2017
Local Services Plan
For Mental Hygiene Services

Columbia County Dept of Human Services
August 4, 2016

NEW YORK STATE OF OPPORTUNITY.

Office of Mental Health | Office of Alcoholism and Substance Abuse Services | Office for People With Developmental Disabilities

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2017 Needs Assessment Report
Columbia County Dept of Human Services (70140)
Certified: Alison Calhoun (7/26/16)

Consult the LSP Guidelines for additional guidance on completing this exercise.

Attachments

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PART A: Local Needs Assessment

1. Assessment of Mental Hygiene and Associated Issues - In this section, describe the nature and extent of mental hygiene disabilities and related issues. Use this section to identify any unique conditions or circumstances in the county that impact these issues. You have the option to attach documentation, as appropriate.

Columbia County's 62,122 residents are distributed across 635 square miles (~99 persons/sq.mi.) and live in 18 towns, 4 villages and 1 city. Hudson is the county's only designated city and has a large portion of the county's population, with approximately 6,600 residents and an additional 4,100 in the contiguous town of Greenport. Other towns in the county with a significant number of residents include Kinderhook (~8,500), Claverack (~5,900) and Ghent (~5,300). According to the American Community Survey of 2013, 19% of the population in Columbia County was under 18 years old, 61% were aged 18-64, and 20% were 65 years of age and older. The median age was 46.4 years. 34% of the population receives some type of public health insurance and 20% of the population are Medicaid beneficiaries (79% of those are Medicaid only and 21% are dual Medicaid and Medicare). According to the U.S. Census Bureau, of Columbia County households in 2010, a substantial number (27%) were comprised of people living alone. In 2010, 22.6% of the population in Columbia County was under 19 years old, 59.1% were aged 19-64, and 18.2% were 65 years of age or older. This is considerably higher than the NYS rate of 13.5%. Columbia County is the second oldest county in the state for those aged 65 and older and the oldest county in the state for those aged 85 and older. As a result, some of the most critical issues in the county are related to an older population attempting to age in place and the system of community-based social supports that it requires. Moreover, this population is often the focus of ongoing discussions about the inadequacy of the system to ensure seamless, coordinated transitions between care settings. According to the most recent report released by the NYS Community Action Association, 10.4% of all Columbia County residents live under the poverty line, representing 14% of all children (under 18) and 6% of all seniors (65 and older). OMH: A review of the NYS Conference of Local Mental Hygiene Directors (CLMHD) Behavioral Health Portal's "Estimated Need Prevalence" data (pulled from SAMHSA data) for Columbia County reveals that there continues to be a high number of individuals presenting with a need for mental hygiene services. In 2013, an estimated 10,065 adult individuals (18+) presented with a diagnosable mental illness; more than 2,000 were identified as having a serious mental illness. According to NYS DOH, in 2014, Suicide was the 6th most common cause of death in Columbia County and we had the highest suicide rate per 100,000 residents than any other county in the capital region (17 versus the regional average of 12). OASAS: According to the CLMHD Behavioral Health Portal's "Estimated Need Prevalence" data there continues to be a significant alcohol and substance use disorder problem in Columbia County. In 2013 approximately 4,127 individuals in Columbia County had an alcohol and/or substance use disorder. More specifically, 6.3% (287) are 12-17 years old, 17.1% (933) are 18-25 years old and 6.5% (2907) are 26 years old or older have an alcohol use and/or substance use disorder. The data also suggests that in 2013, only 467 unique individuals received substance use treatment which means that approximately 90 percent of those needing alcohol and/or substance use disorder treatment did not receive a needed SUD treatment. A review of NYS DOH data reveals that In 2012, of the inpatient hospital admissions for substance use disorders, individuals diagnosed with Alcohol Use Disorder accounted for the highest number (175) followed by Opioid Use (115), Cannabis/NOS/NEC (113), Cocaine Use (57) and other SUD diagnoses (55). From 2010 to 2014, the number of Opioid related inpatient hospital admissions increased by 34.8% and the number of Opiod related emergency department admissions increased by 112.8%. It is unknown how many Narcan kits have been distributed locally and we are unable to accurately report the number of Narcan reversals administered. OPWDD: According to the CLMHD data dashboard's "Estimated Need Prevalence" data, in 2014 there were approximately 637 developmentally disabled individuals in Columbia County in need of services. In 2015 only 599 individuals were receiving services through OPWDD, potentially leaving a portion of this population un-served. It is unclear what conclusions can be drawn from this.

2. Analysis of Service Needs and Gaps - In this section, describe and quantify (where possible) the prevention, treatment and recovery support service needs of each disability population, including other individualized person-centered supports and services. Describe the capacity of existing resources available to meet the identified needs, including those services that are accessed outside of the county and outside the funded and certified service system. Describe the gaps between services needed and services provided. Describe existing barriers to accessing needed services. Identify specific underserved populations or populations that require specialized services. You have the option to attach documentation, as appropriate.

OMH Our efforts to expand the geographic reach and to fill service continuum gaps continue. The Columbia County Mental Health Center continues to establish school based clinic satellites in different school districts throughout the county. A mobile crisis assessment team (MCAT) was established July 1, 2015 using OMH Article 28/31 Reinvestment funding. In the first year of operation, MCAT reported that 94.1% of individuals served did not require subsequent hospitalization and 99.2% did not require police contact immediately following MCAT contact. There were 1316 individuals served (971 unduplicated individuals) including 5255 phone calls and 499 in person responses. This two person response team is shared between Columbia and Greene Counties, covering 1300 square miles and operates 7 days per week, 8 hours per day. With additional funding, this program could be expanded by adding additional staff to enable increased face to face response to simultaneous locations and also extend the hours. Columbia County has a small community hospital in Hudson (Columbia Memorial Health [CMH]) with a 22 bed Article 28 adult inpatient psychiatric unit serving the region. CMH also offers outpatient behavioral health services for children and adults. CMH provided data indicates that their Emergency Department completed approximately 1449 psych evaluations in 2015, which is an increase of 46% from 2008. Other than the county operated OMH outpatient clinic, this is the only other outpatient clinic in the county. A small number of private practitioners exist – offering outpatient behavioral health services, but only to non-Medicaid eligible individuals. Limited family advocacy support services are available. The county does not have (and may benefit from): a Child and Family Clinic Plus (funding ended in 2012), a Children's Inpatient Unit, an ACT Team, a Crisis Residence, a Partial Hospital and/or an Intensive Adolescent Day Treatment program. Development of such service options is challenging due to the anticipated low volume of use and resulting high cost. According to the NYS Capital DSRIP Region Needs Assessment, Columbia County has a capacity of 70 slots for Personalized Recovery-Oriented Services (PROS). There is no Partial Hospitalization program, Assertive Community Treatment team, Intensive Psychiatric Rehabilitative Treatment (IPRT) or Continuing Day Treatment (CDT) in the county. The outpatient mental health clinic service use in 2014 was approximately 1,218 adults (806 Medicaid recipients and 412 Non-Medicaid recipients). The outpatient mental health clinic service use for children was approximately 325 (245 Medicaid recipients and 80 Non-Medicaid recipients). There are no children's Partial Hospitalization, day treatment or Children's Assertive Community Treatment programs operating in Columbia County. Adult Behavioral Health Housing Programs: There are 12 OMH licensed family care beds, 14 OMH licensed congregate treatment beds and 43 OMH licensed apartment treatment beds. There are 24 unlicensed housing support program beds and 39 unlicensed supported housing beds. There are no Child Behavioral Health Housing Programs in Columbia County, however we do have 18 HCBS children's waiver slots which puts us at the highest ratio of slots per 100,000 children in the capital region. The following list identifies the licensed mental health workforce in the county: 4 Psychiatrists, 32 Psychologists, 69 LCSWs, 65 LMSWs, 9 MHCs, 10 NP- Psychiatry, and 7 "other" for a total of 196 providers (32 providers per 10,000 residents). According to County Health Rankings and Roadmaps, the ratio of Columbia County's population to our Mental Health Providers is 740:1 with the NYS average being 420:1. OASAS There is a shortage of available Medication Assisted treatment (MAT) slots/providers (e.g. Suboxone and Vivitrol) given the Opioid abuse epidemic. The services available often are not accompanied by the requisite counseling services. We do not have an OASAS Detoxification Unit or a Methadone Maintenance Treatment Program. There is a Vivitrol program at the Columbia County Jail that is just getting started. Columbia County has one OASAS prevention program. More than $180K of annual OASAS state aid prevention funding was cut in 2011, decimating 60% of Columbia County's prevention services. There are three part 822 clinics (only one in a community setting). There are 13 beds of Part 819 Community Residence (CR) operated by Twin County Recovery Services. An increase of capacity of 5 (13 to 18) CR beds (and site relocation) are being pursued as per recommendation of OASAS and agreement by the CSB. There are 8 Supported Housing beds shared between both Columbia and Greene Counties. According to the NYS Capital DSRIP Region Needs Assessment, the following list identifies the certified and credentialed substance use disorder professionals in the county: 7 Physicians authorized for Buprenorphine prescription, 19 CASACs and 2 Certified Rehabilitation

