ANALYSIS OF STATE FISCAL YEAR 2014 PROGRAM ACTIVITIES

Prepared by:

The Ohio Department of Mental Health and Addiction Services

Office of Prevention and Wellness

Office of Quality, Planning, and Research

and

The Ohio Department of Developmental Disabilities

Overview

Ohio policymakers and stakeholders identified a need to provide more community-based services to support families with children and youth at-risk of harming themselves or others due to a mental illness and/or a developmental disability. In response to this identified need, Governor Kasich allocated $5 million to be spent in Fiscal Years (FY) 2014 and 2015 to the Ohio Department of Developmental Disabilities (DODD) and Ohio Department of Mental Health & Addiction Services (OhioMHAS) to launch the Strong Families, Safe Communities program. The program helps communities create and provide care coordination and targeted crisis intervention services for children and youth at risk for violence, aggression, or out-of-home placement. Since communities vary in the type of services needed and the infrastructure available to support the services, this program engages local systems to identify the most appropriate community-based solutions and emphasize collaboration across agencies. In order to identify these solutions, partners collaborate across the system to develop and implement the solutions suited for the identified families.

During the first year of the program, $1.9 million was awarded to 13 projects, administered by seven Community Boards (Boards). The seven Boards are as follows:

- Athens, Hocking, Vinton, and Jackson
- Belmont, Harrison, Monroe
- Butler
- Clark, Greene, Madison
- Hamilton
- Licking, Knox
- Stark, Columbiana, Wayne, Holmes, Portage

The projects focused on crisis stabilization for children and youth with intensive needs. Services delivered directly to the children/youth and their families included crisis services and outreach; pre-screening/assessment of at-risk youth, therapeutic respite services, wrap-around services, family connections and support, ongoing support coordination, and trauma responsive activities. In addition to services provided directly to children/youth and their families, the projects engaged in community-based planning to identify service gaps, training of staff and community representatives, and the development of infrastructure required to deliver the services. At the end of the first FY, approximately 489 children/youth and their families were served, thus exceeding initial targets by 124.

The purpose of this report is to provide the reader with information concerning the Strong Families, Safe Communities program activities. The report is divided into the following sections:

- Methods—a description of how the data were collected and analyzed
- Results—information about local program activities and services provided to children/youth and families
- Discussion - recommendations in which these and similar programs can be supported and expanded in the future.

Methodology

Data Source

Grantees submitted quarterly Performance Monitoring Worksheets (PMW). (Refer to Appendix A for a PMW template). The analytical team extracted information for this study from the PMWs for the fourth quarter ending June 30, 2014, or in a few instances, activities reflect a prior quarter results.

As one can ascertain from the attached PMW template, project staff submitted the following information about activities for each project's objectives: a description of the activity, start and end dates, the proposed indicator associated with the objective, proposed target number for FY, quarterly total, cumulative year-to-date total, and a description of the impact on the targeted population/system. Project staff was not required to report unduplicated counts for the objective and/or for the project. In the instances where the analysts were unable to ascertain an unduplicated count and/or descriptions lacked specification, analysts contacted project staff for counts and clarification.

Data Analysis

Qualitative Analysis.

Analysts used a mix-method approach to examine project information. Qualitative analysis was used to classify activities into categories and sub-category groupings. Following consensual methods procedures for coding qualitative information (Hill, Thompson, and Williams, 1997), the analytical team assigned an analyst to examine key words and phrases concerning activities reported on the PMWs. The analyst searched the following three PMW fields for key words and phrases: the activity's description, the proposed indicator, and the impact on the targeted population/system. After reviewing the key words and phrases that emerged from the PMW fields, the analyst then developed a classification scheme and coded activities into main and sub-categories. The analytical team reviewed the classification scheme and made adjustments to the scheme.

Quantitative Analysis.

Quantitative analysis was limited to frequency counts of total activities that occurred and people who received direct services. The analytical team used the proposed target number for FY and the cumulative year-to-date total to determine the number of organizational readiness activities and clients/families served for each objective's activity. The analytical team contacted project staff to clarify types of direct services provided and the number of people served overall as well as in individual activities.

Geographical Grouping.

The analytical team sorted results into geographical groupings of the sponsoring Boards. Boards were divided into the following three categories: urban, mid-sized urban, and Rural/Appalachia. Urban and mid-sized urban areas are all located in Standard Metropolitan Statistical Areas (SMSAs). Urban Boards have populations over 300,000. Mid-sized urban have populations under 300,000. Rural counties are located outside of an SMSA. If a county has a federal designation of Appalachia, the county is classified as Appalachian regardless of its location within or outside SMSA boundaries.

