Tompkins County
COMMUNITY MENTAL HEALTH SERVICES BOARD

Tompkins County Whole Health
201 East Green Street
Ithaca, New York 14850-5421

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Mental Health Subcommittee Meeting
Via Zoom
May 19, 2026 @ 1:00 – 2:30 p.m.
Meeting Minutes

Minutes Approved
June 16, 2026

Present: Larry Roberts, Mary Hutchens; Jessica Conner; Ben Komor; Cindy Freidmutter; Tracy Decker
Excused: Larry Roberts, Aderonke Ilegbusi, and Susan Tabrizi
Unexcused:
Guests Present: Dr. Melissa Dhundale, TST BOCES; Jessica Hoff, TST BOCES; Cheryl Willer, Catholic Charities
Staff Present: Karan Palazzo, LGU AA; Dan Stevens, Clinician TCWH

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The meeting was called to order at 1:04 pm by Mary Hutchens, who filled in for Larry. Introductions were made. Cindy moved to approve the March and April 2026 minutes, seconded by Dr. Conner.

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Privilege of the Floor & Announcements: Dr. Conner shared that the Developmental Disabilities Subcommittee is hosting a resource fair at Boynton Middle School today from 4:30 – 6:30 pm.

Discussions:

Adverse Childhood Experiences (ACE) in Tompkins County Youth Working to Build Resiliency in Children, Youth, and Families:

Melissa Dhundale, MD, FAAP, Medical Director of School Health Systems at T-S-T BOCES, explained how a regionalized school health system was built by embedding a medical team (herself as pediatrician/medical director and PA Jess Hoff) within TST BOCES to support most Tompkins County school districts. Previously subcontracted for limited hours, she now focuses full-time on school health: required physicals (sports and mandated grades), nursing support, immunizations, concussion and athletic placement compliance, and translating complex NYS regulations into usable processes.

Recognizing major mental health access gaps, they now focus heavily on behavioral health by adding standardized screening (questions on safety, food access, trusted adults, plus the PSC-17) and using a six-tier referral/connection model that ranges from simple consults with schools/PCPs to multi-party case conferences with psychiatric specialists and higher-level crisis coordination. They run a 40-week psychiatric education program for pediatric providers, host regular interprofessional meetings and practices, such as Northeast Pediatrics, which is developing universal consent tools and substance use policies to better coordinate care for youth with complex needs.

Jess Hoff, a Physician Assistant at TST BOCES, expanded on how the embedded BOCES medical team operationalizes care coordination and system change. She walked through a typical case where a school flags an elementary student with social determinants issues (transportation, food), complex medical needs (e.g., sleep apnea), and emerging depression; the team conducts an assessment (including the PSC-17), secures consent, and then convenes an interprofessional meeting with the PCP, school staff, and the Project TEACH psychiatric consultants to align next steps and ongoing communication.

She described standing "running kids" meetings with local pediatric practices to keep high-risk students on everyone's radar and highlighted the 40-week Psychiatric Education for Pediatric Providers (PEP) program, which combines didactics, shadowing at Brighter Days mental health urgent care, and mentorship from child psychiatry specialists to build regional pediatric capacity for managing behavioral health. Finally, she outlined two legislative initiatives they're advancing: **Bridges to Care**, allowing school medical directors/designees to prescribe short-term "bridge" medications (e.g., albuterol, EpiPens) for students without a PCP, and an **opt-in policy for districts to allow students to carry Narcan on school grounds**, expanding access to overdose reversal.

Dan Stevens, a Clinical Therapist with Children and Youth Services at TCWH, described how the Tompkins County Mental Health children and youth team is embedded in schools to reduce barriers to access and how he uses ACEs in practice. At intake, they administer an ACE questionnaire alongside a social determinant of health screener to assess trauma history and contextual factors, then use that information to shape treatment planning and focus areas (emotional regulation, family stress, foster care involvement, etc.). Dan emphasized that most kids he sees have at least one ACE, that transportation and access remain major barriers, and that school-based satellites (currently in multiple districts, with planned expansion to BJM, New Roots, and possibly South Hill) are critical because families can more easily reach schools than clinic sites. His school-based work blends individual therapy (largely play-based with coping skills), collaboration with school staff (nurses, social workers, IEP teams), and coordination with the clinic's prescriber for medication management. He also highlighted gaps: a lack of local pediatric respite, communication challenges when youth go to out-of-county respite, and the need for stronger, more systematic collaboration with all pediatric practices—not just Northeast Pediatrics, with whom they have a particularly well-developed relationship.

Key Gaps and Challenges

Structural & Service Gaps

<u>No local pediatric respite care</u>

- Children needing respite must go to programs outside Tompkins County, making coordination and continuity of care difficult.
- Discharges from out-of-county respite are sometimes not communicated back to local providers.

<u>Limited pediatric-focused urgent/acute behavioral health options</u>

- Need for a local pediatric floor/urgent care that can handle behavioral health crises and then hand off smoothly back to community providers (schools, clinics, PCPs).

<u>Insufficient pediatric crisis specialization</u>

- Care One's crisis team is valued, but there is a gap in pediatric-specialized crisis response and follow-up.
- Incomplete school-based mental health coverage
    - School satellite services are expanding, but still not in every school (e.g., BJM, South Hill, and New Roots are still being worked on and limited by space).

<u>Access & Transportation Barriers</u>

Transportation is a major barrier to care

- Families (especially those with children who use wheelchairs) struggle to get to downtown clinics, Brown Road, or regional services.
- Only one bus runs in/out of some rural schools (e.g., Enfield), making clinic-based intakes difficult.

Underused but promising transit options that need coordination

- Gadabout and TCAT are accessible but not fully integrated into **structured plans for families** (e.g., unknown whether Gadabout can pick up a parent at work, bring them to school, then to appointments).
- Need for **intentional collaboration** with Gadabout and FLIC to turn existing services into a reliable care pathway for families.

Communication, Consent, and Coordination Challenges

Consent barriers limiting "wrap-around" care

- Difficulty obtaining and standardizing releases/consents so schools, PCPs, therapists, and school health teams can talk easily and quickly about shared kids.

Therapist time and funding for collaboration

- Therapists often do not have paid time to attend interprofessional meetings with schools and PCPs.
- This limits the ability to build full "huddles" around youth, even when the school health team and PCPs are meeting regularly.

Information gaps with social determinants screeners

- SDOH forms are sometimes filled out by parents without staff present; unclear if answers refer to the parent's situation or the child's, complicating interpretation and follow-up.

Cross-system communication at transitions

- When kids go to respite, crisis, or new schools (e.g., transfer to New Roots), communication back to school-based teams and local clinicians can be inconsistent, affecting continuity of care.

Capacity & Resource Constraints

Limited mental health resources for youth overall

- Broad acknowledgment of insufficient child/youth mental health capacity in the community; the school health team spends much of its time filling gaps

Physical space constraints for expanding school satellites

- New Roots and some other schools lack the dedicated space required by OMH for mental health satellites, slowing expansion.

Primary care coverage & medical home issues

- Some students lack a primary care provider (medical home), which:
    - Delays access to needed medications (e.g., asthma meds, EpiPens).
    - Forces school health team into stopgap roles and motivates legislative fixes (e.g., Bridges to Care, Narcan opt-in).

The meeting adjourned at 1:55 pm.

The Next Meeting is Tuesday, June 16, 2026 @ 1 pm