies to address challenges.

2f. Prevention - Background Information

Chenango County has an OASAS substance abuse prevention program that supports one full time school-based prevention worker and program that serves four out of eight school districts in the county. Chenango County does not have a Prevention Council and receives little prevention OASAS prevention state aid compared to neighboring counties. Area schools have expressed interest in additional substance abuse prevention programming.

In response to the opioid epidemic, the Chenango Substance Abuse Prevention Coalition was organized and is currently planning to pursue prevention funding through Drug Free Communities and partner with Central New York Prevention Resource Center for support. The plan is to expand prevention strategies to enhance community prevention efforts and environmental efforts.

OMH prevention is less defined however it's important to point out that what we see coming into our outpatient OMH clinic setting is **preventable** in the sense that it is related to trauma and the impact of social determinants. While there is recognition through PHIP and DSRIP regarding the social determinants of health, we do not have comprehensive prevention strategies through OMH. So much of mental illness is the result of environmental exposures including trauma, and not an organic illnesses. This is an opportunity to intervene and interrupt.

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

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

Increase substance abuse prevention efforts at the community level by expanding school-based substance abuse prevention services and environmental prevention strategies in Chenango County.

Increase prevention of mental health conditions by engaging with community partners to provide early detection and early intervention; Educate the community regarding the impact of adverse events across the lifespan of human development.

Objective Statement

Objective 1: Pursue expanding school-based prevention services throughout the eight school districts.

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

Objective 2: Through the Chenango Substance Abuse Prevention Coalition develop a comprehensive environmental prevention plan.

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

Objective 3: Offer trainings to raise awareness and educate the community regarding the importance of creating and supporting healthy communities to support healthy human development.

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

Change Over Past 12 Months (Optional)

Some progress has been made toward this goal but we have also experienced setbacks and the further realization of the prevention efforts that are still needed in our county.

We further expanded our presence in the schools through our OMH School-Based Satellite Clinics in 2018. At the end of 2018, there were school-based mental health services were available in each of the Chenango County school districts. This has also given us opportunities to expand our substance abuse prevention services in the schools. With some additional state dollars from Senator Akshar we will be implementing an evidenced based substance abuse prevention program in several school districts. In order to sustain our substance abuse prevention efforts in the schools the funding for prevention efforts will need to be expanded. Unfortunately the senate dollars will not continue into 2020.

Recently information about SUD prevention state aid dollars was gathered from surrounding counties, similar in size and demographics to Chenango County. In comparison, Chenango County receives disproportionately less in comparison to surrounding counties. Plan is to further advocate, through our local state representatives and officials, for additional state assistance to further expand our SUD prevention efforts.

The Chenango Substance Abuse Prevention Coalition, through the Chenango Health Network recently submitted a Drug-Free Communities (DFC) grant application in 2018 and unfortunately did not receive an award. Chenango Health Network is planning on reapplying for DFC grant dollars in 2019.

2h. Recovery and Support Services - Background Information

Over the past several years we have added peer positions throughout our OMH operated programs, including the outpatient clinic. Recently the Mobile Crisis and Assessment Team (MCAT) added a full time peer recovery coach to our local crisis services. We are exploring a partnership with other organizations to assist us in the area of increasing our peer recovery resources. The county does not currently have an infrastructure to recruit, train and supervise peer recovery coaches.

Other than recovery support groups in the community, we do not have enough recovery supports available. We need a Recovery Center / Recovery Community Organization where individuals can access recovery supports and wellness activities, particularly during evenings, weekends and holidays.

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

Expand the availability of trained peer recovery services in Chenango County.

Objective Statement

Objective 1: Increase Peer Recovery Services in Chenango County

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

Objective 2: Partner with an organization who can assist us in building an infrastructure to recruit, train and supervise peers

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

Change Over Past 12 Months (Optional)

This is a new goal.

2j. SUD Outpatient Services - Background Information

The county operated SUD outpatient clinic, Chenango County Behavioral Health Clinic, is the only outpatient OASAS certified provider in Chenango County. Chenango County Behavioral Health Clinic offers open access and in reviewing access and utilization, the clinic is operating at capacity with no waitlist.

