Tompkins County Combined CHA-CHIP-CSP
2017 Update

Completed by: Ted Schiele
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Priority	2017 Progress to Date	Implementation Partner *(Please select from the dropdown)*	Partner Role(s)	Strengths	Challenges? How will they be addressed?	Focus Area	Goal	Objectives	Disparities	Interventions/ Strategies/Activities	Family of Measures
Promote Mental Health and Prevent Substance Abuse	6 trainings at TCPL in 2017	Community-based organizations	Certified Trainers	Strong program, well received by the community	Sufficient training staff	**Promote Mental, Emotional, and Behavioral Well-Being**	**Goal 1.1: Promote mental, emotional, and behavioral well-being in communities.**	Objective 1.1.1: Increase the use of evidence-informed policies and evidence-based programs which are grounded on healthy development of children, youth and adults.	Rural pop. Families at risk Incarcerated pop. People in crisis Youth School teachers	**Expand Mental Health First Aid training to target at-risk families, rural populations, law enforcement, first responders, and schools.**	# of training options at venues familiar and/ or convenient to people of color within the City of Ithaca.
	zero in 2017; this is a priority in 2018	Community-based organizations		Equity for disparate pop	Outreach to communities requires ample education as well as promotional channels.						# of training options in rural towns and school districts.
	Trainings held Tues & Wed PMs in 2017; some families attended. 2018 will incl wkends to promote more family involvement	Community-based organizations		Equity for disparate pop							# of training options at times and places convenient to families.
	Tompkins lost its 1 school in 2017 (Ithaca City Sch Dist did not renew). COSER being worked up btw NYOMH & NYSEd for School Based FamNav pgm thru BOCES in AY2018-19.	K-12 School	Schools embed the Family Navigator program.	* Model was created 5 years ago and has been successful in adjacent county. * Community-based Family Navigator in Tompkins County has supported over 200 families across all school districts and is connected to families who are referred to SPOA (Single Point of Access) * Current Team has created a training manual for new Navigators	Funding is the current challenge and several options are being explored: * Funding through a BOCES COSER * Funding through individual school districts * Exploring RFPs related to Family Engagement				Rural schools and rural school districts Families in crisis	**Create/strengthen partnerships between the mental health services, families, schools, and all child-serving systems to imbed mental health screening, assessment, treatment, and access to family peer support in order to ensure early identification and treatment of mental health needs for infants, early childhood, school age children, and adolescents within all normative settings. [Revised]**	# schools with School-Based Family Navigator Partnership navigator assigned.
	Currently 2 Family Navigator peer counselors	Community-based organizations	Franziska Racker Centers trains and manages the Family Navigator program.	* Two current Navigators are well established and connected in the community	* Not enough staffing to provide support for each school district in the county.						# of trained Family Navigator peer counselors.
	OMIT MEASURE				Work with UKA is peripheral to the focus of this strategy, and our partners report that most schools are using an assessment and they were only involved in reviewing for certain content in the UKA.						~~# of school districts exploring use of the Universal Kindergarten Assessment (UKA)~~
	OMIT MEASURE				See above.						~~# of school districts where UKA has been implemented~~

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	20 referrals for CARE Team meetings in past 12 months (including 4 in the first two weeks of January 2018)	Community-based organizations	Franziska Racker Centers trains and manages the CARE Team program	* No diagnostic criteria for requesting a meeting which means intervention can occur before crises arise * No cost as many agencies agree that staff incorporate facilitation of meeting into their current positions * Incorporates system of care values (family driven, youth focused, trauma informed, integrated/individualized approach)	Lack of awareness about availability of model. Outreach will occur in 2018 to all schools, community agencies, DSS and other providers of services to youth and families.				Families in crisis Schools	**Expand implementation of the, CARE Team model as an early intervention for youth and their families in need of mental and emotional health services and support, using the principles of solution-focused therapy. [Revised]**	# families participating in a CARE team process
	23 people attended Care Team training wk of 10/16/17.	Community-based organizations	Training, placement, SPOA administration	* Ithaca City School District sent many staff to training and several schools have expressed interest in incorporating this model into their menu of interventions for youth who are struggling * Youth and families have expressed satisfaction with this model.	* Need buy-in from other child serving systems (I.e. DSS, Probation, Medical Practitioners, etc) in order to increase number of facilitators. Outreach will occur to these systems in 2018. * Need additional facilitators in order to meet anticipated increased demand. A second CARE Team facilitator training is scheduled for this spring. * Need for alternative to CARE Teams facilitated by neutral parties. CARE Team trainers are currently training some staff to facilitate Solution focused meetings- facilitated by staff who are already involved with a youth/family.						# family & youth services agencies with a trained CARE team facilitator
	OMIT MEASURE	Community-based organizations			Measure is not sufficiently relevant to the intervention						~~# of agencies, parents, families, youth involved in the Collaborative Solutions Network (CSN)~~
	OMIT MEASURE	Community-based organizations	X	X	Omit because it is too far from effort to address MH in its early or pre- stages						~~# CANS Assessments~~

