DESCRIPTION KEY

Purpose: MH programs were surveyed over a **two week period** (3/30-4/10) to report on individual MH programs ability to: administer psychotropic medication injections **(Colume E)** and their ability to deliver services via telemental health (**Column F**). **Column G** signifies the percentage of total services that are being delivered via telehealth as opposed to onsite or mobile unit care delivery. **Comments** (tab 2) were gathered to guage the temperature of what is happening in the Regions.

Percentage Calculations: were not statistically captured but were estimates provided by leadership contacted in each organization.

File Source: OMH's "Find a Mental Health Program" site. **https://my.omh.ny.gov/bi/pd/saw.dll?PortalPages**

Programs Surveyed: Clinics, PROS Programs with Clinical Tx, CPEP, Partial Hospitalization, CCBHC's, some FQHCs

Comments (Tab 2): Column A depicts comments that were provided in the following categories: **Workforce/Staffing Models** during COVID-19 crisis, **Telehealth Mobilization** (telephonic services, TMH video-conferencing when applicable), **Financial/Billing**, and **General Comments**. **Row 1 Headers** identify the comments according to **Challenges, Opportunities** to expand further**, Discoveries** (made by MH programs), and **Innovations** that may have resulted due to change in services.

Tangible Value: All RPC staff received positive comments from all contacts for reaching out to their organizations.

MOHAWK VALLEY

# PROGRAMS	# CONTACTED	# RESPONSES	% DOING INJECTIONS	% OF PROGRAMS DOING TMH	AVG % OF SEVICES BEING DELIVERD VIA TMH
11	7	7	100%	100%	89%

NORTH COUNTRY

# PROGRAMS	# CONTACTED	# RESPONSES	% DOING INJECTIONS	% OF PROGRAMS DOING TMH	AVG % OF SERVICES BEING DELIVERD VIA TMH
11	11	10	80%	100%	96%

SOUTHERN TIER

# PROGRAMS	# CONTACTED	# RESPONSES	% DOING INJECTIONS	% OF PROGRAMS DOING TMH	AVG % OF SERVICES BEING DELIVERD VIA TMH
13	13	5	80%	100%	86%

TUG HILL

# PROGRAMS	# CONTACTED	# RESPONSES	% DOING INJECTIONS	% OF PROGRAMS DOING TMH	AVG % OF SERVICES BEING DELIVERD VIA TMH
15	11	7	71%	100%	82%

WESTERN

# PROGRAMS	# CONTACTED	# RESPONSES	% DOING INJECTIONS	% OF PROGRAMS DOING TMH	AVG % OF SERVICES BEING DELIVERD VIA TMH
53	31	17	100%	94%	93%

CAPITAL REGION

#PROGRAMS	# CONTACTED	# RESPONSES	% DOING INJECTIONS	% OF PROGRAMS DOING TMH	AVG % OF SERVICES BEING DELIVERD VIA TMH
29	29	20	70%	100%	90%

FINGER LAKES

#PROGRAMS	# CONTACTED	#RESPONSES	% DOING INJECTIONS	% OF PROGRAMS DOING TMH	AVG % OF SERVICES BEING DELIVERED VIA TMH
34	34	33	100%	100%	77%

LONG ISLAND

#PROGRAMS	# CONTACTED	#RESPONSES	% DOING INJECTIONS	% OF PROGRAMS DOING TMH	AVG % OF SERVICES BEING DELIVERED VIA TMH
65	64	53	91%	91%	81%

MID HUDSON

#PROGRAMS	# CONTACTED	#RESPONSES	% DOING INJECTIONS	% OF PROGRAMS DOING TMH	AVG % OF SERVICES BEING DELIVERED VIA TMH
84	83	66	61%	97%	75%

CENTRAL NY

#PROGRAMS	# CONTACTED	#RESPONSES	% DOING INJECTIONS	% OF PROGRAMS DOING TMH	AVG % OF SERVICES BEING DELIVERED VIA TMH
28	28	25	88%	96%	86%