We lack detox resources in Chenango County. When an individual is in need of detox they most often must travel to a neighboring county where there are usually long waitlists. One of the area health providers is gearing up to provide ambulatory detox services (Suboxone) within their primary care settings and they are doing this through the Leatherstocking DSRIP but will only be providing this services to their existing patients.

Medication Assisted Treatment is not readily available in the county. Individuals who require MAT must travel outside the county. There are Suboxone providers in the county however most are not willing or interested in coordinating care with outpatient SUD treatment. Some of these providers operate on a cash only basis and there have been problems with drug diversion in many instances.

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

Expand community outpatient services and supports at the county / regional level.

Objective Statement

Objective 1: Develop a detox and/or crisis stabilization resource and support in the county/ region.

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

Objective 2: Implement Vivitrol program in the county jail.

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

Objective 3: Reach out to area Suboxone providers in effort to coordinate treatment.

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

Change Over Past 12 Months (Optional)

While the demand for outpatient treatment services in the Chenango County Behavioral Health Service has remained consistently high, we have also moved to OPEN ACCESS in order to improve our ability to ease access and respond to the urgent needs in our communities. This has placed a great deal of stress on the overall system and has required adding additional positions within the outpatient clinic.

With the opening of a detox facility in Broome County, access to detox services has improved. Detox continues to be the initial greatest need and gap in services for individuals coming into our outpatient clinic through OPEN ACCESS.

We have started a Vivitrol program in the county jail. **There have been very few individuals who are interested in receiving Vivitrol once they receive education about the drug.**

We continue to reach out to area Suboxone providers to encourage a partnership with our treatment program and have had some success. However, a large local healthcare provider is currently providing Suboxone and is promoting the idea that individuals who are prescribed Suboxone and who are engaged in outpatient clinic do not do any better than individuals who are only receiving Suboxone. This has created some challenges when working with individuals who are involved in Drug Treatment Court or Family Treatment Court. We are working to address this. Local law enforcement agencies report a significant increase in Suboxone diversion and describe it as the main currency used in illegal drug transactions.

21. Heroin and Opioid Programs and Services - Background Information

Heroin and opioid abuse continues to be a problem in the county placing a great strain on the overall healthcare system, law enforcement and local jail. The effects have also taken a great toll on individuals and families.

The Chenango Substance Abuse Prevention Coalition has organized their efforts to address the heroin and opioid crisis. Projects focused on harm reduction, Hep-C education, prevention and treatment and access to treatment. Prevention efforts are focusing on school-age children and youth and the need for countywide environmental strategies to prevent substance abuse.

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

Through the efforts of multiple stakeholders at the local and regional level, develop services and supports to improve and expand the community response to the heroin and opioid crisis.

Objective Statement

Objective 1: CSAPC in coordination with community stakeholders will make recommendations to the LGU

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

Change Over Past 12 Months (Optional)

We have made some inroads through the Chenango Substance Abuse Prevention Coalition in raising awareness and educating the public regarding substance abuse challenges in our county. We have implemented a needle exchange program, medication takeback events and medication drop boxes strategically located throughout the county.

The Coalition has invested in furthering efforts in the area of advocating for prevention, access to treatment and harm reduction.

The distribution of Narcan throughout community stakeholders has been generally accepted although there is still work to be done. OASAS has made free trainings available to community members, educators and providers.

We now have a needle exchange program available in Chenango County and are currently considering a mobile program.

In coordination with CSAPC, law enforcement and public health, medication take-back events have taken place throughout the localities.

The Chenango County Behavioral Health Services OASAS outpatient clinic has increased capacity and fully implemented OPEN ACCESS. The demand for these services remains high and further magnifies system challenges that still need to be addressed.

In general, there is increased awareness and acceptance about the need to have harm reduction options available while also encouraging individuals to enter SUD treatment and recovery.