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	Next survey: October 2018	K-12 School	BOCES, Alcohol & Drug Council, County Youth Services all collaborate with district superintendents and building principals to administer the survey	Biannual comparative survey data with a consistent population sample size	Cost, staffing resources, class time, teacher and principal buy-in. Remedy: Keep the pressure on and keep working for District demand for the data.	**Prevent Substance Abuse and Other Mental Emotional Behavioral Disorders**	**Goal 2.1: Prevent underage drinking, non-medical use of prescription pain relievers [and other opioids] by youth, and excessive alcohol consumption by adults.**	Objective 2.1.1: Reduce the percentage of youth in grades 9-12 reporting the use of alcohol on at least one day for the past 30 days (Baseline: 26 per 100, 2014-15 Tompkins County CTC Survey, Table 7.43, pg. 110).	Not specifically targeted	**Build awareness of underage drinking prevalence and focus on social norms that intervene in incidences of underage drinking**	Alcohol related risk & protective factors in bi-annual high school & middle school survey.
	Most recent survey and report update was Spring 2014 (Report dated 5/1/14).	College	Cornell Health collects the data	3-year project provided survey data from 5 semesters.	Social norms data was only collected during one of the 5 semesters. No further surveys currently scheduled due to limited funding and competition among survey interests, all of whom want to avoid over-surveying the population (survey fatigue).						Related college data: Cornell Alcohol & Social Life Surveys.
	TC3 "#ThinkAgain" social norms campaign reached >500 students over the Spring 2017 semester.	College	Tompkins Cortland Community College (TC3) fulfilled a SAMHSA STOP Act grant (Sober Truth on Preventing Underage Drinking)	#ThinkAgain campaign uses current social norms data to relate the idea that, 'if you think TC3 students behave this way, #thinkagain.'	Ongoing challenges. 2017 OASAS College Environmental Prevention grant will support expansion and enhancement of AOD prevention efforts.						TC3 social media campaigns
	Media campaigns: 186 Completed Activities, 2017 Q1-2 (per semiannual report to federal funder of Tompkins Co's STOP Act grant.)	Other (please describe partner and role(s) in column D)	County Youth Services	Media outreach primarily advertised the underage drinking tipline: radio, outdoor signage, movie theaters, newspapers, theater, music, & sports programs.	These campaigns utilized STOP Act grant funding, which will be unavailable when the grant ends within the next year. New, targeted outreach campaigns will be planned accordingly.						Collaborative media & social media campaigns targeting M&HS students, their parents, and college students.
	No progress as of 12/2017	City government		Establishes consequences for offending parties, not only the property owner.	Lots of preparation and education resources required. Stakeholders must include representation from 3 colleges.						Passage of county-wide social host liability law