Feedback/ Comments	Challenges	Opportunities	Discoveries	Innovations
Workforce/Staffing Models	**70 % Surveyed reported challenges**	**60% Surveyed reported opportunities for review**	**30% Surveyed reported discoveries deploying telehealth**	**20 % Surveyed Reported Innovation**
	Staff is split (remote/onsite); doing telephone sessions; unable to reach some clients due to phones not having minutes and wrong numbers. Suggesting pandemic/disaster management plans be put into place. Clients are really looking for the support. Per Diems stopped working, so other clinicians are reaching out.	Opportunity with teleMH and children - those that we usually see at school, we are now able to engage with the parent/caregiver and discuss BH management and other topics; children are liking being on screen; other challenges with those without cameras so phone only and internet slow/no access in certain regional locations.	Concern is young children are not as willing to talk on the phone for sessions. Many clients did not want video due to not having those capacities electronically as well as not wanting therapist to see their home as they are embarrassed by their living conditions. Older clients are not comfortable using the technology.	All clinicians were given agency phone to do calls, zoom, Facetime.
	Operating pretty much the same; challenge is clinicians and their own personal health/safety and their family obligations; unable to work at home even though OMH has autherized, Glens Falls Hospital will not allow; one clinician has taken FMLA due to no childcare; others are considering and this impacts our case loads, etc. Does not understand GFH's admin decision.	Submitted waiver to OMH, attestation to provide telehealth; we are not prescribing; administering injections.	Clients not wanting to be evaluated at home; don't want to come to clinic.	Mostly phone services as the majority of their clients do not have access to the Internet. The transition has been smotther than expected and clients like the tleementla health services. They are using Free Conference Call service for groups and have noticed that clients who have anxiety issues and are ususally quiet are more comfortable via the phone group and are speaking up more in their sessions**.**
	We are doing well under these circumstances. One of our challenges is engaging clients over the phone and ensuring they answer during their time slot, so we have had a bit of a dip in overall productivity that we are hoping we can improve upon this month.	Only concern still are intakes - controlled subs need to come to clinic 3 staff, and 1 doctor. Evalations: can't do on phone if controlled substances - not ideal.	Working w/OMH FO to lend telephonic support services to staff personnel in MedCen ICU evenings; going well; making masks for clients; low functioning clients want remote calls; high functioning want FTF but are managing.	Field 25% ACT; 75% telephonic; some issues with client phones - buying minutes on Amazon, getting creative with burner phones and accessing minutes.
	Walk-in clinic still operational with an NP-Psych & Psychologist; all clinicians are working from home; week 1 was like stopping a battleship but they are back to full-steam operations	Guidance changing this afternoon (4/3). They do not have State approved iPads or laptops; they are doing 100% of their injections and deploying 5 ppl from their mobile workforce team to go track down most high risk clients to deliver injections and meds.	Partial Hosp an issue, normally 24 clients, down to 8 a day; ppl don't want to come in -financial comcern for us; looking for hospital discharge locations and having trouble finding them; providers finding their sea legs on doing telephonic intake/assessments but seeing the value of it - need more guidance if this will continue on level of care and billing guidance.	
	I think we are doing as well as any other program that is mandated to stay open. Unfortunately, the hospital system does not currently endorse a "work from home" telehealth model; has been challenging.		Doing intakes through Doxy or phone. No injections for new patients. We are in the process of changing systems. Had to purchase laptops and the VPN licenses for staff who can manage it for billing. They are expecting a financial impact, but it's hard to know as notes were being done by hand instead of EHR.	
	One of our challenges is engaging clients over the phone and ensuring they answer during their time slot, so we have had a bit of a dip in overall productivity that we are hoping we can improve upon this month.			
	Still accepting referrals but process is slow due to remote process.			
	Not accepting new patients, suspended all intakes.			
	Still offering injectable meds for enrolled clients only- at prescriber's discretion- some switch to oral meds.			

Feedback/ Comments	Challenges	Opportunities	Discoveries	Innovations
	Challenges with staff activited with accounts last few days - offering tutorials.			
	Doing injectible at clinic if deemed not safe for staff to go to home.			
	We have kept door open for crisis, appointments in which clients prefer or have to come in due to no phone, injections, and walk ins. Again, we have adapted well and are pleased to have a staff team that could adapt so gracefully.			
Telehealth Mobilization				
*Telephonic client services				
	Those without cameras so phone only and internet slow/no access.	Medicare won't pay for telephonic, only video. Advocacy needs to be done on this as the clinic doesn't have the capability with their computers for video. Still providing the services, but may not be reimbursed. Clients are appreciative.	The clients and staff appear to appreciate the opportunity to do telephonic services; our productivity has actually gone up from face to face contact in some instances; we have staff on a work from home rotation, so we have about 10 staff in the building out of 60.	
	Challenge with telehealth is client not having access/means; many of current clients that switched to telehealth are more engaged than before because they appreciate the safety/not going out of home.	MD is evaluating and arranging for face to face meetings if there is a hgh level of clinic need.		
	Providers having issues trying to do initial psych evals difficult for prescribers; generally getting it now; no specific guidance on pych evals telephonically.	Can now get verbal approval in terms of due dates; get a verbal approval with written consents; email docs impossible; more clarification about 599 regs, need more leeway on consent.		
	Doing groups through phone conference, looking to doubling it to 16. Barriers were getting staff connected remotely and getting conference lines set up.	Full services including accepting new clients in all clinics and ACT. Believes about 5% are face to face but uncertain about this number.		
	Most significant challenge has been lack of “IT” infrastructure to enable staff to work offsite. Working with County to purchase lap top computers with video capability and VPN to access clinical software remotely. Also ordering webcams for older computers. Staff are adjusting to changes and doing a great job.	Some clients in supportive housing are not sharing phones with other clients so that we can actually reach out to them due to COVID fears.		
	Starting to get feedback from clinicians that telehealth is not the same as in person. This is particularly noted with kids and people who have significant symptoms. Works for some, not all in the short term.	Program is working on setting up telephone/video capacity- Site is currently closed.		

