

# Ohio Mental Health and Addiction Services (OhioMHAS) Community Plan Guidelines SFY 2014

## Environmental Context of the Plan/Current Status

1. Describe the economic, social, and demographic factors in the Board area that will influence service delivery. (NOTE: There will be an opportunity to discuss the possible effects of Medicaid expansion upon your local system in question #12.)

Jefferson County, Ohio which is part of the Ohio Valley Region has been declining in population since the late 1980s. In fact, the population has decreased by nearly 6% since 2010. Our populations of Senior Citizens (aged 60+), disabled persons, unemployed people, and Medicaid eligible people exceed state and national averages. The economy has been in decline for over 30 years due to our history as a heavily industrialized manufacturing region – plants have closed and downsized, and the jobs are no longer plentiful. Jefferson County is ranked 7<sup>th</sup> in the State with a 10% unemployment rate. This ranking is similar to other riparian, Appalachian counties – and most notably – other counties that are severely impacted by Ohio’s opiate epidemic. Over 33% of people seeking mental health or drug and alcohol treatment services in our county report being unemployed.

Based on 2010 census statistics, 19.67% of people in our county live below the poverty level as compared to about 14% for the population of the State with 20.2% of children living below poverty level. Also, 5.3% of children and 15.9% of adults in the County have no health insurance. Of people seeking AOD services, 48% are indigent. Moreover, employers often can’t hire because of clients inability to pass and maintain a negative drug screen. There is an increase in the amount of homeless families with children.

About 6% of County citizens identify as ethnic minorities compared to 12% at the State level, yet our minority client population is about 12% for both MH and AOD services. Factors such as graduation rates, teen pregnancies, and HIV/AIDS statistics remain relatively stable. There has been an increase in violent crimes in Steubenville, OH which is the County Seat and largest city (population 22,500) in the County. Of course, Jefferson County was one of the first areas with high opiate use/abuse and ultimately higher overdoses due to that. Drug overdoses involving opiates, according the Jefferson County Coroner’s Office, constitute the majority of overdose cases.

Some salient statistics about Jefferson County customers of MH and AOD services show that nearly 65% have some type of entitlement; 22% of children-clients have parents who abuse substances; 14% are victims of physical abuse; 13% are victims of sexual abuse; 10% are domestic violence victims; and 15% are school drop-outs.

Therefore, we continue to see a population that is ageing, that is the working-poor and/or indigent that is being affected by prescription drug use/abuse and that has poor physical health. Individuals are coming into the system sicker and later than before, and with more physical complications than before.

## Assessment of Need and Identification of Gaps and Disparities

2. Describe needs assessment findings (formal & informal), including a brief description of methodology. Please include access issues, gap issues and disparities, if any. (NOTE: ORC 340.03 requires service needs review of: (1) child service needs resulting from finalized dispute resolution with Family & Children First Councils; and, (2) outpatient service needs

of persons currently receiving treatment in state Regional Psychiatric Hospitals)

Service gaps are determined from analysis of client requests, provider input, and Board data. Identified needs are: Ambulatory Detox; Housing for SPMI families; residential program for AOD clients; intensive services for SAMI population; more funding and reputable treatment providers for opiate-addiction treatment; services and housing for sex offenders; and funding to serve the working poor population.

Transportation is also a major barrier for client in accessing services.

### Strengths and Challenges in Addressing Needs of the Local System of Care

3. In addressing questions 3, 4, and 5, consider service delivery, planning efforts, and business operations when discussing your local system. Please address client access to services and workforce development. (*see definitions of "service delivery," "planning efforts" and "business operations" in Appendix 2*).

What are the strengths of your local system that will assist the Board in addressing the findings of the need assessment? (*see definition "local system strengths" in Appendix 2*). |

Strengths are: An experienced and dedicated workforce that work as a team to provide services; A structured performance improvement program to monitor the impact of any changes implemented or needs addressed; Partnering with local physical health providers – particularly the "Free Clinic;" and Increased involvement and service delivery in the school setting.

Our system has comparatively easy access to services for clients. Compared to national averages wait time for initial assessment is only 6.04 day while wait time to see treatment therapist is only 5.5 days. Wait lists for most services – except psychiatry - are non existent. Additionally, referrals to CPST, vocational training, and housing assistance programs happen within 2-4 days after first appointment.