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	No BASICS trainings in 2017	College	Alcohol & Drug Council of Tompkins County provides BASICS services for off campus infractions. Cornell University covers on campus infractions.							**Improve access to early intervention programs for underage drinking**	Increase # trained in BASICS
	City Court referrals go to Alcohol & Drug Council of TC. Cornell delivers BASICS to 400-500 students/yr.	College		Consistent, evidence-based intervention for students seeking support for excessive drinking or students who are mandated by the campus judicial process.	In 2017 Cornell relocated the program to another division within Cornell Health in order to provide better service with fewer trained staff.						Increase # BASICS referral agencies
	Completed by Mental Health and Substance Abuse Subcommittees of the Community Services Board	Local governmental unit					**Goal 2.2: Prevent and reduce occurrence of mental, emotional and behavioral disorders among youth and adults.**	Objective 2.2.1: Reduce the percent of adult Tompkins County residents reporting 14 or more days with poor mental health in the last month by 10% to no more than 6.2% (Baseline: 6.9%, 2013-14 eBRFSS, Tompkins County, age-adj.)	Pops. with mental illness Rural pops.	**Assess feasibility, support, and implementation of outpatient treatment programs for patients with behavioral health needs, including Assertive Community Treatment (ACT) Teams to help reduce avoidable hospital utilization and readmissions.**	Implement a focus group to establish the work plan for identifying appropriate outpatient programs.
	Access and support to all Tompkins communities has significantly improved with an ACT Team now located in Ithaca. The move was in partnership with Elmira Psychiatric Center (EPC).	Community-based organizations		Same day access to MH & SA outpatient treatment programs	Request to expand ACT services based on referrals and needs. Single Point of Entry (SPOE) is monitoring ACT referrals/ linkage for expansion assessment.						# of rural communities where ACT Team referrals are accepted/ available
	SPOE now processing /monitoring all ACT Team referrals										# of referrals to ACT Teams

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	Completed	Local governmental unit			Working with Catholic Charities and Challenge on HCBS. Barrier: the only service offered now is employment support. HCBS lists 16 services, some of which are difficult to provide, e.g. respite care. The barriers are structural (Medicaid)				Adults for whom service gaps challenge their ability to successfully re-enter the community	**Increase Home and Community Based Services (HCBS) for adults, to stabilize community habitation for Medicaid recipients with behavioral health conditions. [Revised]**	Identify service gaps that may appropriately be filled by HCBS
	Ongoing. As referrals to HCBS increase there is increased outreach to and support for agencies to initiate services				Pending HCBS improvements from NYS in service options and payment to attract more providers to provider this in Tompkins.						# agencies providing HCBS
	OMIT MEASURE				Staff training is not relevant as services are provided by partnering agencies						~~Identify HCBS services for which there are currently appropriately trained staff~~
	2017 was a pilot year and there were only 2 test organizations that participated (the goal was min. 2 per county in the 13-county Southern Tier and Hudson Valley PHIP regions).			Provides a best practices based approach for work sites of all types to begin to incorporate mental health wellness activities into their workplace wellness offerings; developed through a partnership between behavioral health and marketing professionals from the Hudson Valley and Southern Tier PHIP regions; pilot-testing year in 2017 has allowed for the toolkit to be refined before a wider introduction in 2018	a) Worksites, especially those with weak or no wellness programs, are hesitant to take on activities that are outside their scope of business. Pilot-testing in 2017 has allowed for refining toolkit activities adding more supports. b) Reporting is not independent since the toolkit relies on workplaces to self-direct and self-evaluate; Southern Tier PHIP prioritized relationship building with pilot worksites, to ensure that HR and other managers are comfortable identifying both their successes and challenges in implementing the toolkit. The challenges are also an opportunity to develop additional resources for the worksites.				Not specifically targeted	**Based on recommended practices (see Altarum Institute's Enabling Employee Wellness: What Do We Know About What Works?), utilize the HealthlinkNY Community Network Workplace Wellness Mental Health Toolkit to enhance behavioral health-related offerings provided by Tompkins County employers, increase adoption of relevant employer policies, and reduce stigma associated with mental, emotional, behavioral (MEB) health. [Revised]**	# of organizations utilizing the toolkit
	This info not yet available										# of organizations conducting self-audits of organizational culture around MEB Health