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	Barriers/challenges include the usual w/tele services (clients don't have access to smart phone/computer for virtual sessions, or access to internet services), client's phones won't accept blocked telephone numbers	Only offering food pantry/soup kitchen. All other programs-SUSPENDED.		
	Only patients being seen at clinic are those needing injectibles; everyone else on teleMH; "so far, so good" under lockdown.	Telemed being used for established patients only.		
	We have a small team in the building each day to cover the phones, injections, crisis calls, intakes, and administration; staff that work from home use their phone and zoom; using reminder text messages, phone calls, our website, and press releases to communicate.			
*Telemental health videoconf				
	Barriers are clients who do not want to accept restricted numbers. Some clients don't have emails, so it is difficult to set up zoom video sessions.		Staff outreach to clients who have no techology or need assistance; received some Social Service issued cell phones; some are housing clients - we are providing private spaces to do a video conference.	
	Coordinating contacts with other partners...HHCM, AOT, Mobile Integration Team (MIT), etc. for broader client picture.		We are using worksheets that we created for care givers and other means that seem to be working; some children are enjoying "being on camera".	
	Using Zoom for initial new clients. Using warm handoffs to help with keeping client engaged through telehealth. Using Doxcimity to help with HIPAA compliance. Having trouble finding clinics to pass clients along to.			
	We have been preparing for telehealth for some time now so had equipment (laptops), video platform chosen etc. Staff were working from home within three days of the Governor's order. We have been utilizing Zoom and telephonic services for 98% of all services. We have a skeleton crew on site for injections and face to face for those without any other access. We are providing open access services, MAT, med management etc... We started groups back up today via Zoom.			
	Operate DASH Crisis Center only walk-in model of its kind: was seeing 25-30 walk-ins a day (24 hour service): no one coming in, huge impact if they can't bill, can cut some expenses inc. payroll and rent. Otherwise, ramped up productivity to full capacity for clinics and 20% staff who administer injections in the field.			
	Intakes did drop off, but still getting calls. Unsure of fiscal impact, but think they will be impacted as some clients don't want to engage through telehealth, especially the younger children. Clients in shelters don't want to do sessions.			

Feedback/ Comments	Challenges	Opportunities	Discoveries	Innovations
Financial/ Billing				
	Serving 33 clients with one ipad. They don't get the supplies with the same frequency as the hospital and aren't getting mail runs so communication is harder. Difficulty engaging with children through telemental health. Need more ipads in all clinics/sites to support telehealth.			
	Taking new referrals, doing it through video conference. Issue is insurance companies approving and allowing this to be appropriately reimbursed. We just don't know yet.			
	Doing 4 hours of group therapy a day, continuing normal format, video conference for groups; tough engagement- wise to ensure they are focused. Accepting new patients, vetting more through the referral than normally to ensure they will engage in it remotely.			
	I am just hoping billing is successful. Honestly, getting billing codes/procedures all set has been the most challenging.			
	Other than PPE, concerned about revenue, about 3 weeks off reimbursements due to instability of rstructuring for COVID.			
	Billing revenue impact; PROS billing at base rate: 15min/4 call requirements ~$175k/mo. Hard to get 4 calls and bill telephonically at 95%. Approx. $350k for 3 PROS programs are at risk. Sending email with specific concerns.			
	Will definitely have a fiscal impact to the group due to units of service definitions/reimbursement. Can't bill for a full day like when they are in-person.			
	Much lower census that will impact them fiscally. Should be at 30, but at 12. Challenge for billing with partial hospitalizations- need 4 hours to bill a full-day, but will lose a whole day if a child misses a session or parts of it.			
	Able to bill and clinicians have a full schedule. They are not anticipating any revenue disruption. Referrals have slowed.			
	Getting in touch with clients can be tough with blocking numbers. It will have a fiscal impact to an extent, due to it being grouped based. Trying to match up the individual to a particular group to even it out.			
Other General				
	Challenges for coordinating transportation for injections with the drivers to stay and wait for the participants.			
	Thought I'd share an observation from the field.			

Feedback/ Comments	Challenges	Opportunities	Discoveries	Innovations
	In my conversations there is an interesting difference in how telehealth is being seen.			
	Clinicians find it very limiting in how it restricts their ability to truly assess the person and conduct psychotherapy. This varies a lot from client to client.			
	It is working pretty well for medication management and works better with well establish clients since they have a relationship with the provider. It does not work well with new clients.			
	Some HCBS providers think all services should be continued via tele health. I think if you were to transcribe the conversations of telehealth you would have a hard time distinguishing what service is being provided.			
	Interesting dilemma. How are these services different from the care coordination being done by the care coordinators and MCOs?			
	We also are starting to get feedback from clients that they want to come in and see their therapist not get another phone/zoom call.			
	I don't think clinical outcomes will be valid (reduction in ED visits, hospitalizations). Our kids are doing great! No school, sleeping in, doing some school work but pretty much doing what they want.			
	I think there will be a big push from the HCBS providers to keep telehealth.			
	It is important to get the client experience and not just through the peer organizations since they are providers and it is much easier to deliver telehealth services but from the recipients of the services. Sue Matt, DCS Otsego County, RPC Co-Chair, Mohawk Valley			