Counselors. Columbia is the only county in the capital region without a Board Certified Addiction Medicine Physician. However, an internal survey of the local providers completed in Fall 2015 reflects only 3 Physicians authorized for Buprenorphine prescription. OPWDD As a result of the Front Door NY OPWDD assumption of SPOA responsibilities, LGUs are without the knowledge of volume and type of eligibility and service requests, response timeline or unmet need. This knowledge is required to meet our Article 41 obligation in order to create a local plan. The OPWDD "Front Door" process has resulted in slow response and poor care for individuals with I/D Disabilities. Anecdotal (no data is available to LGUs) reports reflect routine delays in eligibility determination and service approval of 6 months to 2 years. The provider community is burdened with non-reimbursable tasks on the front end of this process. Access challenges to psychological testing due to under market rates/health professional shortages create significant delays through the first gate of many involved in the process. During 2016, OPWDD Region 3 DDRO staff have been assisting the LGU in obtaining local data to identify and resolve issues. In 2013, we lost the only Article 16 clinic service provider in the county. This year The Center for Disability Services lost 1 full time psychiatrist and 1 full time nurse practitioner which severely restricted their ability to provide medication management services. This affected approximately 47 people in Columbia County. We are continuing to explore options for the local provision of mental health services to individuals with I/DD experiencing co-occuring mental health issues. The sheltered workshop program run by the local NYSARC chapter continues to decrease in size due to reduced state aid funding. They are working to transition the sheltered workshop to an integrated business model. Cross Disability Un-met Need • A severe prolonged shortage of psychiatrists (especially child psychiatrists) negatively impacts the behavioral health service delivery system in Columbia County. As a result, individuals who may benefit from psychopharmacy services go without, or are served by not adequately trained PCPs. Advocacy for Health professional Shortage Area designation to incentivize workforce attraction and retention through loan forgiveness is being pursued again. • Only a handful of small sized non-profits provide services to county residents currently. These organizations continue to be concerned about the increasing level of critical mass and business line diversification needed to remain financially viable. Organizational consolidations and IPA formations are being considered and pursued. Conversion from "Meaningful Use" incentives to penalties is a concern for our provider community. The financial impact of the advent of the projected 2018 end of legacy APG/fee-for-service reimbursement mental health clinics is a concern. The 90 % "volume-to-value" Medicaid and Medicare reimbursement model transition projected for 2020 is also a significant concern. Cultural and infrastructure changes will be needed and organizations have been encouto make use of technical assistance resources such as CTAC. Aggressive efforts are being made by the LGU to prepare providers for this transition to "selling their product" on the open market of managed care as well as tracking performance data and establishing related CQI processes. Our provider community must prepare to comply with NCQA 2014 Level 3 Medical Home Standards to effectively compete in a future integrated community healthcare market. Our provider community must begin to build IT capacity to meet MAPP/RHIO standards to effectively compete in a future integrated data driven, value based community healthcare market. Our LGU has proactively begun designing an expanded standardized web based SPOA model (i.e. beyond simply OMH services) to prepare a more broadly marketable service to sell to PPSs, MCOs, and ACOs. • A related issue of concern is the lack of organizational preparedness of a subset of our potential HCBS Waiver providers (especially peer service providers) to bill Medicaid and comply with regulations. • The gradual elimination/ reduction of "low-demand", maintenance, non "medically necessary" services over the past ten years across the continuum of OMH, OASAS and OPWDD (due to Olmstead, Medicaid reimbursement financing versus state aid financing models) has inadvertently created service gaps for individuals unable to tolerate structure. These individuals previously obtained stabilization, enhanced self esteem and identity through programs such as SUD Prevention, Psychosocial Club, CDT, and sheltered workshops. • Housing -Several variables have accentuated the supported housing bottleneck in Columbia County (as in other communities) including: i. The closure/restriction of all Section 8/Housing Choice voucher waiting lists ii. The lack of expansion of HUD Super NOFA pro rata share iii. The elimination of funding for COC designated Tier II HUD Super NOFA projects (2016 – Greene County Community Action DV Supported Housing) iv. The limitations of exclusive development of restrictive stock (dedicated for NYS OMH PC, OPWDD DC, OASAS ATC and DOCCS Prison census reduction/ MRT goal-specific housing) v. The gentrification of the City of Hudson vi. Relatively low stock and high occupancy of rental housing vii. The gap (without access to subsidy) between Fair Market Rent (FMR) rates and rent affordable to an individual receiving SSI (e.g. 1 bedroom FMR equals $711/ month and 30% of SSI payment of $220- leaving a gap of $491/month) The current Adult Housing SPOA waitlist includes 22 individuals.

3. Assessment of Local Needs - For each category listed in this section, indicate the extent to which it is an area of need by checking the appropriate check box under "High", "Moderate", or "Low" for each population: Youth (Under 21) and Adults (21 and Over). When considering the level of need, compare each issue category against all others rather than looking at each issue category in isolation. For each issue that you identify as a "High" need, answer the follow-up question to provide additional detail.