Results

Organizational Readiness Activities

As Table 1 indicates, organizational readiness activities were split into three sub-categories, which were assessing needs, building capacity, and sustaining the projects. Not all projects engaged in needs assessment (five projects or 38.5%) and sustainability activities (three or projects or 23.1%). However, all 13 projects engaged in at least one capacity building activities. The three sub-categories were not necessarily distinct phases since some organizations were involved in various sub-categories concurrently. For instance, a mid-sized urban organization conducted a service needs assessment and worked with community partners on a sustainability plan.

Organizational readiness activities, particularly needs assessment and building capacity activities, often occurred prior to projects delivering direct services. Organizational readiness activities, as the category name suggests, were centered on tasks that prepared the organization and community to begin offering direct services. For instance, in order to offer crisis intervention services, staff had to be hired and trained prior to the service being offered.

Assessing the Need Activities.

Urban, mid-sized urban, and rural/Appalachian organizations undertook needs assessment activities. According to Table 1 results, these activities varied among the organizations. For instance, an urban organization conducted organization readiness surveys with staff and community partners. A mid-sized organization assessed the training needed to implement the proposed project, while a rural/Appalachian organization developed a strategic plan.

Building Capacity Activities.

The capacity building sub-category, unlike the needs assessment and sustainability sub-categories, was further sub-divided into six additional sub-groupings. (Refer to Table 1). These sub-groupings included 1) collaboration with community partners, 2) consultations with experts, 3) dissemination, 4) evaluation, 5) infrastructure development, and 5) training. As mentioned earlier, all 13 projects undertook at least one capacity building activity.

As Table 1 shows, Strong Families/Safe Communities projects were most apt to be involved with infrastructure activities (nine or 69.2%) or with training activities (eight or 61.5%). Since the scope of work was new to these organizations, the communities developed organizational and community capacity to support the new service delivery mechanism. Since organizations were offering different types of new and expanded services, infrastructure needs differed across projects and communities. Infrastructure needs also differed across projects due to available organizational and community services as well as the extent to which organizations/communities already had the necessary network supports in place to deliver the new and/or expanded services. Examples of infrastructure activities included: setting up referral systems, recruiting staff, developing evaluation and tracking tools, and preparing service curricula for staff.

According to both Table 1 and Table 2 results, Strong Families, Safe Community project funds were expended on various types of training sessions. Training was provided to clinicians and line staff

responsible in delivering the new services and to community stakeholders and families. Participants accessed over 1,507 training slots. Community members accessed 1,069 or 70.9% of the slots; agency staff, 336 or 22.3%; and clinicians, 102 or 6.8%. In addition to training about the actual services being offered, some sessions dealt with issues often experienced by the people and families accessing these services. Examples of these trainings included suicide prevention and system of care values.

Training community partners may prove to be an integral factor in building the service delivery capacity for many projects. The delivery mechanisms associated with the Strong Families, Safe Communities project often involve multiple agencies. For instance, law enforcement officials are typically the first responders to a crisis. Thus, training can provide law enforcement officials with important information about knowing how to manage the crisis and what community services are available.

Sustainability.

Three organizations mentioned that staff and community partners were engaged in sustainability efforts. (Refer to Table 1). Of the three projects engaged in sustainability activities, one was located in an urban community and the other two in mid-sized urban communities. Community partners were involved in all three projects' sustainability efforts. These efforts included identifying potential funding sources to maintain and expand program funding.

According to researchers who have studied how innovations (i.e., new services and strategies) are sustained, organizations and their community partners need to engage in capacity building activities that will integrate the project within the organization's daily operations and will provide on- going, essential benefit to a diverse set of community stakeholders (Drucker, 1990; Johnson, Hays, Center, and Daly, 2004; Shediac-Rizkallan and Boone, 1998). Integration, in turn, is dependent upon changing both the organizational and public health system in which the innovation (i.e., service) was introduced (Altman, 1995; Goodman, et al., 1998; Johnson, et al). There are numerous capacity building elements that can assist an organization with sustainability efforts. Examples include developing evaluation tools to gauge the project's performance of the project and training staff and community staff on the project's use and benefits of the project. Even though only three projects explicitly listed sustainability activities on their PMWS, all the projects undertook capacity building activities that are integral in building both the organizational and public health system's capacity to offer a more diverse service array on a long-term basis.

