2021 Mental Hygiene Executive Summary

Genesee County Mental Health Services

Certified: Lynda Battaglia (9/11/20)

The Genesee County Department of Mental Health continues to strive for community based, high quality, person-centered options for individuals within our community. These goals will coincide with the major changes anticipated in the New York State shift to Medicaid Managed Care and Value Based Payments. It is our belief that community based programs hold the key to successful recovery outcomes. We will continue to work with our community partners to make our service delivery system fit the needs of our special populations.

Genesee County has taken the initiative to convene a Regional Network of partners in an effort to improve Behavioral & Physical Healthcare outcomes. This new consortium will take the lead in the use of data analytics, best practices and peer support to improve the lives of persons with mental health, substance abuse and intellectual disabilities needs. The consortium is currently a membership of 14 county run services and additional providers within their boundaries. A Director for the consortium has been hired and this grroup continues to grow and time passes..

COVID-19 Pandemic Effects on Mental Hygiene Services Delivery System Local Services Plan Supplemental Survey

COMPLETE

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Q1

Contact Information

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Q2

LGU:

Genesee County Mental Health Services

Q3

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

The impact of COVID-19 across systems of the Mental Hygiene world has been significant. With no time to spare, agencies were forced to develop plans to continue services for the population they serve, in a delivery method that was unfamiliar to most; and in some cases, not best practice. The reduction of onsite services, although needed in order to reduce staffing levels for safety reasons, created a strain on various programs, as well as individuals and families across all systems. The majority of agencies were thrown into the use of providing services via telehealth. While this may be an advanced method to provide services, for many residents needing continued services, the capability of such service was foreign. Either lack of technology, living in more rural areas where internet was not available or lack of knowledge regarding use of such technology, limited some populations with receiving services. Lack of transportation and lack of technology has left some individuals without any ability to obtain services. As a result, the emergency regulations allowing Telephonic services was essential. This service allowed providers to stay somewhat connected with their clients throughout the pandemic. However, after time has passed, and the pandemic lingers, and while telephonic services are still provided, the inability to “see” your provider is now starting to take a toll. Increased isolation, anxiety, depression, agitation, substance use and increased hospitalization has been felt across all systems, throughout this Pandemic. For immediate assistance, hospitals, law enforcement and mobile crisis teams were utilized at an increased rate. As providers grappled with their own plans, services needed to continue, the communication to discuss complex cases was delayed which unintentionally delayed treatment. With an already strained budget, any withhold will have an impact on services across all systems. Specific racial/ethnic groups or populations that have been disproportionately impacted by COVID-19 is unknown at this time. The impact appears to have hit all racial and ethnic groups within this community. In regards to differences with children and adult services, both were impacted. For children needing services, and typically receiving services within a school, was now altered. This created a challenge for parents, providers and children. Children receiving a telehealth session were sometimes in the presence of their parents/guardian which resulted in the child being more guarded. Providers are also met with unplanned expenses, such as needing to purcahse laptops and equipment in order to keep connected with their clients.

Q4

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

Overall, the need for Mental Health has increased. Although locally, MH observed a dip in services at the climax of the pandemic, the need for services quickly increased as months passed. The demand for people needing to speak with, or meet with, a clinical person remains steady. Signs and symptoms of increased anxiety, depression, isolation and increased incidences of self-harm, overdoses and suicide attempts has been evident. The ability to provide telehealth services either via videoconference or telephonic, has been essential. It should be noted that on site services, including, walk in hours, were still available however, not the first choice by clients in how to receive such services. Increased need in MH was evident for both children and adults. Although locally, MH was just starting to provide telehealth services, it became evident very early on that not all providers, including clinical staff, had technology to delivery services in this method. Getting access to such equipment was time sensitive and staff had to use what provided, even if this meant using an outdated phone.