	Youth (< 21)			Adult (21+)		
Issue Category	**High**	**Moderate**	**Low**	**High**	**Moderate**	**Low**
Substance Use Disorder Services:						
a) Prevention Services	◉	○	○	○	◉	○
b) Crisis Services	○	○	◉	○	◉	○
c) Inpatient Treatment Services	○	◉	○	◉	○	○
d) Opioid Treatment Services	◉	○	○	◉	○	○
e) Outpatient Treatment Services	○	○	◉	○	○	◉
f) Residential Treatment Services	◉	○	○	◉	○	○
g) Housing.	◉	○	○	◉	○	○
h) Transportation.	◉	○	○	◉	○	○
i) Other Recovery Support Services	○	◉	○	○	◉	○
j) Workforce Recruitment and Retention	○	◉	○	○	◉	○
k) Coordination/Integration with Other Systems	○	◉	○	○	◉	○
l) Other (specify):	○	○	○	○	○	○
Mental Health Services:						
m) Prevention	◉	○	○	◉	○	○
n) Crisis Services	○	◉	○	○	◉	○
o) Inpatient Treatment Services	◉	○	○	○	○	◉
p) Clinic Treatment Services	○	○	◉	○	○	◉
q) Other Outpatient Services	○	◉	○	○	◉	○
r) Care Coordination	○	○	◉	○	○	◉
s) HARP HCBS Services (Adult)				○	○	◉
t) HCBS Waiver Services (Children)	○	◉	○			

u) Other Recovery and Support Services	○	◉	○	○	◉	○
v) Housing	◉	○	○	◉	○	○
w) Transportation	◉	○	○	◉	○	○
x) Workforce Recruitment and Retention	○	◉	○	○	◉	○
y) Coordination/Integration with Other Systems	○	◉	○	○	◉	○
z) Other (specify):	○	○	○	○	○	○
Developmental Disability Services:						
aa) Crisis Services	○	○	◉	○	◉	○
bb) Clinical Services	◉	○	○	◉	○	○
cc) Children Services	○	◉	○			
dd) Adult Services				◉	○	○
ee) Student/Transition Services	◉	○	○	○	◉	○
ff) Respite Services	○	◉	○	○	◉	○
gg) Family Supports	◉	○	○	◉	○	○
hh) Self-Directed Services	○	○	◉	○	○	◉
ii) Autism Services	◉	○	○	○	○	◉
jj) Person Centered Planning	○	◉	○	○	◉	○
kk) Residential Services	○	◉	○	◉	○	○
ll) Front Door	○	◉	○	◉	○	○
mm) Transportation	◉	○	○	◉	○	○
nn) Service Coordination	○	◉	○	○	◉	○
oo) Employment	◉	○	○	◉	○	○
pp) Workforce Recruitment and Retention.	◉	○	○	◉	○	○
qq) Coordination/Integration with Other Systems.	○	○	◉	○	◉	○
rr) Other (specify):	○	○	○	○	○	○

Follow-up Questions to "Prevention Services" (Question 3a)

3a1. Briefly describe the issue and why it is a high need for the populations selected.
Youth: One small OASAS Prevention program is operated (more than $180K of annual funding was cut in 2011- decimating 60% of our prevention services).
Adult: NYS OASAS increased county state aid funding for adult prevention service in the Columbia County Jail by $10,000 in 2016.

Follow-up Questions to "Inpatient Treatment Services" (Question 3c)

3c1. Briefly describe the issue and why it is a high need for the populations selected.
There are no Inpatient Treatment Services for either adults or youth located in Columbia County. Residents must travel out of county to access these services. Family members are limited in their ability to support a client's recovery work and discharge planning for this reason.

Follow-up Questions to "Opioid Treatment Services" (Question 3d)

3d1. Briefly describe the issue and why it is a high need for the populations selected.
There is a shortage of available Medication Assisted treatment (MAT) slots/providers (e.g. Suboxone and Vivitrol) given the Opioid abuse epidemic. The services available often are not accompanied by the requisite counseling services. We do not have an OASAS Detoxification Unit or a Methadone Maintenance Treatment Program. There is a Vivitrol program at the Columbia County Jail that is just getting started.

Follow-up Questions to "Residential Treatment Services" (Question 3f)

3f1. Briefly describe the issue and why it is a high need for the populations selected.
There is an all male Part 819 Community Residence located in the county with a capacity of 13. An increase of capacity of 5 (13 to 18) and site relocation is being pursued as per recommendation of OASAS and agreement by the CSB. No housing options for adult females or any adolescents are available in the county.

Follow-up Questions to "Housing" (Question 3g)

3g1. Briefly describe the issue and why it is a high need for the populations selected.
St. Catherine's Center for Children operates a supportive housing program funded by OASAS/HUD offering 8 apartments split between both Columbia and Greene Counties. The funding for this project (formerly Shelter Plus Care) is insufficient. The quantity of total stock is also insufficient.

Follow-up Questions to "Transportation" (Question 3h)

3h1. Briefly describe the issue and why it is a high need for the populations selected.
No public transportation is available throughout the county. An individual's ability to live as independently as possible is partially contingent upon their ability to access services, shopping, education, work and social events. Medicaid transportation is provided by a number of public and private not-for-profit providers. This population tends to have a higher proportion of people with revoked or suspended licenses making it especially difficult for them to make it around the rural county.

Follow-up Questions to "Prevention" (Question 3m)

3m1. Briefly describe the issue and why it is a high need for the populations selected.
No prevention services exist in the county for adults or children.

Follow-up Questions to "Inpatient Treatment Services" (Question 3o)

3o1. Briefly describe the issue and why it is a high need for the populations selected.
The county does not have a children's inpatient unit or residential treatment facility. Family members are limited in their ability to support a client's recovery work and discharge planning for this reason.

Follow-up Questions to "Housing" (Question 3v)

3v1. Briefly describe the issue and why it is a high need for the populations selected.
Adult - There is consistently a long wait list for Adult Housing SPOA. The current wait list is 22 individuals. Youth - No runaway and homeless youth shelter beds are available or transitional supported housing options for 18-25 year old young adults.

Follow-up Questions to "Transportation" (Question 3w)

3w1. Briefly describe the issue and why it is a high need for the populations selected.
No public transportation is available throughout the county. An individual's ability to live as independently as possible is partially contingent upon their ability to access services, shopping, education, work and social events. Medicaid transportation is provided by a number of public and private not-for-profit providers.

Follow-up Questions to "Clinical Services" (Question 3bb)

3bb1. Briefly describe the issue and why it is a high need for the populations selected.
In 2013, we lost the only Article 16 clinic service provider in the county. This year The Center for Disability Services lost 1 full time psychiatrist and 1 full time nurse practitioner which severely restricted their ability to provide medication management services. This affected approximately 47 people in Columbia County. We are continuing to explore options for the local provision of mental health services to individuals with I/DD experiencing co-occurring mental health issues.

Follow-up Questions to "Adult Services" (Question 3dd)

3dd1. Briefly describe the issue and why it is a high need for the populations selected.
The gradual elimination/ reduction of “low-demand”, maintenance, non “medically necessary” services over the past ten years across the continuum of OMH, OASAS and OPWDD (due to Olmstead, Medicaid reimbursement financing versus state aid financing models) has inadvertently created service gaps for individuals unable to tolerate structure. These individuals previously obtained stabilization, enhanced self esteem and identity through programs such as SUD Prevention, Psychosocial Club, CDT, and sheltered workshops.