2q. Developmental Disability Clinical Services - Background Information

Chenango County has great difficulty recruiting and retaining qualified health professionals including social workers, psychologists, nurses, nurse practitioners and psychiatrist. There are severe shortages of psychiatric services. The medical community reports the same challenges and there is currently a shortage of primary care providers available in the county. Access to specialty services is challenging and typically require traveling to larger urban areas.

Individuals with I/DD who require medical and specialty services are often served in Broome County. The existing health disparities threaten true community integration for individuals with I/DD. Local medical, behavioral health and dental providers report they are not equipped to provide care to individuals with I/DD, pointing to the need for more training.

As more individuals with I/DD are now living in the community, there is greater access to substances and has led to substance abuse in some cases.

According to 2015 OPWDD data, 36% of individuals with I/DD are dually diagnosed with a mental health disorder. The lack of psychiatric or behavioral health practitioners available to serve the dually diagnosed remains a great challenge at the local level.

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

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

Increase the number of providers at the local level to deliver medical (including primary care), behavioral health and dental services to individuals with I/DD.

Objective Statement

Objective 1: Provide training and support to local providers in effort to increase their skill level and confidence in serving individuals with I/DD

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

Change Over Past 12 Months (Optional)

No Change.

2t. Developmental Disability Respite Services - Background Information

Chenango County lacks respite services for individuals with I/DD. This places strain on the current provider system, the family and creates situations where a crisis is much more likely to occur. Often the crisis leads to a trip to the emergency room or local CPEP which of course is more costly and rarely resolves the crisis situation. The lack of respite services often threatens stability of program placement.

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 more respite options for individuals with I/DD and/or I/DD/MH.

Objective Statement

Objective 1: Work with local voluntary OPWDD providers and the state agency to expand respite opportunities in Chenango County.

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

Change Over Past 12 Months (Optional)

No progress toward this goal. Providers report that the rates do not support the program.

2u. Developmental Disability Family Supports - Background Information

Chenango County lacks family support services for individuals with I/DD. This places strain on the current provider system, the family and creates situations where a crisis is much more likely to occur. Often the crisis leads to a trip to the emergency room or local CPEP which of course is more costly and rarely resolves the crisis situation. The lack of family support services often threatens the stability remaining with family.

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

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

Increase Family Support Services for individuals with I/DD and/or I/DD/MH.

Objective Statement

Objective 1: Work with local voluntary OPWDD providers and the state agency to expand family supports in Chenango County

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

Change Over Past 12 Months (Optional)

Catholic Charities of Chenango County has implemented a Family Support Program that serves individuals with autism and have also expanded services to serve other populations. These services work to provide in-home supports to support stabilization and prevent the need for more intensive out of home placements.

Providers anticipate an increase in Family Supports as the result of the planned transition from MSC to Care Coordination through the CCO.

2ac. Adverse Childhood Experiences (ACEs) (NEW) - Background Information

Training to better understand the impact of ACE's across the lifespan has occurred in some pockets of the county. There is the need to provide additional and ongoing training in order to create a culture that recognizes the importance of preventing exposure to adverse childhood events while also building protective factors to encourage resiliency.

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

Educate and raise awareness about ACEs and how this information can be used across systems to promote well-being and healthy communities.

Objective Statement

Objective 1: Conduct ACEs screenings in every medical and behavioral health setting.

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

Objective 2: Develop resources for ongoing ACEs trainings

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

Change Over Past 12 Months (Optional)

New Goal.

New York State Prevention Agenda Survey
Chenango County Community Srvs Board (70010)
Certified: Ruth Roberts (5/20/19)

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:

The LGU has worked to bring together community stakeholders which include primary care, behavioral health, hospital including the emergency department, housing, social service organizations and care management, in order to better understand and address the social determinants of health. The LGU participated in the Community Health Assessment as a key informant and attending the ongoing Stakeholders Meetings. The LGU remains committed to working with local partners toward the priority goals in the 2019 - 2021 Community Health Assessment.