Table 1 Strong Families, Safe Communities FY 2014 Organizational Readiness Activities			
Activity	**Agency Type**	**# of Agencies**	**Examples:**
Assessing Need	**Total**	**5**	
	Urban	1	Organizational readiness surveys conducted
	Mid-Sized Urban	3	Service needs assessment completed; Baseline survey of family needs conducted; Training assessment completed
	Rural/Appalachian	2	Respite needs, resource availability, and service option assessment completed; Strategic plan developed
Building Capacity		**13**	
Collaboration	Total	3	
	Urban	0	
	Mid-Sized Urban	2	Stakeholder group convened Multi-system needs meeting convened for parents connectedness and education
	Rural/Appalachia	1	Continuity of care meeting held
Consultations	Total	2	
	Urban	1	Theory to Practice consultations held
	Mid-Sized Urban	1	Consulting team organized
	Rural/Appalachia	0	
Dissemination	Total	4	
	Urban	2	Information about evidence-based practice research disseminated to community and organization
	Mid-Sized Urban	2	Referral information about program provided to participating community agencies
	Rural/Appalachia	0	
Evaluation	Total	1	
	Urban	0	
	Mid-Sized Urban	1	Program evaluation of service impact started
	Rural/Appalachia	0	
Infrastructure	Total	9	
	Urban	3	Trauma-informed care curricula developed; Agency created an additional DBT team to expand existing DBT services
	Mid-Sized Urban	4	Referral system created Evaluation and tracking tools developed; Crisis team recruited; Respite options developed; Mobile Urgent Treatment Team implemented
	Rural/Appalachia	2	Rapid Responder team started at agency; Wraparound Service Coordinator hired
Training	Total	8	
	Urban	4	Staff were trained on new assessment, screening, and planning tools; Staff received trauma informed care training and core competency training
	Mid-Sized Urban	3	DBT training for clinicians conducted; TIP training was provided
	Rural/Appalachia	4	Rapid Responder team members received training; Youth Mental Health First Aid training was provided to community members; Community and organizational staff received training about violence, abuse, trauma, and diverse needs
Sustaining the Project	***Total***	***3***	
	Urban	1	Community partners worked on resource proposal for sustainability
	Mid-Sized Urban	2	Organizations worked with community partners to identify potential funding sources to maintain and expand program
	Rural/Appalachia	0	

Table 2 Strong Families/Safe Community FY 2014 Trainings Delivered to the Agencies, Community Partners, Community Volunteers, and Families			
Agency Type	**Training Type**	**Targeted Audience**	**Number Trained**
Urban			
	Core Competencies	Clinicians	29
	Screening/Assessment Tools	Agency Staff	43
	Screening/Assessment Tools	Community Partners	110
	Trauma Informed Care	Agency Staff	221
Mid-Sized Urban			
	Train REST Trainers	Community Volunteers	7
	Suicide Prevention Training	Community Partners	310
	Dialectical Behavior Therapy Introduction	Community Partners	122
	Dialectical Behavior Therapy—Clinical	Clinicians	25
	System of Care Values	Community	33
	Risk Assessments and Behavioral Analysis and Options	Community	76
	Trauma Informed Care	Community	236
	Trauma Informed Care—Clinical	Clinicians	48
	Hi-Fidelity Wrap Around	Agency Staff	54
Rural/Appalachia			
	CRISIS Intervention Training	Law Enforcement	47
	Virginia Student Treat Assessment	Schools	38
	Youth Mental Health First Aid Certification	Staff	2
	Youth Mental Health First Aid Training	Rapid Response Teams; Family and Children First Council Directors; Juvenile Probation Officers; Case Managers; School Social Workers	90
	High Needs Youth Treatment	Agency Staff	6
	Hi-Fidelity Wrap Around	Agency Staff	4
	Strengthening Families	Agency Staff	5
	Respite Family Training	Agency Staff	1
Summary: Strong Families/Safe Community Training Slots Accessed by Type of Participant During FY 2014			
Type of Participant		**Slots**	**% of Participants**
Clinicians		102	6.8%
Agency Staff		336	22.3%
Community		336	70.9%
Total		1,069	

Direct Services

Number of People Served.