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	4 have been identified by the pilot organizations										# of toolkit activities undertaken by participating organizations
	These results will come with the self-audits										# of unique MEB health needs identified by participating workplaces
	OMIT INTERVENTION	Hospital			New protocol model has been implemented in the Behavioral Services Unit at Cayuga Medical Center (hospital)				Persons subject to readmission due to unsuccessful community re-entry	~~**Implement DSRIP project 2.b.iv, Care Transitions, Health Coach model, for Medicaid participants admitted to the inpatient behavioral health unit in order to support compliance with discharge plans and improve continuity of care. [Revised]**~~	# of Medicaid patients receiving a visit from the Health Coach while in the hospital and # of home visits received post discharge.
	92.6% of patients were not readmitted within 30 days (75 readmissions out of 1,010 total admissions, 2017 YTD.)	Hospital	Behavioral Services Unit (BSU) at Cayuga Medical Center is the inpatient facility.	With Utilization Review (UR), transition is an element of the treatment team's process in real time, rather than a new/ separate point of contact.	UR was introduced in Q3 of 2017, so many aspects of the protocol are still being worked out within BSU and in conjunction with Care Transition team members outside the BSU.					**Implement a Utilization Review protocol within the Behavioral Services Unit to identify alternatives to inpatient care that are, available in the community, appropriate for the individual, and cost effective, in order to limit the occurrence of patient readmissions and reduce length of stay. [New]**	# of patients who received UR services and were not readmitted within 30 days of being discharged.
	Not available	Headstart						Objective 2.2.2: By Dec. 31, 2018, reduce the number of youth grades 9-12 who felt sad or hopeless by 10% to no more than 28.5% (Baseline: 31.7%, 2014-15 Tompkins County CTC Survey, Table 7.95, pg. 134, total YES! + yes).	Families in crisis	**Increase access to mental health services for families in rural populations by staffing Headstart satellite locations. [New]**	# of families seen at outreach sites
	Not available										# client appointment slots
	Not available										# of satellite locations where MH staff see families.

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					Our partner agency, Family & Childrens Services of Ithaca, determined that this intervention and associated measures were no longer the best option for addressing Objective 2.2.2.				~~Families in crisis~~	~~**Introduce Home-Based Therapy (HBT) [for youth] to expand mental health services for rural populations. HBT addresses barriers to treatment due to travel time and transport to centralized clinic locations, need for childcare, difficulty in scheduling appointments. [Revised]**~~	~~# of meetings held to educate referral sources about the benefits of the Home-Based Therapy.~~
											~~# of therapists trained to provide Home-Based Therapy.~~
											~~# of CCOS (Children's Crisis Outreach Services) families who receive extended therapy through the home based care program~~
	2 Care Mgt Agencies (CMA) = Franziska Racker Centers (FRC) & Elmira Psychiatric Center (EPC). Current enrollments: FRC 16, EPC 10.	Community-based organizations		* Children and youth are being referred by school staff and community providers for Care Management. * SPOA Coordinator and both Care Management Agencies are working together to provide outreach to the community regarding Health Home Care Management and assisting families in enrolling efficiently and quickly.	* Lack of awareness about availability and/or confusion about the purpose of Care Management. * Outreach by SPOA Coordinator and Care Management Agencies to occur in 2018 with all child-serving providers document.				Youth with multiple diagnoses	**Increase utilization of Children's Health Home Care Management to support comprehensive care for eligible Medicaid enrollees from birth through age 21. [Revised]**	# of enrollments

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	Under review following the Youth Transformation guidance from NYS.				Final NYS Youth Transformation guidance from NYS.				Youth who are subjected to service gaps	**Increase State Plan Amendment services (SPA) for youth, to stabilize community habitation for Medicaid recipients with behavioral health conditions. [Revised]**	Identify service gaps that may appropriately be filled by SPA
	Ongoing. As referrals to SPA increase there is increased outreach to and support for agencies to initiate services.				Pending final NYS guidance.						# agencies providing services
	OMIT MEASURE				Staff training is not relevant as services are provided by partnering agencies						~~Identify SPA services for which there are currently appropriately trained staff~~
	2 trained providers currently available to provide services	Social Services	TC DSS is the staffing agency for Family Treatment Court/ Family Drug Court, which is the sole referring agency.	Home-based, skills focused	Currently, referrals stem from court filings against parents of child neglect due to drug use. Would like to utilize SafeCare as a prevention tool for flagged families under care of any DSS service program. Would like to utilize a new (Q4 2017) SAMHSA grant for this expansion of referrals.				Families in crisis	**Integrate SafeCare into the continuum of care to support, promote, and sustain family-based recovery. SafeCare is an evidence based (Georgia State Univ. SPH) home visitation coaching model for families with children ages 5 & under. Expand referral to SafeCare beyond single current --- parental neglect due to drug use --- to include preventive referral criteria for families at risk. [Revised]**	# of trained providers
	1 coach + full accreditation for TC Health Dept.	Local health department		Trained coach on the team greatly increases referral capacity and completes requirements for accreditation.							# of trained coaches.
	15 families referred, 7 completed (graduated from) the program	Other (please describe partner and role(s) in column D)	Judicial								# Referrals to SafeCare as preventive measure.
	12 staff trained at Cayuga Addiction & Recovery Services (May 2017) 4 staff trained at CMC Behavioral Health Unit (Nov 2017)	Community-based organizations	Catholic Charities-T/T, CARS, CMC-BHU, F&CS-Ith, ADC-TC, TCMH, all trained & facilitated by CNY Regional Center for Tobacco Health Systems at St. Joseph's Health	Many organizations are interested in training and additional resources for staff. Many OMH connected agencies receive additional training through OMH	Many organizations have limited time available for trainings. We adjust our training to meet their needs. If we don't teach a certain topic they will still have all the resources but they must take the time to "educate" themselves on those other areas if needed.		**Goal 2.4: Reduce tobacco use among adults who report poor mental health.**	Objective 2.4.1: Reduce the prevalence of cigarette smoking among adults who report poor mental health by 15%	Persons in treatment for poor mental health who use tobacco	**Improve Quality Assurance for utilizing evidence-based models for treating tobacco dependence in line with PHS guidelines, OMH system of care, or OASAS protocol, for organizations that provide mental health and substance abuse services.**	# of staff trained in the "5 A's" (Ask, Advise, Assess, Assist, Arrange) or other model