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:

We have efforts in place to address the goals above or are in the process of developing a plan to address in the future. Focus Area 1: Promote Well-Being - We are working with a local agency to increase access to safe, affordable and clean/sober housing options. Working with the local housing coalition to improve options available in the county. We are engaging schools and communities and providing education and support regarding the importance of early childhood development and the impact of adverse childhood events; looking at ways to increase protective factors and build resiliency; hope is to cultivate a culture across various systems where this is recognized and integrated in practice; we have offered and will be expanding the offering of Mental Health First Aid to various community partners and schools; through the efforts of the Community Services Board and Subcommittees we are strengthening the messaging about the importance and benefits of inclusion. Focus Area 2: Mental and Substance Abuse Disorders Prevention Chenango County has received disproportionately low amounts of state aid for SUD prevention services and as the result of local efforts there is much more attention and interest in increasing our prevention efforts. This will require advocating through our state representatives and officials for additional state dollars; we are working with local primary care providers to increase MAT services for individuals who are opioid dependent; Opioid use is on the decline and methamphetamine abuse has increased, we need better protocols to respond; Additional work with schools, healthcare providers about the impact of ACEs is needed, training and other resources will need to be available; the Chenango County Suicide Coalition continues to engage local schools and agencies to raise awareness and educate on the prevention of Suicide; the Chenango County Behavioral Health Clinic along with other community partners continue to promote wellness and recovery efforts among individuals who have a serious mental illness.

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:

We have actively participated in bringing together local community partners including Chenango County Department of Health, Chenango Memorial Hospital, Chenango County Behavioral Health Services, Bassett and UHS Healthcare Primary Care, Catholic Charities of Chenango County, Chenango Health Network, Inc., Chenango County Probation, local law enforcement, local schools, and several other stakeholders including consumers, family members and community representatives. These groups meet regularly to consider the needs in our community. The LGU has actively participated in the development of the Community Health Assessment and the Community Health Improvement Plans.

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:

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

No

Yes, please explain:

There continues to be regulatory barriers that must be considered and navigated when considering the Prevention Agenda. The Prevention Agenda requires that all systems are in alignment with policy and regulations.

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:

The only Article 31 and 32 clinics in the county are county operated and we continue to implement or consider implementation of EBPs in the outpatient clinic. We appreciate the offering of trainings and support from OMH and OASAS in our effort to further expand and implement EBPs.

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:

For the goal Prevention Chronic Disease - Preventative Care and Management, the LGU plans to promote Wellness, and Wellness, Self Management strategies.

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:

We will continue to implement the use of the Patient Activation Measure (PAM) surveys and Patient Navigation services. We will also make effort to further foster the relationship between behavioral health and physical health providers toward the goal of achieving better overall health outcomes.

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

Un/Underemployment and Job Insecurity

Poor Education

Food Insecurity

Poverty/Income Inequality

Adverse Features of the Built Environment

Adverse Early Life Experiences

Housing Instability or Poor Housing Quality

Poor Access to Transportation

Discrimination/Social Exclusion

Other

Please describe your efforts in addressing the selections above:

1) Working with local employers and the Chamber of Commerce to increase employment opportunities. Considering the challenges of the ALICE (Asset Limited, Income Constrained, Employed) population through various efforts through the United Way. 2) Working with area schools, the faith community and social service organizations to address food insecurity 3) There is a Housing Coalition that is working addressing poor housing and homelessness. 4) In order to decrease discrimination and social exclusion, community coalitions and events where efforts are made to raise awareness and educate the public. 5) Various efforts are taking place to break the cycle of poverty 6) Progress has been made in educating schools and healthcare providers regarding ACEs; continued effort is required to further push into the policies and cultures of our local institutions. 7) We have a small rural public transportation system that has limited routes. 8) Generational Disability. Similar to Generational Poverty, we are challenged to break the cycle.