Follow-up Questions to "Student/Transition Services" (Question 3ee)

3ee1. Briefly describe the issue and why it is a high need for the populations selected.
School Districts (DOE)do not have sufficient resources to fulfill their critical non-educational systemic role in screening and referral for assessment. Without such diagnoses prior to 21 years of age, service access if poor.

Follow-up Questions to "Family Supports" (Question 3gg)

3gg1. Briefly describe the issue and why it is a high need for the populations selected.
The Olmstead ruling and CMS directives encouraging integrated and non-institutional services have had the unintentional effect of burdening family and residential care givers.

Follow-up Questions to "Autism Services" (Question 3ii)

3ii1. Briefly describe the issue and why it is a high need for the populations selected.
Spectrum disorder prevalence has reported nationally to have increased. This has not been confirmed locally, but will be pursued via local EI provider and OPWDD DDRO. Once this is known our response will be planned.

Follow-up Questions to "Residential Services" (Question 3kk)

3kk1. Briefly describe the issue and why it is a high need for the populations selected.
Priority 3 residential services need response is inadequate. During 2016, OPWDD Region 3 DDRO staff have been assisting the LGU in obtaining local data to identify and resolve issues. The most recent regional data showed 69 priority 3 individuals waiting for certified residential opportunities in the Taconic Region.

Follow-up Questions to "Front Door" (Question 3ll)

3ll1. Briefly describe the issue and why it is a high need for the populations selected.
The OPWDD “Front Door” process has resulted in slow response and poor care for individuals with I/D Disabilities. Anecdotal (no data is available to LGUs) reports reflect routine delays in eligibility determination and service approval of 6 months to 2 years. The provider community is burdened with non-reimbursable tasks on the front end of this process. Access challenges to psychological testing due to under market rates/health professional shortages create significant delays through the first gate of many involved in the process.

Follow-up Questions to "Transportation" (Question 3mm)

3mm1. Briefly describe the issue and why it is a high need for the populations selected.
No public transportation is available throughout the county. An individual's ability to live as independently as possible is partially contingent upon their ability to access services, shopping, education, work and social events. Medicaid transportation is provided by a number of public and private not-for-profit providers. Also, this population has low incidents of obtaining a license and it is very costly to maintain individual transportation.

Follow-up Questions to "Employment" (Question 3oo)

3oo1. Briefly describe the issue and why it is a high need for the populations selected.
The sheltered workshop program run by the local NYSARC chapter continues to decrease in size due to reduced state aid funding. They are working to transition the sheltered workshop to an integrated business model.

Follow-up Questions to "Workforce Recruitment and Retention" (Question 3pp)

3pp1. Briefly describe the issue and why it is a high need for the populations selected.
The Justice Center's Incident reviews which often lead to long administrative leaves for employees and the legal threats inherent with work in this field are a challenge to recruitment and retention. Direct support professionals are often paid minimum wage for physically and emotionally challenging work.

Local needs generally do not change significantly from one year to the next. It often takes years of planning, policy change, and action to see real change. In an effort to assess what changes may be happening more rapidly across the state, indicate below if the overall needs of each disability population got better or worse or stayed about the same over the past year.

4. How have the overall needs of the **mental health** population changed in the past year?

- (●) a) Overall needs have stayed about the same.
- ( ) b) Overall needs have improved.
- ( ) c) Overall needs have worsened.
- ( ) d) Overall needs have been a mix of improvement and worsening.
- ( ) e) Not sure.

4a. If you would like to elaborate on why you believe the overall needs of the mental health population have stayed about the same over the past year, briefly describe here

It remains to be seen how the July 1st upstate Medicaid Managed Care transition impacts the adequacy of the services in the population.

5. How have the overall needs of the **substance use disorder** population changed in the past year?

- ( ) a) Overall needs have stayed about the same.
- ( ) b) Overall needs have improved.
- (●) c) Overall needs have worsened.
- ( ) d) Overall needs have been a mix of improvement and worsening.
- ( ) e) Not sure.

5c. If you would like to elaborate on why you believe the overall needs of the substance use disorder population have worsened over the past year, briefly describe here

Controlled Substance Abuse Opioid death epidemic. It remains to be seen how the July 1st upstate Medicaid Managed Care transition impacts the adequacy of the services in the population.

6. How have the overall needs of the **developmentally disabled** population changed in the past year?

- (●) a) Overall needs have stayed about the same.
- ( ) b) Overall needs have improved.
- ( ) c) Overall needs have worsened.
- ( ) d) Overall needs have been a mix of improvement and worsening.
- ( ) e) Not sure.

6a. If you would like to elaborate on why you believe the overall needs of the developmentally disabled population have stayed about the same over the past year, briefly describe here

OPWDD Front Door process inadequacy and poor quality of life consequences for individuals impacted by elimination of non-integrated, non-competitive employment options remains a concern.

In addition to working with local mental hygiene agencies, LGUs frequently work with other government and non-government agencies within the county and with other LGUs in their region to identify and address the major issues that have a cross-system or regional impact. The following questions ask about the nature and extent of those collaborative planning activities.

7. In the past year, has your agency been included in collaborative planning activities related to the Prevention Agenda 2013-2018 with your Local Health Department?

(●) a. Yes
( ) b. No

7a. Briefly describe those planning activities with your Local Health Department.

The Local Health Department has been holding monthly CHIP development meetings in which the LGU has participated.

8. In the past year, has your agency participated in collaborative planning activities with other local government agencies and non-government organizations?

(●) a. Yes
( ) b. No

8a. Briefly describe those planning activities with other local government agencies and non-government organizations.

There are members from the following organizations on the Community Services Board and Subcommittees who are actively involved in the planning process: Columbia Memorial Health, Local Department of Social Services, Twin County Recovery Services, Columbia Opportunities, Catholic Charities of Columbia Greene Counties, Mental Health Association of Columbia Greene Counties, NAMI, Greater Hudson Promise Neighborhood, Columbia County Jail, Healthcare Consortium, Berkshire Farm Center and Services for Youth, Coarc, Columbia County Department of Health, Camphill Hudson, and Columbia Greene Community College. Many of these members are also involved in the task forces and Mental Hygiene Network described in 9a. We participate in DSRIP PPS of Albany Medical Center Hospital (AMCH).

9. In the past year, has your agency participated in collaborative planning activities with other other LGUs in your region?

(●) a. Yes
( ) b. No

9a. List each activity and the LGU(s) involved in that collaboration and provide a brief (one or two sentence) description of the activity.

Columbia Greene Controlled Substance Awareness Task Force - Meets quarterly with a mission to address the heroin and prescription drug crisis through prevention, intervention, treatment and recovery. Columbia Greene Suicide Prevention Task Force - Meets quarterly to address suicide prevention in Columbia and Greene Counties. Columbia Greene Mental Hygiene Network - meets bi-monthly to advance the Local Government Unit’s planning strategies which focus primarily of cross system initiatives.

9b. Did your collaborative planning activities with other LGUs in your region include identifying common needs that should be addressed at a regional level?

(●) a. Yes
( ) b. No

9c. Did the counties in your region reach a consensus on what the regional needs are?

(●) a. Yes
( ) b. No

9d. Briefly describe the consensus needs identified by the counties in your region

See AMCH DSRIP PPS plan priorities and Columbia Greene CHIP planning priorities.

2017 Multiple Disabilities Considerations Form
Columbia County Dept of Human Services (70140)
Certified: Alison Calhoun (7/26/16)

Consult the LSP Guidelines for additional guidance on completing this form.
LGU: Columbia County Dept of Human Services (70140)

The term "multiple disabilities" means, in this context, persons who have at least two of the following disabling conditions: a developmental disability, a mental illness, or an addiction. In order to effectively meet the needs of these individuals, several aspects should be addressed in a comprehensive plan for services. Accordingly:

1. Is there a component of the local governmental unit which is responsible for identifying persons with multiple disabilities?

◉ Yes
○ No

If yes, briefly describe the mechanism used to identify such persons:

The Local Government Unit (LGU) and Department of Human Services has several components working simultaneously to identify and serve the multi-disabled. LGU staff hold key roles as Dual Recovery Coordinator for Mental Illness and Chemical Dependency, Office of Mental Health Single Point of Access (SPOA) for children's and adult case management and adult housing. The LGU is actively engaged in facilitating the Children's System of Care philosophy which merged with Department of Social Services Continuum of Care to address youth and family issues which cross systems of care. Medicaid Health Homes focus primarily on individuals identified as chronic or multi disabled. The LGU's involvement with the Health Departments MAPP processes followed by the 2013-2017 Health Plan resulted in a Public Health Leadership Team which has prioritized public health strategies on mental health and substance abuse.

2. Is there a component of the local governmental unit which is responsible for planning of services for persons with multiple disabilities?

◉ Yes
○ No

If yes, briefly describe the mechanism used in the planning process:

The Dual Recovery Coordinator and the Planner/Contract Manager have direct input to county planning and indirect input to contract agency planning and program design. The LGU convenes the Mental Hygiene Network, a Tier II Director Level group of mental hygiene provider agencies. The Mental Hygiene Network meets bi-monthly to advance the Local Government Unit's planning strategies which focus primarily of cross system initiatives. Single Points for mental health case management and housing and the Community Services Board Subcommittees are an integral part in the planning process for the multi-disabled person. The ideal model being pursued by our CSB and increasingly incentivized by NYSDOH is integrated service delivery in recognition that more often than not an individual presents symptoms of a variety of behavioral health concerns as well as chronic medical conditions. Having all Medicaid medical and behavioral health points of service be at the very least competent in broad disorder screening, referral and follow up is essential. Models of providing "whole-person" single site broad disorder treatment service are also being pursued to the extent that regulatory relief permits this.

3. Are there mechanisms at the local or county level, either formal or informal in nature, for resolving disputes concerning provider responsibility for serving persons with multiple disabilities?

◉ Yes
○ No

If yes, describe the process(es), either formal or informal, for resolving disputes at the local or county level and/or at other levels of organization for those persons affected by multiple disabilities:

The Mental Hygiene Network addresses adult and children system issues. A case-by-case arbitration can also be accessed through the Director of Community Services.

Mental Hygiene Priority Outcomes Form
Columbia County Dept of Human Services (70140)
Plan Year: 2017
Certified: Alison Calhoun (7/26/16)

Consult the LSP Guidelines for additional guidance on completing this form.

2017 Priority Outcomes - Please note that to enter information into the new items under each priority, you must click on the "Edit" link next to the appropriate Priority Outcome number.

Priority Outcome 1:

1) Decrease use of non-prescribed controlled substances and increase responsible controlled substance prescribing practices

Progress Report: (optional) *new*

Priority Rank: 1

Applicable State Agencies: OASAS OMH

Aligned State Initiative: *new*

☑ The Prevention Agenda 2013-2018
☑ Combat Heroin and Prescription Drug Abuse

Is this priority also a Regional Priority? *new* Not Sure

Strategy 1.1

Provide Community Education Forums METRICS: i) 2 additional forums will be held by May 2017
Applicable State Agencies: OASAS OMH

Strategy 1.2

Increase Medication Assisted Treatment (MAT) Options and Capacity METRICS i) Evaluated need for local Methadone treatment by May 2017 ii) Evaluated need for local detox and rehab by May 2017 iii)Expand Vivitrol, Suboxone and other MAT capacity
Applicable State Agencies: OASAS OMH

Strategy 1.3

Expand community capacity to administer Narcan METRICS i) Encourage and support Catholic Charities' Project Safe Point in their education of administration and distribution of kits (100 additional kits distributed by May 2017)
Applicable State Agencies: OASAS OMH

Strategy 1.4

Expand convenience and options of Medication drop Boxes (Current capacity = 2) METRICS i) Will advocate for pharmacies to create drop boxes and expand capacity by 2 (4)
Applicable State Agencies: OASAS OMH

Strategy 1.5

Expand School Based OASAS Substance Abuse Prevention Services METRICS i) Expand SA Prevention services from 2 districts (Hudson and Ichabod Crane) to 3 districts (Chatham) by May 2017
Applicable State Agency: OASAS

Strategy 1.6

Increase mandated continuing education for health professionals regarding responsible controlled substance prescribing METRICS i) Institute Policy and Procedure within Columbia County Department of Human Services by May 2017 ii) Advocate for adoption by Columbia Memorial Health and behavioral health providers
Applicable State Agencies: OASAS OMH

Priority Outcome 2:

Enhance community knowledge of behavioral health disease model, prevention/ risk reduction and symptom management

Progress Report: (optional) *new*

Priority Rank: 2

Applicable State Agencies: OASAS OMH

Aligned State Initiative: *new*

☑ The Prevention Agenda 2013-2018
☑ The State Health Innovation Plan (SHIP)/State Innovation Models (SIM)

☑ Population Health Improvement Plan (PHIP)

Is this priority also a Regional Priority? *new* Not Sure

Strategy 2.1

Decrease stigma, decrease rate and severity of disease, and increase utilization of existing behavioral health services
Applicable State Agencies: OASAS OMH

Priority Outcome 3:

Improve Physical and Behavioral Health of residents (expand multi-disorder screening and referral for assessment and treatment capacity at all points of service)

Progress Report: (optional) *new

Priority Rank: 3

Applicable State Agencies: OASAS OMH OPWDD

Aligned State Initiative: *new

☑ The Prevention Agenda 2013-2018
☑ The State Health Innovation Plan (SHIP)/State Innovation Models (SIM)
☑ Population Health Improvement Plan (PHIP)
☑ Medicaid Delivery System Reform Incentive Payment Program (DSRIP)
☑ Adult Medicaid Behavioral Health Managed Care Implementation
☑ Child Medicaid Behavioral Health Managed Care Implementation
☑ OMH Transformation Plan
☑ Combat Heroin and Prescription Drug Abuse

Is this priority also a Regional Priority? *new* Not Sure

Strategy 3.1

Establishment of collocated OMH licensed MH and OASAS licensed SA services at piloted Family Care practices (3 a i Model 1) METRICS i) Advocacy with Columbia Memorial Health (CMH) to establish one pilot collocation (DSRIP 3 a i- Model 1) project by May 2017 ii)Advocacy to NYS DOH/CMS to approve pending Hudson River Health Care (HRHC) FQHC collocation project by May of 2017
Applicable State Agencies: OASAS OMH

Strategy 3.2

Implementation of routine PHQ-9, C-SSRS, SBIRT, etc screenings by CMH point of service, (3 a i, others) METRICS i)Advocate with CMH for ED pilot to begin by May 2017 ii) Confirm use by HRHC FQHC by October 2016
Applicable State Agencies: OASAS OMH OPWDD

Strategy 3.3

Referrals (or increased referrals) to Mental Health Associations's Mobile Crisis Assessment Team (MCAT) by CMH ED, Ambulatory Care and Inpatient Services (3, a ii) METRICS i) Increase monthly volume of referrals from CMH to MCAT from 10.5% to 15% by May of 2017
Applicable State Agencies: OASAS OMH

Strategy 3.4

Law Enforcement and EMT Personnel will enhance behavioral health crisis management and behavioral health screening/referral skills METRICS i) Crisis Intervention Training (CIT) or Police CIT course will be offered to all County Law Enforcement and EMT organizations by May 2017
Applicable State Agencies: OASAS OMH OPWDD

Strategy 3.5

Increase cross referrals between OMH & OASAS licensed outpatient services. METRICS i) Determine baseline volume of cross referrals.
Applicable State Agencies: OASAS OMH

Strategy 3.6

Continued implementation of broad based acute and chronic pain management practice guidelines and monitoring METRICS i) Advocacy with CMH for expansion of pilot throughout the CMH organization ii) Implement Policy and Procedure within DHS services by May 2017 iii) Advocate to implement policy and procedure within TCRS services by May 2017
Applicable State Agencies: OASAS OMH

Strategy 3.7

HIXNY RHIO virtual chart sharing METRICS i)CMH and CCDHS will have the capacity to share chart content via HIXNY RHIO platform by May 2017
Applicable State Agencies: OASAS OMH OPWDD

Strategy 3.8

Increased Training in Motivational Interviewing regarding MH and SA issues and Trauma Informed Care METRICS i)Utilize regional/ local training opportunities by May of 2017 of Motivational Interviewing and Trauma Informed Care
Applicable State Agencies: OASAS OMH

Strategy 3.9

Enhance community capacity to offer BH "First Aid" METRICS i)Utilize regional/ local training opportunities by May of 2017 of each of the following: Youth MH First Aid, MH First Aid, Psychological First Aid, Trauma Debriefing for first responders/caregivers
Applicable State Agencies: OASAS OMH OPWDD

Strategy 3.10

Enhance commercially insured residents ability to access in-network local outpatient BH providers METRICS i) Advocacy to NYS Dept of Financial Services to confirm network adequacy of commercial plan when reports of inability to access are reported to LGU
Applicable State Agencies: OASAS OMH OPWDD

Priority Outcome 4:

Increase access to safe, affordable, flexible EBP supportive housing

Progress Report: (optional) *new*

Priority Rank: 4

Applicable State Agencies: OASAS OMH OPWDD

Aligned State Initiative: *new*

- [x] Medicaid Delivery System Reform Incentive Payment Program (DSRIP)
- [x] OMH Transformation Plan
- [x] OPWDD People First Transformation

Is this priority also a Regional Priority? *new* Not Sure

Strategy 4.1

Expansion of capacity (and relocation) of Twin County Recovery Services (TCRS) Men's Residence ; The Red Door METRICS i)TCRS will purchase property for relocation/expansion by May 2017
Applicable State Agencies: OASAS OMH OPWDD

Strategy 4.2

Support Mental Health Association of Columbia Greene Counties in the completion and rent up of Greenport Commons
Applicable State Agency: OMH

Strategy 4.3

Expand viable residential options for OPWDD Priority 2 and 3 designated individuals METRICS i) Obtain Columbia County specific Taconic DDRO Residential Vacancy Management data to establish un-met need
Applicable State Agency: OPWDD

Strategy 4.4

Support individuals diagnosed with I/ DD by enhancing access to support METRICS i)Increase use of OPWDD ISS supports from 10 (current) to 20 by May of 2017
Applicable State Agency: OPWDD

Strategy 4.5

Expand BH set aside supported housing stock (current capacity= 37) METRICS i) Enhance behavioral health-serving CBO knowledge of the housing development process by providing one community training (e.g. Camphill Hudson, Galvan Foundation) by May 2017 and have one CBO application submitted by May of 2017 ii) Explore option of utilizing pre-existing residential properties in good condition iii) Host Housing Forum to inform public and obtain input by May 2017 iv) Explore Peer Operated Stabilization and Wellness Center by May 2017 v) Provide 2 "Roommate 101" 6-session course training opportunities to tenants and issue 10 certificates of completion by May 2017

Applicable State Agencies: OASAS OMH OPWDD

2017 Community Service Board Roster
Columbia County Dept of Human Services (70140)
Certified: Alison Calhoun (7/25/16)

Consult the LSP Guidelines for additional guidance on completing this form.

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 Representitive", etc. to indicate the particular community interest being represented. Members shall serve four-year staggered terms.

Member	
Name	Nancy L. Hoag, PhD
Physician	No
Psychologist	Yes
Represents	Public Representative
Term Expires	12/31/2016
eMail	DrNancyHoag@gmail.com

Member	
Name	Ronald Pope, DO
Physician	Yes
Psychologist	No
Represents	Columbia Memorial Health
Term Expires	12/31/2018
eMail	rpope@cmh-net.org

Member	
Name	Mary Daggett
Physician	No
Psychologist	No
Represents	Columbia Memorial Health
Term Expires	12/31/2017
eMail	mdaggett@cmh-net.org

Member	
Name	Pat Anders
Physician	No
Psychologist	No
Represents	NAMI Columbia County
Term Expires	12/31/2017
eMail	anderhous@gmail.com

Member	
Name	Kathryn Applegate
Physician	No
Psychologist	No
Represents	Columbia Opportunities, Inc.
Term Expires	12/31/2017
eMail	kapplegate@columbiaopportunities.org

Member	
Name	Christina Fish-Acker
Physician	No
Psychologist	No
Represents	Public Representative
Term Expires	12/31/2017
eMail	mcffa@verizon.net

Member	
Name	James Haskin
Physician	No
Psychologist	No
Represents	Center for Advocacy Voice and Empowerment
Term Expires	12/31/2016
eMail	jhaskin@mhacg.org

Member	
Name	Lee Jamison
Physician	No
Psychologist	No
Represents	Public Representative
Term Expires	12/31/2017
eMail	Ber02244@berk.com

Member	
Name	Donna Lynk Campion
Physician	No
Psychologist	No
Represents	Public Representative
Term Expires	12/31/2016
eMail	donnalynk1314@yahoo.com

Member	
Name	Beth Schuster
Physician	No
Psychologist	No
Represents	Twin County Recovery Services, Inc.
Term Expires	12/31/2017
eMail	beths@twincountyrecoveryservices.org

Member	
Name	Elizabeth Young
Physician	No
Psychologist	No
Represents	Public Representative
Term Expires	12/31/2016
eMail	Ell516ey@yahoo.com

Member	
Name	Kary Jablonka
Physician	No
Psychologist	No
Represents	Columbia County DSS
Term Expires	12/31/2017
eMail	kary.jablonka@columbiacountyny.com

Member	
Name	Diane Whiteman
Physician	No

Psychologist	No
Represents	Family
Term Expires	12/31/2019
eMail	dianewhiteman65@gmail.com

OMH Transformation Plan Survey
Columbia County Dept of Human Services (70140)
Certified: Alison Calhoun (7/25/16)

Consult the LSP Guidelines for additional guidance on completing this exercise.

The OMH Transformation Plan aims to rebalance the agency's institutional resources by further developing and enhancing community-based mental health services throughout New York State. By doing so the Plan will strengthen and broaden the public mental health system to enhance the community safety net; allowing more individuals with mental illness to be supported with high quality, cost-effective services within home and community-based settings and avoid costly inpatient psychiatric stays.

Beginning with the State fiscal year (SFY) 2014-15 State Budget and continuing through SFY 2015-16, the OMH Transformation Plan "pre-invested" $59 million annualized into priority community services and supports, with the goals of reducing State and community-operated facilities' inpatient psychiatric admissions and lengths of stay. In addition, $15 million has been reinvested from Article 28 and 31 inpatient facilities to further support the OMH Transformation Plan goals.

1. Did your LGU/County receive OMH Transformation Plan Reinvestment Resources (State and Locally funded) over the last year?

- ○ a) Yes
- ◉ b) No
- ○ c) Don't know

2. Please provide any other comments regarding Transformation Plan investments and planning.

2017 Mental Hygiene Local Planning Assurance
Columbia County Dept of Human Services (70140)
Certified: Alison Calhoun (7/26/16)

Consult the LSP Guidelines for additional guidance on completing this form.

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 2017 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 2017 Local Services planning process.

Assessment of Mental Hygiene and Associated Issues

Columbia County's 62,122 residents are distributed across 635 square miles (~99 persons/sq.mi.) and live in 18 towns, 4 villages and 1 city. Hudson is the county's only designated city and has a large portion of the county's population, with approximately 6,600 residents and an additional 4,100 in the contiguous town of Greenport. Other towns in the county with a significant number of residents include Kinderhook (~8,500), Claverack (~5,900) and Ghent (~5,300).

According to the American Community Survey of 2013, 19% of the population in Columbia County was under 18 years old, 61% were aged 18-64, and 20% were 65 years of age and older. The median age was 46.4 years. 34% of the population receives some type of public health insurance and 20% of the population are Medicaid beneficiaries (79% of those are Medicaid only and 21% are dual Medicaid and Medicare).

According to the U.S. Census Bureau, of Columbia County households in 2010, a substantial number (27%) were comprised of people living alone. In 2010, 22.6% of the population in Columbia County was under 19 years old, 59.1% were aged 19-64, and 18.2% were 65 years of age or older. This is considerably higher than the NYS rate of 13.5%. Columbia County is the second oldest county in the state for those aged 65 and older and the oldest county in the state for those aged 85 and older. As a result, some of the most critical issues in the county are related to an older population attempting to age in place and the system of community-based social supports that it requires. Moreover, this population is often the focus of ongoing discussions about the inadequacy of the system to ensure seamless, coordinated transitions between care settings.

According to the most recent report released by the NYS Community Action Association, 10.4% of all Columbia County residents live under the poverty line, representing 14% of all children (under 18) and 6% of all seniors (65 and older).

OMH: A review of the NYS Conference of Local Mental Hygiene Directors (CLMHD) Behavioral Health Portal's "Estimated Need Prevalence" data (pulled from SAMHSA data) for Columbia County reveals that there continues to be a high number of individuals presenting with a need for mental hygiene services. In 2013, an estimated 10,065 adult individuals (18+) presented with a diagnosable mental illness; more than 2,000 were identified as having a serious mental illness.

According to NYS DOH, in 2014, Suicide was the 6th most common cause of death in Columbia County and we had the highest suicide rate per 100,000 residents than any other county in the capital region (17 versus the regional average of 12).

OASAS: According to the CLMHD Behavioral Health Portal's "Estimated Need Prevalence" data there continues to be a significant alcohol and substance use disorder problem in Columbia County. In 2013 approximately 4,127 individuals in Columbia County had an alcohol and/or

substance use disorder. More specifically, 6.3% (287) are 12-17 years old, 17.1% (933) are 18-25 years old and 6.5% (2907) are 26 years old or older have an alcohol use and/or substance use disorder. The data also suggests that in 2013, only 467 unique individuals received substance use treatment which means that approximately 90 percent of those needing alcohol and/or substance use disorder treatment did not receive a needed SUD treatment.

A review of NYS DOH data reveals that In 2012, of the inpatient hospital admissions for substance use disorders, individuals diagnosed with Alcohol Use Disorder accounted for the highest number (175) followed by Opioid Use (115), Cannabis/NOS/NEC (113), Cocaine Use (57) and other SUD diagnoses (55). From 2010 to 2014, the number of Opioid related inpatient hospital admissions increased by 34.8% and the number of Opiod related emergency department admissions increased by 112.8%. It is unknown how many Narcan kits have been distributed locally and we are unable to accurately report the number of Narcan reversals administered.

OPWDD: According to the CLMHD data dashboard's "Estimated Need Prevalence" data, in 2014 there were approximately 637 developmentally disabled individuals in Columbia County in need of services. In 2015 only 599 individuals were receiving services through OPWDD, potentially leaving a portion of this population un-served. It is unclear what conclusions can be drawn from this.

Analysis of Service Needs and Gaps

OMH

Our efforts to expand the geographic reach and to fill service continuum gaps continue. The Columbia County Mental Health Center continues to establish school based clinic satellites in different school districts throughout the county. A mobile crisis assessment team (MCAT) was established July 1, 2015 using OMH Article 28/31 Reinvestment funding. In the first year of operation, MCAT reported that 94.1% of individuals served did not require subsequent hospitalization and 99.2% did not require police contact immediately following MCAT contact. There were 1316 individuals served (971 unduplicated individuals) including 5255 phone calls and 499 in person responses. This two person response team is shared between Columbia and Greene Counties, covering 1300 square miles and operates 7 days per week, 8 hours per day. With additional funding, this program could be expanded by adding additional staff to enable increased face to face response to simultaneous locations and also extend the hours.

Columbia County has a small community hospital in Hudson (Columbia Memorial Health [CMH]) with a 22 bed Article 28 adult inpatient psychiatric unit serving the region. CMH also offers outpatient behavioral health services for children and adults. CMH provided data indicates that their Emergency Department completed approximately 1449 psych evaluations in 2015, which is an increase of 46% from 2008. Other than the county operated OMH outpatient clinic, this is the only other outpatient clinic in the county. A small number of private practitioners exist – offering outpatient behavioral health services, but only to non-Medicaid eligible individuals. Limited family advocacy support services are available. The county does not have (and may benefit from): a Child and Family Clinic Plus (funding ended in 2012), a Children's Inpatient Unit, an ACT Team, a Crisis Residence, a Partial Hospital and/or an Intensive Adolescent Day Treatment program. Development of such service options is challenging due to the anticipated low volume of use and resulting high cost.

According to the NYS Capital DSRIP Region Needs Assessment, Columbia County has a capacity of 70 slots for Personalized Recovery-Oriented Services (PROS). There is no Partial Hospitalization program, Assertive Community Treatment team, Intensive Psychiatric Rehabilitative Treatment (IPRT) or Continuing Day Treatment (CDT) in the county. The outpatient mental health clinic service use in 2014 was approximately 1,218 adults (806 Medicaid recipients and 412 Non-Medicaid recipients). The outpatient mental health clinic service use for children was approximately 325 (245 Medicaid recipients and 80 Non-Medicaid recipients). There are no children's Partial Hospitalization, day treatment or Children's Assertive Community Treatment programs operating in Columbia County.

Adult Behavioral Health Housing Programs: There are 12 OMH licensed family care beds, 14 OMH licensed congregate treatment beds and 43 OMH licensed apartment treatment beds. There are 24 unlicensed housing support program beds and 39 unlicensed supported housing beds. There are no Child Behavioral Health Housing Programs in Columbia County, however we do have 18 HCBS children's waiver slots which puts us at the highest ratio of slots per 100,000 children in the capital region.

The following list identifies the licensed mental health workforce in the county: 4 Psychiatrists, 32 Psychologists, 69 LCSWs, 65 LMSWs, 9 MHCs, 10 NP- Psychiatry, and 7 "other" for a total of 196 providers (32 providers per 10,000 residents). According to County Health Rankings and Roadmaps, the ratio of Columbia County's population to our Mental Health Providers is 740:1 with the NYS average being 420:1.

OASAS

There is a shortage of available Medication Assisted treatment (MAT) slots/providers (e.g. Suboxone and Vivitrol) given the Opioid abuse epidemic. The services available often are not accompanied by the requisite counseling services. We do not have an OASAS Detoxification Unit or a Methadone Maintenance Treatment Program. There is a Vivitrol program at the Columbia County Jail that is just getting started.

Columbia County has one OASAS prevention program. More than $180K of annual OASAS state aid prevention funding was cut in 2011, decimating 60% of Columbia County's prevention services.

There are three part 822 clinics (only one in a community setting). There are 13 beds of Part 819 Community Residence (CR) operated by Twin County Recovery Services. An increase of capacity of 5 (13 to 18) CR beds (and site relocation) are being pursued as per recommendation of OASAS and agreement by the CSB. There are 8 Supported Housing beds shared between both Columbia and Greene Counties.

According to the NYS Capital DSRIP Region Needs Assessment, the following list identifies the certified and credentialed substance use disorder professionals in the county: 7 Physicians authorized for Buprenorphine prescription, 19 CASACs and 2 Certified Rehabilitation Counselors. Columbia is the only county in the capital region without a Board Certified Addiction Medicine Physician. However, an internal survey of the local providers completed in Fall 2015 reflects only 3 Physicians authorized for Buprenorphine prescription.

OPWDD

As a result of the Front Door NY OPWDD assumption of SPOA responsibilities, LGUs are without the knowledge of volume and type of eligibility and service requests, response timeline or unmet need. This knowledge is required to meet our Article 41 obligation in order to create a local plan.

The OPWDD "Front Door" process has resulted in slow response and poor care for individuals with I/D Disabilities. Anecdotal (no data is available to LGUs) reports reflect routine delays in eligibility determination and service approval of 6 months to 2 years. The provider community is burdened with non-reimbursable tasks on the front end of this process. Access challenges to psychological testing due to under market rates/health professional shortages create significant delays through the first gate of many involved in the process.

During 2016, OPWDD Region 3 DDRO staff have been assisting the LGU in obtaining local data to identify and resolve issues.

In 2013, we lost the only Article 16 clinic service provider in the county. This year The Center for Disability Services lost 1 full time psychiatrist and 1 full time nurse practitioner which severely restricted their ability to provide medication management services. This affected approximately 47 people in Columbia County. We are continuing to explore options for the local provision of mental health services to individuals with I/DD experiencing co-occurring mental health issues.

The sheltered workshop program run by the local NYSARC chapter continues to decrease in size due to reduced state aid funding. They are working to transition the sheltered workshop to an integrated business model.

Cross Disability Un-met Need

- A severe prolonged shortage of psychiatrists (especially child psychiatrists) negatively impacts the behavioral health service delivery system in Columbia County. As a result, individuals who may benefit from psycho pharmacy services go without, or are served by not adequately trained PCPs. Advocacy for Health professional Shortage Area designation to incentivize workforce attraction and retention through loan forgiveness is being pursued again.

- Only a handful of small sized non-profits provide services to county residents currently. These organizations continue to be concerned about the increasing level of critical mass and business line

diversification needed to remain financially viable. Organizational consolidations and IPA formations are being considered and pursued. Conversion from "Meaningful Use" incentives to penalties is a concern for our provider community. The financial impact of the advent of the projected 2018 end of legacy APG/fee-for-service reimbursement mental health clinics is a concern. The 90 % "volume-to-value" Medicaid and Medicare reimbursement model transition projected for 2020 is also a significant concern. Cultural and infrastructure changes will be needed and organizations have been encouraged to make use of technical assistance resources such as CTAC. Aggressive efforts are being made by the LGU to prepare providers for this transition to "selling their product" on the open market of managed care as well as tracking performance data and establishing related CQI processes. Our provider community must prepare to comply with NCQA 2014 Level 3 Medical Home Standards to effectively compete in a future integrated community healthcare market. Our provider community must begin to build IT capacity to meet MAPP/RHIO standards to effectively compete in a future integrated data driven, value based community healthcare market. Our LGU has proactively begun designing an expanded standardized web based SPOA model (i.e. beyond simply OMH services) to prepare a more broadly marketable service to sell to PPSs, MCOs, and ACOs.

- A related issue of concern is the lack of organizational preparedness of a subset of our potential HCBS Waiver providers (especially peer service providers) to bill Medicaid and comply with regulations.

- The gradual elimination/ reduction of "low-demand", maintenance, non "medically necessary" services over the past ten years across the continuum of OMH, OASAS and OPWDD (due to Olmstead, Medicaid reimbursement financing versus state aid financing models) has inadvertently created service gaps for individuals unable to tolerate structure. These individuals previously obtained stabilization, enhanced self esteem and identity through programs such as SUD Prevention, Psychosocial Club, CDT, and sheltered workshops.

- Housing -Several variables have accentuated the supported housing bottleneck in Columbia County (as in other communities) including:

  i. The closure/restriction of all Section 8/Housing Choice voucher waiting lists

  ii. The lack of expansion of HUD Super NOFA pro rata share

  iii. The elimination of funding for COC designated Tier II HUD Super NOFA projects (2016 – Greene County Community Action DV Supported Housing)

  iv. The limitations of exclusive development of restrictive stock (dedicated for NYS OMH PC, OPWDD DC, OASAS ATC and DOCCS Prison census reduction/ MRT goal-specific housing)

  v. The gentrification of the City of Hudson

  vi. Relatively low stock and high occupancy of rental housing

vii. The gap (without access to subsidy) between Fair Market Rent (FMR) rates and rent affordable to an individual receiving SSI (e.g. 1 bedroom FMR equals $711/ month and 30% of SSI payment of $220- leaving a gap of $491/month)

The current Adult Housing SPOA waitlist includes 22 individuals.