Based on the PMWs submitted, Strong Families, Safe Communities organizational staffs indicated that the projects would provide direct services to approximately 365 individuals and/or families during FY 2014. (Refer to Table 3). Projects reported that 489 individuals and/or families actually received services. Overall, projects exceeded targets by 124 individuals/families or 34%. Of the three geographical types, mid-sized urban projects provided services to the majority of individual/families (403 or 82.4% of the total), followed by urban projects with 49 individuals/families or 10.0%, and rural/Appalachia projects with 37 individuals or 7.6% of the total. It was not surprising that mid-sized urban projects reported serving the largest number of people since these projects, overall, had estimated that they deliver the most services among the geographical groups. However, unlike urban areas which did not meet projected targets and rural/Appalachia projects that only exceed projected targets by seven individuals, mid-sized urban surpassed projected targets by 147 people.

Table 3
Strong Families Safe Communities
Number of People/Families Served During FY 2014

	Target	Actual	% of Total
Project Total	365	489	
Urban	79	49	10.0%
Mid-Sized Urban	256	403	82.4%
Rural/Appalachia	30	37	7.6%

Direct Services Delivered.

Table 4 shows the types of Strong Families/Safe Communities services provided, the anticipated target of people/families to receive the service, and the actual number of people /families receiving the service, as reported on the PMWs in FY 2014. The following seven types of services were provided: 1) pre-screening/assessment, 2) evidence-based practices, 3) crisis services/outreach, 4) wraparound services, 5) residential step-down services, 6) respite services, and 7) family assistant services. Of the seven services delivered, crisis services/outreach services were the most frequently provided service, followed by pre-screening/assessment activities.

Strong Families, Safe Communities projects provided crisis services/outreach services to 189 individuals/families. Mid-sized urban projects served the majority of participants (184 or 97.4%), compared to rural/Appalachia projects serving five participants (2.6%) and urban projects serving no participants. One mid-sized urban project developed a mobile outreach/crisis team while a rural/Appalachia project created a rapid response team to assist both individuals and their families with a crisis situation. In both instances, individuals received additional services that included respite care and follow-up treatment.

Strong Families, Safe Communities project staff pre-screened/assessed 151 people. Mid-sized urban project staff screened or assessed the majority of the participants (139 or 92.1%). In comparison,

urban project staff screened or assessed 12 participants (7.9%), while rural/Appalachia staff did not report any pre-screenings or assessments. Examples of pre-screens and assessments included quality of life baseline surveys conducted by staff at an urban project and wrap-planning offered by mid-sized urban project staff.

Table 4
Strong Families/Safe Communities Direct Services Offered During FY 2014

Services	Agency Type	Target for Services	Actual Served	Examples
Pre-Screening/Assessment	**Total**	**48**	**151**	
	Urban	0	12	Quality of Life baseline surveys
	Mid-Sized Urban	48	139	Pre-screenings; Wrap Around Planning
	Rural	0	0	
Evidence-Based Practices	**Total**	**7**	**1**	
	Urban	7	1	Dialectical Behavioral Therapy
	Mid-Sized Urban	0	0	
	Rural	0	0	
Crisis Services/Outreach	**Total**	**134**	**189**	
	Urban	0	0	
	Mid-Sized Urban	134	184	Mobile Outreach/Crisis Team
	Rural/Appalachia	0	5	Rapid Response Team; Virginia Student Threat Assessment Guidelines
Wraparound Services	**Total**	**44**	**48**	
	Urban	9	9	
	Mid-Sized Urban	20	20	Gas cards for transportation to appointments Gym membership for health Car repairs
	Rural/Appalachia	15	19	Home Visits
Residential Step-Down	**Total**	**8**	**8**	
	Urban	0	0	
	Mid-Sized Urban	8	8	
	Rural/Appalachia	0	0	
Respite Services	**Total**	**39**	**62**	
	Urban	6	32	
	Mid-Sized Urban	23	22	
	Rural/Appalachia	10	8	
Family Assistant Services	**Total**	**6**	**2**	
	Urban	0	0	
	Mid-Sized Urban	6	2	
	Rural/Appalachia	0	0	

Discussion

At the time of this writing, the Strong Families, Safe Communities program is in the second year. As with most new programs, the first year requires capacity building, training, and assessment. This analysis showcases these activities. Unlike other new programs, however, the Strong Families program has also demonstrated that individuals and families were served at a greater number than the original target numbers. This section will offer a few ideas of why this program is showing early signs of success and recommendations of how to build upon the success for continued sustainability.