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): Adverse Childhood Experiences (ACEs) training and Bridges to Health (based on the Bridges out of Poverty) training

How many hours: 16

Target audience for training: local professionals and service providers

Estimate number trained in one year: 250

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:

Office of Mental Health Agency Planning (VBP) Survey
Chenango County Community Svcs Board (70010)
Certified: Ruth Roberts (5/6/19)

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:

Below are a few examples as to how the Care Compass Network PPS supported the LGU and the community: 1) Facilitated a Sequential Intercept Mapping exercise where community partners considered ways to prevent, respond and manage individuals who have significant behavioral health conditions and who are at high risk of becoming involved in the criminal justice system. Explored ways to keep high utilizers from overusing emergency response, law enforcement, emergency department, social service programs and court. Considered the need for local county services and supports. 2) Facilitated and hosted a training on "Bridges to Health" where healthcare professionals considered how to better serve individuals who are living in generational poverty. 3) Through a regional planning unit (RPU) model, the PPS brought partners together on a monthly basis to address specific regional challenges related to providing healthcare in the two rural counties of Chenango and Delaware. 4) Provided utilization data to better inform clinical practice and integration. 5) Conducted PAM surveys throughout OMH and OASAS outpatient clinic. 6) Participated in the Navigation project assisting individuals in accessing primary care and specialty care in the community. 7) The LGU, through the county operated outpatient clinic is partnering with Catholic Charities - Chenango County in a Cohort Management Project where high risk / high need individuals are closely monitored with the goal of achieving improved health outcomes and reducing unnecessary ER utilization.

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

- a) Yes No

b) Please explain:

The LGU will support the continuation of conducting PAM surveys across the treatment and service system. The LGU will encourage the county operated outpatient clinic to continue to assist individuals in navigating access to primary care and specialty health services. The LGU will continue to host cross systems efforts such as SIMs, SPOA and working with partners to monitor high risk / high need individuals.

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):

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:

The LGU is committed to: 1) Improving the overall quality of care 2) Focusing on the root causes of poor health or social determinants 3) Assuring access to the appropriate levels of care 4) Improve the patient experience 5) Create ways to continually reinvest in our health care system 6) Reduce cost and increase efficiency 7) Enable and encourage innovation

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

a) Yes No

b) Please explain:

6. Can your LGU support the BHCC planning process?

a) Yes No

b) Please explain:

The LGU, as the Executive Director of the county operated outpatient OMH and OASAS clinic is participating in the BHCC process.

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:

The LGU is currently evaluating the capacity of the county data and IT systems. Currently, the county is considering options which will impact several county departments. The county operated clinic is the only OMH / OASAS outpatient clinic and uses the county IT system.

Community Service Board Roster
 Chenango County Community Srvs Board (70010)
 Certified: Ruth Roberts (4/22/19)

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: John Bennett	<input type="checkbox"/> Physician <input type="checkbox"/> Psychologist	Represents: Community Advocate / Consumer	Term Expires: 12/2020	Email Address:
Name: Louise Gregg	<input type="checkbox"/> Physician <input type="checkbox"/> Psychologist	Represents: Community Advocate / Consumer	Term Expires: 12/2019	Email Address:
Name: Laureen Clark	<input type="checkbox"/> Physician <input type="checkbox"/> Psychologist	Represents: Community Advocate / Retired Probation Director	Term Expires: 12/2020	Email Address:
Name: Fred Heisler	<input type="checkbox"/> Physician <input type="checkbox"/> Psychologist	Represents: Board Supervisor / Family Advocate	Term Expires: 12/2019	Email Address:
Name: Robin Cotter	<input type="checkbox"/> Physician <input type="checkbox"/> Psychologist	Represents: Community Advocate	Term Expires: 12/2019	Email Address:
Name: Kim McCarthy	<input type="checkbox"/> Physician <input type="checkbox"/> Psychologist	Represents: Local Hospital	Term Expires: 12/2019	Email Address:
Name: Grace Nucero-Alger	<input type="checkbox"/> Physician <input type="checkbox"/> Psychologist	Represents: Community Advocate / Board Supervisor	Term Expires: 12/2020	Email Address:
Name: Vacant	<input type="checkbox"/> Physician <input type="checkbox"/> Psychologist	Represents:	Term Expires:	Email Address:
Name: Vacant	<input type="checkbox"/> Physician <input type="checkbox"/> Psychologist	Represents:	Term Expires:	Email Address:

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
 Chenango County Community Srvs Board (70010)
 Certified: Ruth Roberts (4/22/19)

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: John Bennett	CSB Member: <input checked="" type="radio"/> Yes <input type="radio"/> No	Represents: Consumer	Email Address:
Name: Louise Gregg	CSB Member: <input checked="" type="radio"/> Yes <input type="radio"/> No	Represents: Family / Community Advocate	Email Address:
Name: Darlene Gramstad	CSB Member: <input checked="" type="radio"/> Yes <input type="radio"/> No	Represents: Public Health	Email Address:
Name: Lauren Clark	CSB Member: <input checked="" type="radio"/> Yes <input type="radio"/> No	Represents: Retired Probation Director / Community Advocate	Email Address:
Name: Kim McCarthy	CSB Member: <input checked="" type="radio"/> Yes <input type="radio"/> No	Represents: Chenango Memorial Hospital	Email Address:
Name: Lois LoPresti	CSB Member: <input checked="" type="radio"/> Yes <input type="radio"/> No	Represents: Department of Social Services	Email Address:
Name: Fred Heisler, Jr.	CSB Member: <input checked="" type="radio"/> Yes <input type="radio"/> No	Represents: Family / Board of Supervisors	Email Address:

Mental Health Subcommittee Roster
Chenango County Community Srvs Board (70010)
Certified: Ruth Roberts (4/22/19)

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: Kim McCarthy	CSB Member: <input checked="" type="radio"/> Yes <input type="radio"/> No	Represents: Chenango Memorial Hospital	Email Address:
Name: Lauren Clark	CSB Member: <input checked="" type="radio"/> Yes <input type="radio"/> No	Represents: Retired Probation Director / Community Advocate	Email Address:
Name: Jeff Cheseboro	CSB Member: <input type="radio"/> Yes <input checked="" type="radio"/> No	Represents: Community Advocate / Catholic Charities	Email Address:
Name: Brian Wessels	CSB Member: <input type="radio"/> Yes <input checked="" type="radio"/> No	Represents: Area Office on Aging	Email Address:
Name: Darlene Gramstad	CSB Member: <input type="radio"/> Yes <input checked="" type="radio"/> No	Represents: Public Health	Email Address:
Name: Louise Gregg	CSB Member: <input type="radio"/> Yes <input checked="" type="radio"/> No	Represents: Community Advocate / Family	Email Address:
Name: John Bennett	CSB Member: <input type="radio"/> Yes <input checked="" type="radio"/> No	Represents: Family / Community Advocate	Email Address:

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
 Chenango County Community Svcs Board (70010)
 Certified: Ruth Roberts (4/22/19)

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: John Bennett	CSB Member: <input checked="" type="radio"/> Yes <input type="radio"/> No	Represents: Consumer	Email Address:
Name: Heidi Slentz	CSB Member: <input type="radio"/> Yes <input checked="" type="radio"/> No	Represents: OPWDD Regional Office	Email Address:
Name: Brian Wessels	CSB Member: <input type="radio"/> Yes <input checked="" type="radio"/> No	Represents: Area Office on Aging / Long Term Care	Email Address:
Name: Robin Cotter	CSB Member: <input type="radio"/> Yes <input checked="" type="radio"/> No	Represents: Chenango County Catholic Charities	Email Address:
Name: Mallory Carhart	CSB Member: <input type="radio"/> Yes <input checked="" type="radio"/> No	Represents: Springbrook Inc.	Email Address:
Name: Kim McCarthy	CSB Member: <input type="radio"/> Yes <input checked="" type="radio"/> No	Represents: Chenango Memorial Hospital	Email Address:
Name: Meghann Andrews - Whitaker	CSB Member: <input type="radio"/> Yes <input checked="" type="radio"/> No	Represents: SpringBrook Inc.	Email Address:
Name: Laura Thompson	CSB Member: <input type="radio"/> Yes <input checked="" type="radio"/> No	Represents: ACHIEVE	Email Address:

2020 Mental Hygiene Local Planning Assurance
Chenango County Community Srvs Board (70010)
Certified: Ruth Roberts (4/22/19)

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.