- a. Identify those areas, if any, in which you would be willing to provide assistance to other boards and/or to state departments.  
We are a small Board with only 4 FTEs. If staff time permits, we would be happy to assist any entity seeking to improve the overall MH and AOD system!

4. What are the challenges within your local system in addressing the findings of the needs assessment? (*see definition of "local system challenges" in Appendix 2*).

Local system challenges are extremely limited financial resources to expand, develop, or implement new and evidence-based programs. Local inpatient beds are limited and there are no beds for adolescents in the County. Child psychiatrists are in desperate need. Our rural area brings not only transportation challenges to consumers and providers, but also challenges of recruiting and retaining credentialed staff and psychiatrists.

- a. What are the current and/or potential impacts to the system as a result of those challenges?

Non-MCD funding due to a shrinking tax base and decreasing levy that is being consumed at a faster rate in order to offer wrap-around and other vital services. Services to non-crisis consumers without a payer

source are capped by providers. State hospital utilization is increased due to MH consumers co-occurring use of substances (esp. opiates) and involvement with legal system – more clients being sent for restoration.

With the poor transportation network, often clients miss appointments for therapy and med-somatic services with the psychiatrist. The result is many times an inpatient hospitalization because of that barrier.

- b. Identify those areas, if any, in which you would like to receive assistance from other boards and/or state departments.

Recruitment of qualified staff and psychiatrists would be most welcome. Likewise advocacy to the Legislature for additional funding of MH and AOD services is needed. Costs to implement technology are prohibitive. There is concern about the longevity of the MACSIS system.

- 5. Describe the Board’s vision to establish a culturally competent system of care in the Board area and how the Board is working to achieve that vision (*see definitions of “cultural competence” and “culturally competent system of care” in Appendix 2*).

Consumer satisfaction with services and staff has consistently remained in the high 90% range. Ongoing QI around any client issues or concerns assure such ratings. This statistic is inclusive of cultural competency. In the history of the agencies, there have been no problems or reports of any discordant cultural interactions. Agencies and staff are encouraged and often provided training opportunities (from other community partners) to increase cultural awareness and sensitivity.

### Priorities

- 6. Considering the Board’s understanding of local needs, the strengths and challenges of your local system, what has the Board set as its priorities for service delivery including treatment and prevention and for populations? Below is a table that provides federal and state priorities. Please complete the requested information only for those federal and state priorities that are the same as the Board’s priorities, and add the Board’s unique priorities in the space provided. For those federal priorities that are mandatory for the OhioMHAS and not selected by the Board, please check one of the reasons provided (e.g., no assessed local need, lack of funds to meet need, lack of necessary professional staff) or briefly describe the applicable reason.

**Priorities for Jefferson County Prevention and Recovery Board**

**Substance Abuse & Mental Health Block Grant Priorities**

**\*Priorities Consistent OHIOMAS Strategic Plan**

Priorities	Goals	Strategies	Measurement	Reason for not selecting
<b>SAPT-BG:</b> Mandatory (for OhioMHAS): Persons who are intravenous/injection drug users (IDU)	Immediate referral to detox and/or treatment.  Improve capacity to MAT.	Upon assessment pt. will be offered instant referral.  Seek out additional medical providers.	Track referrals to TX.  Add one additional provider.	<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
<b>SAPT-BG:</b> Mandatory: Women who are pregnant and have a substance use disorder (NOTE:ORC 5119.17 required priority)	Neonatal and prenatal harm reduction.	Offer instant referral to detox and/or TX. Assist pt. is seeing neonatal specialist for care.	Track pts. and subsequent referrals.  Pt. follow-through with TX.	<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
<b>SAPT-BG:</b> Mandatory: Parents with substance abuse disorders who have dependent children (NOTE: ORC 340.03 (A)(1)(b) & 340.15 required consultation with County Commissioners and required service priority for children at risk of parental neglect/abuse due to SUDs)	Increase family engagement in care and TX.	Pt. offered CPST, individual and family therapy.	Track referrals and outcomes of TX.	<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
<b>SAPT-BG:</b> Mandatory (for OhioMHAS): Individuals with tuberculosis and other communicable diseases	N/A	N/A	N/A	<input checked="" type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
<b>MH-BG:</b> Mandatory (for OhioMHAS): Children with Serious Emotional Disturbances (SED)	Prevention and Early Intervention.  Immediate referral to TX.	Identify needs of schools and local Head Starts.  Professionals from MH agency available for phone or in-person consult	Increase in schools seeking services.  Increase visits/contacts by the Prevention Specialist.  Track calls and referrals for assessment and TX.	<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
<b>MH-BG:</b> Mandatory (for OhioMHAS): Adults with Serious Mental Illness (SMI)	Promote stability in community and a focus on geriatric population.	Assign pt. to appropriate CPST team.	Track referrals to CPST.	<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds

	Reduce hospitalizations.  Offer Wrap-around supports.	Educate and coordinate better with PCPS.  Encourage use of Drop-In Center.  Refer to housing or vocational CPST services.	Track use of drop-in center.  Hospitalizations and 30-day readmits will decrease.	<input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
Priorities	Goals	Strategies	Measurement	Reason for not selecting
<b>MH&amp;SAPT-BG:</b> Mandatory (for OhioMHAS): Integration of behavioral health and primary care services*	Continue to promote MH and AOD services with PCPs.	Educate pts. and PCPs.  Link services with local free clinic and local FQHC.	Number of referrals from PCPs.  Existence of Health Home.	<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
<b>MH&amp;SAPT-BG:</b> Mandatory (for OhioMHAS): Recovery support services for individuals with mental or substance use disorders	See other			<input type="checkbox"/> No assessed local need <input checked="" type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input checked="" type="checkbox"/> Other (describe): Foster and encourage use of 12 step groups and progs, as well as sue of Drop-In Center.
Additional Priorities Consistent with SAMHSA Strategic Plan and Reported in Block Grant				
*Priorities Consistent OHIOMAS Strategic Plan				
<b>Treatment:</b> Veterans	Ensure veterans easy access to all needed services.	Educate local VA office about services and this population as a priority.  Prioritize some discretionary funding for this population.	Have an established relationship with local office.  Track veterans seeking services and their service needs.	<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
<b>Treatment:</b> Individuals with disabilities	N/A	N/A	N/A	<input checked="" type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):

<b>Treatment:</b> Opiate addicted individuals in the state, including illicit drugs such as heroin and non-medical use of prescription drugs*	Facilitate access to detox, treatment, recovery, and housing services.	Recruit additional MAT provider.  Enlist support from local Opiate Task Force.  Info campaign targeted at population group in community.  Prioritize discretionary funds for this population.	Track this population's use of services and track any gaps or unmet needs.  Track referrals to services - Track how they learned of services.	<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
<b>Treatment:</b> Homeless persons and persons with mental illness and/or addiction in need of permanent supportive housing*	Facilitate access to housing and housing case management.	Prioritize funding for this group.  Maintain current stock and increase stock of safe, affordable housing. Also, better coordinate with local PHA for faster housing.	Wait time for homeless people seeking housing will decrease with goal of having no wait list at all.  Funding and supports for housing will be in place, i.e. no gaps or access problems.	<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
<b>Treatment:</b> Underserved racial and ethnic minorities and LGBTQ populations	N/A	N/A	N/A	<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe): These populations do not appear to be underserved. All minority populations access services at rates much higher than their percentage of the total county population.
Priorities	Goals	Strategies	Measurement	Reason for not selecting
<b>Treatment:</b> Youth/young adults in transition/adolescents and young adults	See other			<input checked="" type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input checked="" type="checkbox"/> Other (describe): Ongoing coordination occurs with CSP or other entities serving this population.
<b>Treatment:</b> Early childhood mental health (ages 0 through 6)*	See other			<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage

				<u>XX</u> Other (describe): See above goal for SED. There is ongoing collaboration with Head Starts and schools.
<b>Prevention:</b> Adopt a public health approach (SPF) into all levels of the prevention infrastructure	N/A			<input type="checkbox"/> No assessed local need <u>XX</u> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
<b>Prevention:</b> Ensure prevention services are available across the lifespan with a focus on families with children/adolescents*	N/A			<input type="checkbox"/> No assessed local need <u>XX</u> Lack of funds <u>XX</u> Workforce shortage <input type="checkbox"/> Other (describe):
<b>Prevention:</b> Empower pregnant women and women of child-bearing age to engage in healthy life choices	N/A			<input type="checkbox"/> No assessed local need <u>XX</u> Lack of funds <u>XX</u> Workforce shortage <input type="checkbox"/> Other (describe):
<b>Prevention:</b> Promote wellness in Ohio's workforce	N/A			<input type="checkbox"/> No assessed local need <u>XX</u> Lack of funds <u>XX</u> Workforce shortage <input type="checkbox"/> Other (describe): This is a wonderful idea. Let's convince legislators and insurance companies that prevention is much less expensive than treatment!!
<b>Prevention:</b> Integrate Problem Gambling Prevention & Screening Strategies in Community and Healthcare Organizations*	Educate PCPs, health clinics, and other providers of problem and of resources for help.	Prevention Specialist will educate audiences of this issue and available resources.	Track referrals for this service.	<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):



**Priorities (continued)**

7. What priority areas would your system have chosen had there not been resource limitations, and why? If you provide multiple priority areas, please prioritize.

Priority if resources were available	Why this priority would be chosen
(1) Residential Treatment for AOD	It is needed as a part of local continuum of services. Currently residents need to be sent to another county.
(2) Ambulatory Detox	Expand service continuum, esp. for opiate users. Less costly than inpatient. No current availability.
(3) Supportive housing for individuals and families	Urgent need exists.
(4) Sober housing	Needs exist and providers exist, but no available funding.
(5)	
(6)	
(7)	
(8)	
(9)	
(10)	
(11)	
(12)	
(13)	
(14)	
(15)	

## Collaboration

8. Describe the Board's accomplishments achieved through collaborative efforts with other systems, consumers and/or the general public during the past two years.

With some financial assistance from the Board and an earmark from the State Legislature, Jefferson Behavioral Health System (JBHS), the major contract agency, was able to establish a Youth Services Center centrally in the county. This funding allowed the agency to purchase a small community school building and make minor renovations for all youth personnel and services. This includes CPST staff, therapists, the youth PH Program, and a part-time child psychiatrist.

Our Board was at the forefront of housing for consumers. The SafeHaven project that opened in 2007 continues to meet all of HUD objectives and receives ongoing operating grant funding. The Drop-In Center at this site has expanded social and recreational groups for residents and other non-resident participants. There are at least 8 different activity groups consisting of tasks such as painting, quilting, card-games, walking (physical activity), etc. Statistics of usage show a consistent increase in participants. Other housing properties owned by the Board have seen some improvements. In November 2013, the Board was awarded funding from OHFA and OhioMHAS to completely renovate 9 units of housing for single-persons with mental illness at the Welsh Property. This award is nearly \$600,000 and will allow for modernization and upgrading of the older fixtures, plumbing, and HVAC systems – allowing us to reduce operating costs. Also, all Board properties are managed by Family Service Association which is a contract provider of MH services. This alliance has been very beneficial for all parties; especially the residents who get an organization that understands their special needs.

Family Service Association also provides payeeship and guardianship services to consumers as a result of a Board subsidy. The agency has been able to expand the amount of payees up to 190 people and there are approximately 45 people who are wards of the agency. Demand for these services has grown and the Board has been able to assist the agency to add 1.5 FTEs of staff and add other equipment to meet the need.

Due to grant from OACBHA, our Board was able to form an Opiate Task Force. Our Executive Director succeeded in getting a nice cross-section of community leaders to participate. Law enforcement in the past was resistant to such efforts; however, now two police agencies in the County will be hosting permanent drug drop-off boxes as a means to getting unused meds out of circulation.

The Jefferson County Prevention and Recovery Board did not fill 1 FTE and moved its office to a facility owned by the Board. The savings in administrative costs can now be offered for expanded treatment. We will also be downsizing the Board from 18 to 14 members. This will also reduce some administrative costs.

The AppCare Collaborative used former ODMH Hot Spot Funding to establish a crisis stabilization unit (CSU) in conjunction with the Belmont-Harrison-Monroe Board. Currently, there are 4 local beds available for clients to avoid hospitalization or be stepped-down from an inpatient stay. Other CSU beds in the Collaborative area are available to our clients as well.

The Board developed a better working relationship with the 5 school districts in the county as well as one private

school. All schools asked for drug prevention and education information to be presented to all students and faculty. School administrators now reach-out more readily to the Board and its contract agencies for assistance. Specifically, one school district asked the Board to provide a suicide prevention gatekeepers training to some faculty and student leaders

### Inpatient Hospital Management

9. Describe the interaction between the local system's utilization of the State Hospital, Private Hospital(s) and/or outpatient services and supports. Discuss any changes in current utilization that you expect/foresee

As mentioned earlier we are seeing patients coming into the public system younger, sicker, with physical health issues, and with co-occurring morbidity of mental illness and substance use/abuse. Due to some of the barriers mentioned above, some consumers come into the system with greater acuity and in greater crisis. Utilization at the state hospital is markedly increased. (The local inpatient unit runs at 93% capacity most of the time. More about this later.) There is also a significant increase in the number of forensic patients being sent to the state hospital. Some reasons for this were mentioned earlier in this paragraph. Other reasons are that local judges and defense attorneys now want expert evaluation of a defendant when he/she intimates any symptoms of mental illness. Jefferson County used to have little to no forensic patients – at this writing – there are 3 patients; one being at Timothy B. Moritz Center because his violent outbursts endangered patients and staff at Athens. We anticipate utilization to stay at this higher level.

Trinity Health System in Steubenville operates a 14-bed behavioral health (BH) unit, along with a 4 bed detox unit, and the 4-bed Crisis Stabilization Unit (CSU). The BH unit runs at capacity due to two other local inpatient units in the area closing. Patients from southern Columbiana County and the northern end of Jefferson County come to Trinity – along with the residents of Brooke and Hancock Counties in West Virginia. Because inpatient capacity in the region decreased, we anticipate this trend to remain.

The CSU at Trinity (operated collaboratively with the Belmont Area Board) had been under-utilized until recently. While we are not certain of the reason, we feel it was due to a learning curve on the parts of both, clients and professionals. Referrals to this unit at present are more consistent with our expectations. At this writing, the unit has been fully occupied and was fully occupied in the two weeks prior.

Overall, we feel that consumers are managed as efficiently as possible and in the least restrictive environment. The CPST unit at Jefferson Behavioral Health System is designed similar to an ACT program that provides a lot of supports to consumers in the community. Additionally, the supportive housing we operate aids in helping current clients to avoid hospitalizations as much as possible.

### Innovative Initiatives (Optional)

10. Many boards have implemented innovative programs to meet local needs. Please describe strategies, policy, or programs implemented during the past two years that **increase** efficiency and effectiveness that you believe could benefit other Ohio communities in one or more of the following areas?

a. Service delivery

Payeeship and guardianship programs in conjunction with provider. These have operated for about 9 years. The Board offered small grants to the provider to purchase hardware, software, and some training.

The Beacon House SafeHaven Project and Program. This opened in 2007, but had been in our planning since about 2004.

b. Planning efforts

Board regularly participate with local health departments and the County Emergency Management Agency (EMA) in “table top” exercises that simulate disaster or epidemic. This is lead by the EMA and involves no cost other than staff time. Provider agencies participate also.

c. Business operations

d. Process and/or quality improvement

Please provide any relevant information about your innovations that might be useful, such as: how long it has been in place; any outcomes or results achieved; partnerships that are involved or support it; costs; and expertise utilized for planning, implementation, or evaluation.

### Advocacy (Optional)

11. Please share a story (or stories) that illustrate the vital/essential elements you have reported on in one or more of the previous sections.

We feel it is important to highlight community supports – such things as safe and affordable housing, social and recreational opportunities, and all other wrap-around services.

Our system noted that consumers with high inpatient hospitalizations (both State and local) when placed in some supervised housing (ACF) or in supportive housing (SafeHaven, Board Apartments) have stayed out of the hospital or have significantly reduced hospital admissions. While our state hospital utilization has increased, the patients are not consumers that have been provided such housing. Conversely, the most recent patients are typically younger, newer to the system, and typically without safe and stable housing. Moreover, we notice consumers in housing often seek subsequent employment participation in some meaningful activity.

The Beacon House SafeHaven program has a Drop-In Center as part of the SafeHaven Concept. This component provides current customers and other people with mental illness a place to socialize and participate in recreational, educational, and creative activities. Our system has high regard for the staff that supervises the Drop-In Center; they do many things beyond the ordinary and mundane. There is quilting, craft-making, cooking, trips to local

points of interest, free manicures for women, and computer skills classes. Participants hold a sale 2-3 times per year to sell any crafted, cooked, or sewed items and ultimately use the proceeds to fund future ventures.

At a bare minimum the Drop-In Center provides a safe, welcoming shelter for persons not completely involved in services – such as: a respite from home life for the afternoon; a place to surf the Internet; a place to have coffee and interact with their peers; or a chance to take a hot shower, do laundry, and get fed before moving on to their next stop. While social and recreational opportunities are not considered treatment, they are part of the continuum of any person’s life and provide much needed and commonplace “therapy” that makes us feel human and connected.

### Open Forum (Optional)

12. Please share other relevant information that may not have been addressed in the earlier sections. Report any other emerging topics or issues, including the effects of Medicaid Expansion, which you believe are important for your local system to share with the Departments or other relevant Ohio Communities.

As the Department knows, money has never adequately followed the consumer into the community. Moreover, with the system’s flat-funding for many years and with subsequent cuts, the MH and AOD systems have not been properly funded to make the consumers safe, welcome, or invested in locally communities. Discretionary funding is vital for the supports and services that help and that keep consumers healthy and stable.

MCD expansion will certainly help the working poor access services and treatment and basic health care. It is our hope that despite some legal challenges to the recent expansion that the expansion remains in place and is properly utilized by eligible families.

## Appendix 1: Alcohol & Other Drugs Waivers

### A. Waiver Request for Inpatient Hospital Rehabilitation Services

Funds disbursed by or through OhioMHAS may not be used to fund inpatient hospital rehabilitation services. Under circumstances where rehabilitation services cannot be adequately or cost-efficiently produced, either to the population at large such as rural settings, or to specific populations, such as those with special needs, a Board may request a waiver from this policy for the use of state funds.

Complete this form providing a brief explanation of services to be provided and a justification for this requested waiver. **Medicaid-eligible recipients receiving services from hospital-based programs are exempted from this waiver as this waiver is intended for service expenditure of state general revenue and federal block funds.**

A. HOSPITAL	ODADAS UPID #	ALLOCATION

**B. Request for Generic Services**

Generic services such as hotlines, urgent crisis response, referral and information that are not part of a funded alcohol and other drug program may not be funded with OhioMHAS funds without a waiver from the Department. Each ADAMHS/ADAS Board requesting this waiver must complete this form and provide a brief explanation of the services to be provided

B.AGENCY	ODADAS UPID #	SERVICE	ALLOCATION

DRAFT

## Appendix 2: Definitions

**Business Operations:** Shared Resources, QI Business Plan, Financial Challenges, Pooled funding, Efficiencies, Strategic Planning, Contracts, Personnel Policies, etc.

**Cultural Competence:** (Ohio's State Inter-Departmental Definition) Cultural competence is a continuous learning process that builds knowledge, awareness, skills and capacity to identify, understand and respect the unique beliefs, values, customs, languages, abilities and traditions of all Ohioans in order to develop policies to promote effective programs and services.

**Culturally Competent System of Care:** The degree to which cultural competence is implemented as evidenced by the answers to these questions:

- Is leadership committed to the cultural competence effort?
- Are policies and procedures in place to support cultural competence within the system, including policies and procedures to collect, maintain and review caseload cultural demographics for comparison to the entire community?
- Are the recommended services responsive to each adult, child and family's culture?
- Is the client and family's cultural background taken into account in determining when, how, and where services will be offered?
- Is staff reflective of the community's racial and ethnic diversity?
- Is staff training regularly offered on the theory and practice of cultural competence?
- Are clients and families involved in developing the system's cultural competence efforts?
- Does Behavioral Health staff interact with adults, children and families in culturally and linguistically competent ways?
- Is staff culturally sensitive to the place and type of services made available to the adult, child and family?
- Does the system of care reach out to the diverse racial, ethnic, and cultural groups in the community?

**Local System Strengths:** Resources, knowledge and experience that is readily available to a local system of care.

**Local System Challenges:** Resources, knowledge and experience that is not readily available to a local system of care.

**Planning Efforts:** Collaborations, Grant opportunities, Leveraging Funds, Data Collection (e.g., Key Performance Indicators, Outcomes), Trainings

**Service Delivery:** Criminal Justice, School Based or Outreach, Crisis Services, Employment, Inpatient/Residential Services, Housing, Faith Communities, etc.