Flexible Funding

The Strong Families, Safe Communities program provided **flexibility in how funds were spent in order to address local needs**. As shown in Table 4, communities developed a variety of services to address local needs. Two examples highlight why flexible funding is important to meet community needs.

For instance, at the outset of planning for this funding, stakeholders in several communities believed that there was a need for respite care in the form of residential treatment. Stakeholders in these communities have come to recognize that the youth and families sometimes just need better alternatives to address a crisis situation. For some communities, residential respite care appears to be a good alternative to help youth and their families. Respite care allows the family to seek a temporary out-of-home placement in order to stabilize the individual who is in crisis. The youth remains within the community, thus maintaining treatment connection to his/her providers and primary caregivers, while being stabilized. The family does not lose custody and can have a closer connection to the youth's on-going treatment and recovery needs. The flexible funding provided in Strong Families/Safe Communities has expanded respite care to a broad spectrum ranging from residential care to "drop off" programs that offer a few hours of respite for the youth to connect with peers and participate in activities that they were not previously able to, while parents are able to take a break.

Increasing the implementation of Wrap Around services is another example of tailoring programs to meet community needs. The Wrap Around model requires a high level of commitment from the community's service organizations, as well as the family, to allow the youth to remain in the home. In the local communities which opted to begin and/or expand Wrap Around services, specialized training of in-home "coaching" and service coordination is now available for families due to these funds. A *recommendation* for future funding is to continue the flexibility of these dollars. If residential respite or inpatient hospitalization is required, the flexibility of this program allows the parents/guardian to maintain custody of the youth while in the treatment facility.

Limited Restriction on Systematic Approaches

A second unique aspect of the Strong Families/Safe Communities program is the **limited restriction on systematic approaches** to address youth with dual diagnoses. The two departments issued requests for applications and screened those applications based on the evidence of collaboration among community child-serving agencies (i.e. mental health, developmental disabilities, schools, children's services, Family & Children First Councils, law enforcement, juvenile courts, etc.). Each

applicant was required to demonstrate how the project would bring representation from mental health and developmental disability professionals. Examples of collaborations include:

- Expansion of the law enforcement training known as Crisis Intervention Team Training (CIT) to include youth with co-occurring mental health and developmental disabilities so that officers have the skills and knowledge to link those individuals in non-criminal situations to appropriate supports, thus reducing incarcerations or out-of-home placements;
- Creation and expansion of intensive care coordination plans with team members including respite care workers, counselors, children's services case managers, juvenile court specialists, school officials, teachers, counselors, Family and Children First Council members, and families, using a "cluster" model of Intensive Home-based Therapy;
- Specialized school-based crisis-response training, which have been provided in several of the southeastern school districts, with individualized district implementation plans

A second major *recommendation* is to continue the requirement for cross-system collaboration, but allow each local community to design its own approach**.** The ability for local communities to design their own collaborative approaches is important. Community-based mental health services, like other public health safety net services, are delivered across fragmented, decentralized networks (Hogan, 1999). Services vary locally in availability and quality with no assurance that access is based on need (Baxter & Mechanic, 1997; Hogan; Jacobson et al., 2005). Because networks are decentralized and fragmented, adaptive strategies are typically localized (Baxter & Mechanic).

Balance between Prevention Initiatives Weaved Together With Intervention Strategies

The Strong Families/Safe Communities program strikes a **balance between prevention initiatives weaved together with intervention strategies**. The Kasich administration realized the necessity to put supports in place to assist the youth and his/her family rather than waiting until after a crisis occurs and reacting to a tragic event. Several of the individual youth served were new to both the developmental disability and the behavioral health systems. According to parents in some of the communities accessing these funds, families do not seek behavioral health services for high-intense needs youth since they have to discuss the challenges they are having at home. The parents fear that by discussing these challenges they may lose custody of their child. By offering local outreach to families that may be silently struggling to cope with their child's violent tendencies, the Strong Families/Safe Communities projects offer relief in the form of respite, hope in the form of education, and a sense of community in the form of mobilizing teams of professionals to provide behavioral health treatment options with a variety of modalities.

An example of this type of project is the Mobile Urgent Treatment Team (MUTT). Within 15 minutes of announcing the MUTT, a phone call came in from a family that needed help. In FY 2014, the MUTT served 203 youth and families. Of those, 173 were new to the behavioral health and developmental systems.