Q5

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

delivery of cross system care was on hold with the Genesee Co. MH Satellite office located on the grounds of GCASA. What once was a convenient method to receive treatment for addiction and Mental Health, was halted and services were independent of one another. This has since resumed. Instead of having a cross system approach, care and treatment became more silod as a result of the pandemic and the need to decrease staffing levels. As for SUD, technology and internet bandwidth for telehealth have arisen as key needs and even minutes for telephonic. Quite a few folks wouldn't participate in those services, though, and a number are now hesitant to return to campus. I would say we have identified that a need for some sort of third option--beyond regular campus and telehealth/telephone--has arisen, but we are struggling to figure what the solution/new option could look like. Also, there was definitely an increased need for food during the pandemic and increased difficulty getting housing for homeless recoverees since assistance services were harder to access, landlords weren't showing places nearly as often, and people weren't really moving. It was a strong reminder that the need for housing is imminent.

Q6

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

OPWDD saw an increase in the need for psychotherapy for their clients, as well as an increase in inpatient services. Families reported an increased in behavioral acting out, with an increase in the number of overall crisis. Having to quarantine created a disruption in routines, which results in an increased of symptoms. Also, having to be quarantined in a less than stimulating environment, without community intervention or support, resulted in an overall decline in this particular population. Providing services via telehealth has been challenging on various levels. In order for one to be fully supported, onsite support is best, with families, individuals and providers becoming virtual, the effectiveness of such support has become less effective. The ability to conduct onsite assessments to determine a person’s needs and treatment course was also significantly impacted. The increased need for help and support on working families and individuals has increased due to the lack of community support as a result of the Pandemic. Residential services have seen an increase need without much relief. Transportation options were limited leaving many with IDD unable to receive services. Additionally, this population is more at risk of higher rates of infection and comorbidity because of the Pandemic. There has been significant increases in request for emergency children’s residential beds and services. More children have been taken to the Emergency room from families that are overwhelmed with no discharge disposition. Currently, there is a wait list for the OLV Intensive Treatment Program beds.

Q7

a. Mental Health providers

: Informational and guidance documents were easily accessible. Documents in relation to regulations and guidance pertaining to the Pandemic were distributed frequently and on multiple occasions. In this situation, having received the same documents was still better than not having received any guidance documents at all.

Q8

b. SUD and problem gambling service providers:

For COVID specifically, I think mostly satisfied. When we had questions on points that were unclear, we were able to get quick answers which was helpful. The initial methadone guidance was less satisfactory, but it is unknown if that was actually OASAS or SAMHSA. An innovative soluation was fostered and approved.

Q9

c. Developmental disability service providers:

The Govenor's Executive Order and OPWDD guidance provided abbreviated/refresher training and recertification to address COVID-19 emergency response. Abbreviated training formats and alternate methods for training, such as webinars, video recording and self-certification documentation (read/sign) was encourgaed with meetings all training requirements. The ability to create and hand out educational docuements to care takers/guardians/families and indidivuals would have been helpful.

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Q10

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

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

Q11

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

Mobile outreach teams were utilized more often

Q12

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

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

Q13

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

For clinic services, access to services has not changed, however, for CDT, access to this service changed significantly. Clients in CDT were quarantined to homes that are operated by DOH. Even with services changing, some residences continue to not allow clients to leave the home and return to CDT. Therefore, access was to this program changed, but it was still accessible.

Q14

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

0

Q15

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

MH providers remained operational

Q16

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

0

Q17 **Respondent skipped this question**

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

Q18

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

Yes

Q19

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

Walk in services remained in place throughout the pandemic and this service was utilized by clients, albeit, not significant numbers but a few.

Q20

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

No

Q21

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

Respondent skipped this question

Q22

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

No

Q23

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

Respondent skipped this question

Q24

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

No

Q25

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

Yes (please describe):
I relied on peer support within the CLMHD. In regards to providers, the collaboration that existed between providers remained stable.

Q26

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

2

Q27

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

Respondent skipped this question

Q28

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

0

Q29

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

Respondent skipped this question

Q30

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

Both

Q31

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

The County requested plans be submitted for minimizing staff while keeping operations in place, as well as submission of re-opening plans.

Q32

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

Program-level Guidance,

Telemental Health Guidance,

Infection Control Guidance,

Fiscal and Contract Guidance,

FAQs,

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

OMH was above average in their distribution of resource documents.

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Q33

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

PPE and cleaning supplies have been difficult to obtain. We have not really had much success at all at procuring large amounts of supplies at any one time. We have had few N95s or KN95s during the pandemic and even few surgical masks at points. We had entire programs that operate for months using exclusively cloth masks. We have not been able to stock up to the recommended 90-day stocks.

Q34

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

Prevention services continued remotely but were challenged in the spring because our prevention program had been largely focused on schools, and not all schools engaged with Prevention remotely. The plan for the fall is a bit clearer and is a mix of in-person and remote service delivery based on the requests of the schools.

The key benefit of the challenges pandemic has been that our Prevention Team has had the opportunity to become more creative about how we approach Prevention in our community. The Prevention Team has been re-envisioning services and thinking about how to increase community-based/community-focused and adult-focused services in addition to the school services and, as noted, has offered a series of remote services not previously offered. This has included but is not limited to inspirational videos, Zoom-delivered evidence-based programming for school children, and Zoom-delivered naloxone trainings for the community. The naloxone trainings were particularly effective. Our first virtual naloxone training yielded about 75 participants—a much higher number than we would typically get or in some cases even be able to accommodate at an in-person training.

Q35

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

For 3-4 months, we were only able to deliver recovery services via telehealth/remote options. We had to close our recovery center to all but our Atwater Community Residence residents. Some people engaged well with Peers via phone. Others felt disconnected without the face-to-face support. The recovery center did offer some virtual activities, but they were not heavily attended. It was difficult to get the word out about what was available as Facebook was our primary mechanism for communication with the community during that time. Many people did not have the technology or the interest in engaging in Zoom-based events. We debated creating and posting some videos for people to just watch, but the vast majority of our staff did not feel comfortable being recorded and posted online. The recovery team would benefit from trainings on how best to deliver remote services.

Similar to Prevention, one key benefit of the challenges of the pandemic was the opportunity for creativity. Our Peers have often assisted people in connected with food pantries in the past (prior to COVID-19). During the
pandemic, however, we expanded that support to food drop-offs for people unable to get to food pantries. We also supported our methadone clinic by providing medication drop-offs when needed for people who were quarantined. In part because we operate a 24/7 Peer support line, and all Peers are given work cell phones so that recoverees can regularly reach out to them, our Peers already had a good amount of experience providing phone-based support. Under COVID-19, however, they strengthened their phone skills to be able to provide support in virtually all situations—including regular support meetings—via phone. For some of our Peers who are outstanding in person but prefer face-to-face contact and work primarily with recoverees who don't necessarily spend a lot of time talking on the phone, this was a challenge that led to important, positive professional growth. From a billing standpoint, the pandemic created opportunities for Peers that simply did not exist before. Specifically, prior to COVID-19:

- While Peers did quite a bit of phone work, they were not able to bill for ANY of it. Peers were only able to bill for in-person work.
- Peers could not bill for any support interaction lasting less than 15 minutes, and could only bill for 15-minute increments of support. While quite a lot of Peer interactions are an hour or more, particularly with Residential recoverees and those at the clinics and recovery center to receive support that many not have been scheduled and those calling on the phone, many other supportive interactions last just 5-10 minutes but were not legally billable before. Interactions lasting 29 (for example) were only billable for 15 minutes.

Under the COVID-19 waivers, Peers have been able to bill for both video-enabled and phone-only support as well as for smaller increments of support down to 5 minutes via phone and 11 minutes in person. This provided a lot more opportunity to receive compensation for a large portion of work that was not previously eligible for compensation. The team is still working to remember to create billable notes in all cases because habits are hard to change, but many have adapted well, and overall, continuing these changes beyond the waivers would be extremely important to our long-term program sustainability.

Q36

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

Again, some patients did while but others did not. Many became used to not coming in for screenings, groups, and sessions and have not wanted to come back in as a result since reopening. With the courts shut down and many state personnel working only remotely, people were mandated to treatment really did not experience any legal consequences for not participating in their treatment, so they chose to limit their participation or not participate. While hard data is not available locally, national data and anecdotal local data suggest overdoses have increased. Toxicologies/supervised screens necessarily occurred less frequently during the pandemic, which limited accountability for some of our patients who struggle most and limited staff's ability to receive important information for decision-making, including but not limited to decisions that could impact diversion.

On the positive side, as with the other areas, COVID-19 offered a great opportunity for staff to get creative and to learn new skills. In the methadone clinic, by mid-March we had received unprecedented (first in the nation) approval for outdoor methadone dosing using our mobile treatment unit. Many staff of our staff had previously never provided telehealth services. Because of the lockdown, we had to move to almost all remote support in our Batavia Outpatient clinic for a period of time virtually overnight. This was a challenge and uncomfortable at points, but our staff rose to the challenge and increased their computer skills and comfort with technology very quickly. Staff also found creative ways to remain connected with and supportive of each other, including but not limited to games such as leaving a stuffed monkey hidden in each other's offices as a "surprised" for when the person came in on their in-office days.

OVERALL, we found almost immediately that our servers were very inadequate to support all of the remote work and was particularly lacking in capacity to support so many people using video technology simultaneously and connecting to our EMR from offsite simultaneously. We also did not initially have enough laptops or licensees for some software for all staff which required laptop sharing and clinic staff continuing to come in to the office at least a day or two a week in turns even during the lockdown period. The cost to upgrade technology is currently at about $100,000 , and the process is still not complete, so the final cost is unknown. We have had to pull money from a variety of grants and other places to make this happen, and we were not able to make it happen as quickly as we wanted. The issue was evident in March and creating challenges and remains as we enter September. We hope to have it resolved within the next month, but it has made for quite a few frustrating moments and days for many staff and placed significant additional burden on our limited IT staff (2 people) .

Q37

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

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

Q38

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

These were challenging questions to answer because many patients and recoverees disconnected during the lockdown period, so their needs were less evident. The demand from an economic standpoint decreased for outpatient and residential services, and residential was not able to safely accept new patients for a period of time, but the need for services remained the same or increased. For inpatient, it's not clear whether need was a LOT greater, however the ability to access inpatient was certainly much lower. Crisis needs did increase since the isolation left people in tough positions with regard to their mental health and SUD triggers.

Q39

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

INPATIENT	**Decreased**
OUTPATIENT	**Decreased**
OTP	**Increased**
RESIDENTIAL	**Decreased**
CRISIS	**Decreased**

Q40

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

Access to inpatient and residential services definitely decreased during the lockdown period. While beds may have been available, for safety reasons programs were not taking people in in some cases and in others were only taking people who could demonstrate they did not have COVID-19 or had been observed safely in another structured 24-hour setting for 1-2 weeks and were able to move from bed to bed with no stops in between. Outpatient access was increased in theory because a whole new world of access was available via telehealth, but for rural patients, in reality it probably decreased because many did not have the technology, ability, or comfort level needed to fully engage in remote services. People who truly wanted and needed in-person assistance had a distinct decrease in access. Crisis services were similar. For OTP, access increased because patients who could not make it in for legitimate reasons could receive a medication drop-off.

Q41

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

Yes (please describe):
Outdoor dosing and medication drop-offs for methadone patients and food deliveriers for some patients

Q42

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

No

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Q43

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

No

Q44

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

The staff whom provide the services will potentially decrease for various reasons; burn out, need to stay home to take care of their own children/family for example. Cuts to funding due to an already exhausted budget and decreased rates, which will lead to decrease in services which then places even more stress on families whom have become primary care taker. The ripple effect of such cuts will be felt over the course of months to come.
Being able to continue with keeping the precautionary measures in place in order to avoid any increased COVID related clusters, while still trying to deliver services.

Q45

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

a. What the future of OPWDD looks like so that the county and LGU can plan for individuals and families in need.

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Q46

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

Respondent skipped this question