Health Coordination Survey
Chenango County Community Svcs Board (70010)
Certified: Ruth Roberts (3/25/19)

Under New York State regulations, providers certified under the following parts are required to "have a qualified individual designated as the Health Coordinator who will ensure the provision of education, risk reduction, counseling and referral services to all patients regarding HIV and AIDS, tuberculosis, hepatitis, sexually transmitted diseases, and other communicable diseases":

- Chemical Dependence Residential Rehabilitation Services for Youth (Part 817)
- Chemical Dependence Inpatient Rehabilitation Services (Part 818)
- Chemical Dependence Residential Services (Part 819)
- Residential Services (Part 820)
- Non-Medically Supervised Chemical Dependence Outpatient Services (Part 821)
- Chemical Dependence Outpatient and Opioid Treatment Programs (Part 822)

Regulatory requirements regarding Health Coordinators and comprehensive treatment plans are defined for each chemical dependence treatment service category in the Official Compilation of the Codes, Rules and Regulations of the State of New York. For additional information, please refer to the applicable regulations located on the OASAS Website.

The **Health Coordination Survey** documents compliance with OASAS regulations and, for those programs that are funded by OASAS, additionally documents requirements of the Federal Substance Abuse Prevention and Treatment (SAPT) Block Grant. Early HIV Intervention Services (EIS), which under the SAPT Block Grant must be provided on site of chemical dependence treatment, are defined as: pre- and post-test counseling for HIV, the actual testing of individuals for the presence of HIV and testing to determine the extent of the deficiency in the immune system, and the provision of therapeutic measures to address an individual's HIV status. OASAS has determined that Health Coordinators and OTP comprehensive treatment planning provide EIS.

All questions on this form should be answered as they pertain to each program operated by this agency. The responses to this survey should be coordinated to ensure accuracy of responses across all programs within the agency. We are asking that the survey be completed by **Monday, April 1, 2020**. Any questions related to this survey should be directed to Matt Kawola by phone at 518-457-6129, or by e-mail at Matt.Kawola@oasas.ny.gov.

1. What is the overall average fringe benefit rate paid to employees by this agency? This number must be entered in number format as a percentage of salary, without the percent sign or symbols (example: 20.5).

42.25 %

2. How are **health coordination** services provided to patients in each program operated by your agency? (check all that apply)

PRU	Program	Paid Staff	In-kind Services	Contracted Services
472	Chenango Co Behavioral Health Svcs OP	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. Please provide the following information for each PRU where those paid staff and in-kind services services are provided. If multiple individuals provide these services at a single program, provide the total hours worked and the hourly pay rate for each individual. For hourly pay rate, use number format without a dollar sign or symbols (example: 37.5).

PRU	Program	Health Coordinator #1			Health Coordinator #2			Hourly Rate (dollars)	
		Services Provided		Hours per Week Worked as a Health Coordinator	Hourly Rate (dollars)	Services Provided			Hours per Week Worked as a Health Coordinator
		On-site	Off-site			On-site	Off-site		
472	Chenango Co Behavioral Health Svcs OP	<input checked="" type="checkbox"/>	<input type="checkbox"/>	35	\$ 37.90	<input type="checkbox"/>	<input type="checkbox"/>	\$	

4. Please provide the following information for each PRU where those contracted services are provided. If multiple contracted individuals provide these services at a single program, provide the total hours worked per week and the average hourly rate paid. For dollars paid, use number format without a dollar sign or symbols (example: 37.5).