Ancillary Services

Lastly, the Strong Families/Safe Communities project staff mentioned using these dollars to pay for **ancillary services that were not previously funded**. Most organizations must stretch their State, Federal, and local funds just to support billable treatment services. Most organizations have very limited funds available, if any, for non-clinical behavioral supports. Examples of these ancillary supports include gas cards for parents to take the youth to a respite event, participation fees for youth to join sports activities or organized clubs, or even training events for counselors on how to engage families and de-escalate situations. A r*ecommendation* here is similar to the first one mentioned above regarding flexibility for funding a variety of strategies that might be less traditional but are resulting in a reduction in out-of-home placements, emergency room visits, calls to law enforcement, judicial system involvement as well as an increase in strong youth and families and safety within their communities.

Summary

To summarize, based on the reported results, we recommend the following:

- *Flexible Funding*—the flexibility in how communities can spend these funds should be continued.
- *Limited Restriction Systematic Approaches*—cross-system collaboration should be required but each local community should design its own approach on how to collaborate across its system.
- *Balance between Prevention Initiatives Weaved Together with Intervention Services*—Prevention education for youth workers and families to identify early warning signs and to develop easily accessible early intervention strategies before a crisis occurs.
- *Ancillary Services*—funding should be flexible to allow for a variety of untraditional strategies that result in a reduction of out-of-home placements, emergency room visits, calls to law enforcement, and involvement in the judicial system as well as an increase in strong youth and families and safety with their communities.

References

Altman, D.G. (1995). Sustaining interventions in community systems: On the relationship between researchers and communities. *Health Psychology, 14*(6), 526-536.

Baxter, R.J., Mechanic, R.E. 1997. The status of local health care safety nets. *Health Affairs, 16*(4): 7-23.

Drucker, P.F. (1990). *Managing the non-profit organization: Principles and practices*, New York: Harper.

Goodman, R.M., Speers, M.A., McLeroy, K. Fawcett, S. Kegler, M., Parker, E., . . . Wallerstein, N. (1998). Identifying and defining the dimensions of community capacity to provide a basis for measurement. *Health Education and Behavior, 25*(3), 256-278.

Hill, C.E., Thompson, B.J., & Williams, E.N. (1997). A guide to conducting consensual qualitative research. *The Counseling Psychologist, 25*, 517-519.

Hogan, M.F. 1999. Public sector mental health care: New challenges. *Health Affairs, 18*(5), 106-111.

Jacobson, P.D., Dalton, V.K., Benson-Grad, J., Weisman, C.S. 2005. Survival strategies for Michigan's health care safety net provider. *Health Services Research, 40*(3), 923-940.

Johnson, K., Hays, C., Center, H., & Daley, C. (2004). Building capacity and sustainable prevention innovations: A sustainability planning model. *Evaluation and Program Planning, 27*, 135-149.

Shediac-Rizkallak, M.C., & Boone, L.R. (1998). Planning for the sustainability of community-based health programs: Conceptual frameworks and future directions for research practice and policy. *Health Education Research*, *13*(1), 87-108.

Appendix A

Performance Monitoring Worksheet

a. Project Name		**b. Sub-Awardee:**
c. Time Period	☐ **State Fiscal Year (SFY)** ☐ **Federal Fiscal Year (FFY)**	**d. Reporting Period: If applicable check appropriate box** ☐ Jul-Sep ☐Oct-Dec ☐Jan-Mar ☐Apr-Jun
e. ODMH Strategic Goal(s)	☐ 1. Restructure Ohio's mental health system to reduce disparities, achieve efficiencies, & assure equitable access to effective core services & supports. ☐ 2. Support the recruitment, development and retention of an efficient, qualified, diverse and culturally competent workforce. ☐ 3. Reform internal & external processes and regulatory framework to align the mental health system with emerging health technology standards. ☐ 4. Accelerate and incentivize clinical excellence for Ohioans at all life stages. ☐ 5. Leverage resources and strengthen collaboration to develop and influence policy that promotes mental health and wellness. ☐ 6. Execute a rapid contingency planning process to address critical events/changes in the environment	

Objective # insert objective #	
Projected Impact on the target population(s) / mental health system	

Objective Activities	Start Date	End Date	Performance Indicator associated with the Objective	Proposed Target # for FY	Quarterly #	Cumulative # Year to Date	Describe impact on the target population(s) / mental health system