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	6 MHSA services orgs utilizing or close to finishing their training & set-up of the screening system			Most organizations are utilizing the 5A's in some manner within their Electronic Health Record but it varies based on the orgs and their EHR system. Our resources have been beneficial as many have requirements through their accrediting bodies to treat tobacco dependence.	There is always a concern of sustainability of a system, which is why we request them to have staff trained and a QA piece in place to monitor the system in addition to implementing the 5A's. The other challenge is that while we integrate it into one EHR, many organizations switch record systems.						# of health systems properly utilizing tobacco screening system
	5 health systems are currently under guidance of a champion, admin, or QA officer			Having an onsite contact/liaison is critical to the systems success.Ensuring that staff are trained, that the QA reports are being completed and that providers are receiving follow up on the QA report is essential for sustainability of the system.	Staff turnover & changing Job Responsibilities: we do our best to keep in regular contact with an organization and if a role/ staff member leaves that was our key contact we ensure that we have a new contact/ liaison.						Involvement by tobacco treatment champion, system administrator, or QA officer
	Hospital (2) LGU (1) LHD (3) MH Services Youth (1), MH Services Adult (1) Rural Health Network (1) PHIP (1)	Community-based organizations		The Health Planning Council (HPC) has an established staff, board, and workplan through which to organize the CHIP Steering Committee. The steering committee that was formed included HPC staff and board members, and stakeholders not affiliated with the HPC.	The HPC has only in the last few years begun incorporating Mental Health (MH) & Substance Abuse (SA) stakeholders on their board. As such, they are as new to this sector as other public health focused stakeholders. We are all learning together.	Strengthen Infrastructure	**Goal 3.1: Support collaboration among leaders, professionals and community members working in MEB health promotion, substance abuse and other MEB disorders and chronic disease prevention, treatment and recovery.**	Objective 3.1.1: Identify and strengthen opportunities for sharing data on access to care, identifying service gaps, studying cost-effectiveness strategies for integration and coordination, and the impact of interventions.	Not specifically targeted	**Through the Health Planning Council, establish a CHIP Steering Committee to evaluate CHIP interventions at regular intervals, and maintain stakeholder engagement and integration of MEB prevention efforts with other community health goals. [Revised]**	# of participating sectors
	6 total: TCHD, TCMH, Franziska Racker Centers, Lakeview Health Services, Health Planning Council, Cayuga Medical Center	Hospital		The participating agencies were key players in developing the CHIP and CSP. This is especially vital when addressing the MH & SA goals and objectives.	It is not easy to get all of the agencies to the table at the same time. and increasing the number of stakeholders to uncover issues not currently addressed adds to the challenge. Keeping the group small for now.						# of participating agencies

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	10	Local governmental unit									# of engaged individuals
	1 Steering committee meeting, 9/18/17.	Local health department		Successful meeting.	Need to plan far in advance.						# of Steering meetings at which CHIP updates are recorded
	4 facilitators in 2016, +2 in 2017-Q4.	Community-based organizations	Trained facilitators	Mental Health Association in Tompkins County (MHA) had two additional employees trained as WRAP facilitators, bringing the agency total to 6, thanks to recently received training grant.	Greater demand for the service, as it becomes more well-known… MHA will continue to send employees to trainings as they become available.			Objective 3.1.2: Identify and strengthen opportunities for implementing MEB health promotion and MEB disorder prevention with individuals	Incarcerated persons Persons hospitalized due to a mental health crisis	**Expand Wellness Recovery Action Plan (WRAP) training to support successful reintegration into the community after hospitalization or incarceration.**	# facilitators trained to deliver WRAP program
	Manuals available to all mbrs of Jenkins Ctr, & all group participants in Day Reporting Pgm, CMC, & Jail	Law Enforcement	Corrections is providing access and support to train inmates	Grants used to purchase manuals for Jenkins Center… Manuals for other locations purchased by those facilities.	Demand is on-going… MHA will continue to apply for funding, and develop partnerships with other collaborating agencies						availability of training manuals
	4 sites: Jenkins Center, Day Reporting Pgm, CMC, Jail	Hospital	Access and support for training individuals	Continuity between locations, consistency… Some individuals are able to participate in WRAP in multiple venues, can serve as a bridge between service providers.	Would like to provide WRAP in other settings, as time and resources allow						# of sites where WRAP is training is provided
	About 80 enrolled	Local governmental unit		Improved interest in services and expanding enrollment in first year of program.	PROS Director offering community presentations to educate community on new PROS rehabilitation model.				Persons with poor mental health	**Expand rehabilitation and integration programs such as PROS (Personalized Recovery Oriented Services) to serve more community members and involve more community services agencies. [Revised]**	# of individuals with severe and persistent mental illness who are enrolled in PROS classes
	About 25 in 2017.			Successful transition toward independence and recovery.							# PROS graduates successfully transitioned to less intensive services
	About 20 in 2017.			Improved community education on rehabilitation model of care offered by PROS.							# community education presentations on the PROS/ rehabilitation model
	OMIT MEASURE				Better captured through other, revised measures						~~Degree of community integration of PROS services~~

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	Cayuga Medical Associates (CMA) has fully implemented the project and has a social worker embedded in their internal medicine practice.	Providers		This project has proven to be helpful in identifying patients that may be at risk for developing a mental health or substance use disorder, or atrisk for exacerbation of an existing condition. Co-location of patients in a single setting is a very patient-centered, effective way to ensure that patients receive the care they need in the right setting. Most patients that are higher risk will only develop a relationship with provider/s in a single setting, so it makes sense to continue to integrate these services when feasible.	Transition period has bumps within practices as protocols, hand-offs, and management are streamlined and stumbles are smoothed out.			Objective 3.1.4: Support efforts to integrate MEB disorder screening and treatment into primary care.	Rural school districts. Persons with or at risk for mental health disorders Individuals with opioid. dependency.	**Integrate behavioral health into the primary care setting, and/or primary care into the behavioral health/substance abuse setting, utilizing the parameters defined through DSRIP project 3.a.i to improve early identification for patients with behavioral health or substance abuse concerns, and ensure appropriate access to services in a single setting. [Revised]**	# of primary care practices in Tompkins County that have integrated behavioral health services
		Providers	REACH Medical Practice, operating under the newly formed nonprofit REACH Project, Inc., will provide Medical Assisted Treatment (MAT) to individuals with opioid dependency, starting Q1 2018.	REACH will contract with a number of local physicians and midlevels to offer primary care in the same setting for this population.							# of behavioral health and/or substance abuse settings in Tompkins County that have integrated primary care services.
	OMIT MEASURE				# of practices is a better upstream measure						~~# of patients receiving behavioral health screenings in the primary care setting~~
	OMIT INTERVENTION				Better addressed through the Integration strategy, which is grounded in a DSRIP project.				All persons at risk for MEB disorder	~~Develop education & coordination between Primary Care Provider (PCP) and Health Home Care Management (HHCM) program agencies for screening and referral to treatment in an integrated model, and to strengthen the care management process.~~	~~# of HHCM agencies involved~~
											~~# of PCP offices involved~~
											~~# of PCP offices with a plan to integrate screening and referral to treatment~~