PRU	Program	Service Provided		Hours per Week Worked as a Health Coordinator	Hourly Rate (dollars)
		On-site	Off-site		

NYS OASAS Clinical Supervision Contact Information Form

(472)

Certified: Matthew Skojec (3/21/19)

The OASAS Division of Practice Innovation and Care Management (PICM) maintains contact information on clinical supervisors in order to communicate on matters of interest and importance to the practice of clinical supervision. This form was developed to collect contact information on all clinical supervisors in OASAS-certified treatment programs. The information will be maintained in the County Planning System and will be required to be updated annually in the spring. This form can be updated at any time throughout the year by contacting the OASAS Planning Unit oasasplanning@oasas.ny.gov and requesting that the form be decertified so that the information can be revised.

To enter the contact information for a clinical supervisor, click on the "Add a Clinical Supervisor" link below. Click on the link again to enter contact information for additional clinical supervisors

Name	Matthew Skojec	Name	Kelly Hunter
Credentials	LCSW-R	Credentials	LCSW-R
Email Address	MattS@co.chenango.ny.us	Email Address	KHunter@co.chenango.ny.us
Phone	607-337-1909	Phone	607-337-1690

Electronic Health Record (EHR) and Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) Program Survey
Chenango Co Behavioral Health Svcs OP (472)
Certified: Ruth Roberts (3/25/19)

The following survey is designed to provide OASAS with program-level information regarding two topics that are integral to ensuring that individuals with Substance Use Disorders (SUDs) receive the highest quality care. Part I asks about Electronic Health Record (EHR) usage and Part II collects information regarding the treatment of individuals identifying as lesbian, gay, bisexual, transgender or questioning (LGBTQ).

Questions related to this survey should be directed to Carmelita Cruz at Carmelita.Cruz@oasas.ny.gov.

PART I- Electronic Health Record (EHR) Survey

An Electronic Health Record (EHR) is a computerized record of health information about individual patients. Such records may include a whole range of data in comprehensive or summary form, including demographics, medical history, medication and allergies, immunization status, laboratory test results, radiology images, vital signs, personal information like age and weight, and billing information. Its purpose is to be a complete record of patient encounters that allows the automation and streamlining of the workflow in health care settings and increases safety through evidence-based decision support, quality management, and outcomes reporting.

The purpose of Part I of this survey is to assess your agency's status on the adoption of an EHR, and which EHRs are most commonly used by OASAS-certified programs.

1. Does your program use an electronic health record?

- No
- Yes, please provide the company and product names of your EHR below:

Company Name (e.g., Allscripts, Netsmart, Core Solutions, etc.):
DocuTrac, Inc. Accumedic Computer Systems, Inc.

Product Name (e.g., Paragon, CareRecord, Cx360, etc.)
QuickDoc Version 8.1.1 - Clinical documentation Accumed12 - Billing

PART II- Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) Policy and Technical Assistance Survey

Research suggests that Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) individuals face health disparities linked to societal stigma, discrimination, and denial of their civil and human rights. OASAS recognizes that culturally sensitive treatment often results in more effective treatment. In order to protect the rights of LGTBQ individuals receiving Substance Use Disorder (SUD) treatment OASAS issued Local Services Bulletin (LSB) 2017-04 "Affirming Care for Lesbian, Gay, Bisexual, Transgender and Questioning Clients in OASAS Programs."

The purpose of Part II of this survey is to gather background information regarding the LGBTQ populations served by OASAS-certified SUD treatment programs so that OASAS may develop technical assistance for providers in order to deliver the best possible care to LGBTQ individuals.

2. Is your program aware of Local Services Bulletin (LSB) 2017-04 "Affirming Care for Lesbian, Gay, Bisexual, Transgender and Questioning Clients in OASAS Programs"

- No
- Yes

3. In your opinion and not relying on data reported to OASAS, please estimate the percentage of total clients treated over the course of a year that identify as lesbian, gay, bisexual, transgender or questioning

7 %

4. Does your program require technical assistance to comply with the requirements of the LSB?

- No
- Yes, I need assistance with the following (check all that apply)
- a) Developing policies and procedures
 - b) Staff training on affirming LGBTQ care
 - c) Staff training on evidence-based practices, such as delivering trauma informed care
 - d) Other, please describe: