

ADAMH Board of Franklin County

COMMUNITY PLAN FOR SFY 2012-2013

SEPTEMBER 1, 2011

MISSION STATEMENT

Our mission is to improve the well-being of our community by reducing the incidence of mental health problems and eliminating the abuse of alcohol and other drugs in Franklin County.

VISION STATEMENT

Citizens in need of care will receive the most progressive and effective mental health and addiction treatment services available. The unique cultural and individual needs of each client will guide how the services are provided, but treatment will always be provided in a timely manner. ADAMH's commitment to these goals establishes its role as a vital partner in Franklin County's health care network and will help to de-stigmatize mental illness.

VALUE STATEMENTS

We believe that the following are important in accomplishing our mission and fulfilling our vision:

- 1 Listening -to our clients and their families needs
- 2 Collaborating -with other systems of care in the community
- 3 Educating – thereby erasing the stigma of mental illness and addiction
- 4 Stewardship – of resources entrusted to our care
- 5 Creativity – look for new and better ways to solve problems and ways to serve
- 6 Respect -assign value to the cultural, educational, or cognitive perspectives offered by others
- 7 Humility -willingness to learn from our mistakes
- 8 Compassion – remember that we exist to help others in need
- 9 Diversity – recognizing uniqueness in everyone we serve

SIGNATURE PAGE

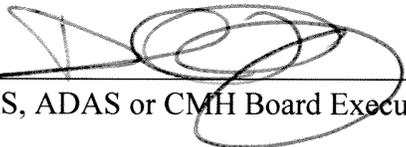
Community Plan for the Provision of Alcohol, Drug Addiction and Mental Health Services
SFY 2012-2013

Each Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Board, Alcohol and Drug Addiction Services (ADAS) Board and Community Mental Health Services (CMHS) Board is required by Ohio law to prepare and submit to the Ohio Department of Alcohol and Drug Addiction Services (ODADAS) and the Ohio Department of Mental Health (ODMH) a plan for the provision of alcohol drug addiction and mental health services in its area. The plan, which constitutes the Board's application for funds, is prepared in accordance with procedures and guidelines established by ODADAS and ODMH. The Community Plan is for State Fiscal Years (SFY) 2012 – 2013 (July 1, 2011 to June 30, 2013).

The undersigned is a duly authorized representative of the ADAMHS/ADAS/CMHS Board. The ADAMHS/ADAS Board hereby acknowledges that the information contained in this application for funding, the Community Plan for SFY 2012 - 2013, has been reviewed for comment and recommendations by the Board's Standing Committee on Alcohol and Drug Addiction Services, and is complete and accurate.

Franklin County

ADAMHS, ADAS or CMH Board Name (Please print or type)



ADAMHS, ADAS or CMH Board Executive Director

8/23/2011
Date

Dona England apf

ADAMHS, ADAS or CMH Board Chair

8/23/11
Date

[Signatures must be original or if not signed by designated individual, then documentation of authority to do so must be included (Board minutes, letter of authority, etc.)].

I. Legislative & Environmental Context of the Community Plan

- A. Economic Conditions**
- B. Implications of Health Care Reform**
- C. Impact of Social and Demographic Changes**
- D. Major Achievements**
- E. Unrealized Goals**

SECTION I: LEGISLATIVE AND ENVIRONMENTAL CONTEXT

Legislative Context of the Community Plan

Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Boards, Alcohol and Drug Addiction Services (ADAS) Boards and Community Mental Health Services (CMH) Boards are required by Ohio law to prepare and submit to the Ohio Department of Alcohol and Drug Addiction Services (ODADAS) and/or the Ohio Department of Mental Health (ODMH) a plan for the provision of alcohol, drug addiction and mental health services in its service area. Three ADAS Boards submit plans to ODADAS, three CMH Boards submit plans to ODMH, and 47 ADAMHS Boards submit their community plan to both Departments. The plan, which constitutes the Board's application for funds, is prepared in accordance with procedures and guidelines established by ODADAS and ODMH. This plan covers state fiscal years (SFY) 2012 – 2013 (July 1, 2011 through June 30, 2013).

The requirements for the community plan are broadly described in state statute. In addition, federal requirements that are attached to state block grant dollars regarding allocations and priority populations also influence community planning.

Ohio Revised Code (ORC) 340.03 and 340.033 – Board Responsibilities

Section 340.03(A) of the Ohio Revised Code (ORC) stipulates the Board's responsibilities as the planning agency for mental health services. Among the responsibilities of the Board described in the legislation are as follows:

- 1) Identify community mental health needs;
- 2) Identify services the Board intends to make available including crisis intervention services;
- 3) Promote, arrange, and implement working agreements with social agencies, both public and private, and with judicial agencies;
- 4) Review and evaluate the quality, effectiveness, and efficiency of services; and
- 5) Recruit and promote local financial support for mental health programs from private and public sources.

Section 340.033(A) of the Ohio Revised Code (ORC) stipulates the Board's responsibilities as the planning agency for alcohol and other drug addiction services. Among the responsibilities of the Board described in the legislation are as follows:

- 1) Assess service needs and evaluate the need for programs;
- 2) Set priorities;
- 3) Develop operational plans in cooperation with other local and regional planning and development bodies;
- 4) Review and evaluate substance abuse programs;
- 5) Promote, arrange and implement working agreements with public and private social agencies and with judicial agencies; and
- 6) Assure effective services that are of high quality.

ORC Section 340.033(H)

Section 340.033(H) of the ORC requires ADAMHS and ADAS Boards to consult with county commissioners in setting priorities and developing plans for services for Public Children Services Agency (PCSA) service recipients referred for alcohol and other drug treatment. The plan must identify monies the Board and County Commissioners have available to fund the services jointly. The legislation prioritizes services, as outlined in Section 340.15 of the ORC, to parents, guardians and care givers of children involved in the child welfare system.

OAC Section 5122-29-10(B)

A section of Ohio Administrative Code (OAC) addresses the requirements of crisis intervention mental health services. According to OAC Section 5122-29-10(B), crisis intervention mental health service shall consist of the following required elements:

- (1) Immediate phone contact capability with individuals, parents, and significant others and timely face-to-face intervention shall be accessible twenty-four hours a day/seven days a week with availability of mobile services and/or a central location site with transportation options. Consultation with a psychiatrist shall also be available twenty-four hours a day/seven days a week. The aforementioned elements shall be provided either directly by the agency or through a written affiliation agreement with an agency certified by ODMH for the crisis intervention mental health service;
- (2) Provision for de-escalation, stabilization and/or resolution of the crisis;
- (3) Prior training of personnel providing crisis intervention mental health services that shall include but not be limited to: risk assessments, de-escalation techniques/suicide prevention, mental status evaluation, available community resources, and procedures for voluntary/involuntary hospitalization. Providers of crisis intervention mental health services shall also have current training and/or certification in first aid and cardio-pulmonary resuscitation (CPR) unless other similarly trained individuals are always present; and
- (4) Policies and procedures that address coordination with and use of other community and emergency systems.

HIV Early Intervention Services

Eleven Board areas receive State General Revenue Funds (GRF) for the provision of HIV Early Intervention Services. Boards that receive these funds are required to develop HIV Early Intervention goals and objectives and include: Butler ADAS, Eastern Miami Valley ADAMHS, Cuyahoga ADAS, Franklin ADAMHS, Hamilton ADAMHS, Lorain ADAS, Lucas ADAMHS, Mahoning ADAS, Montgomery ADAMHS, Summit ADAMHS and Stark ADAMHS Boards.

Federal Substance Abuse Prevention and Treatment (SAPT) Block Grant

The federal Substance Abuse Prevention and Treatment (SAPT) Block Grant requires prioritization of services to several groups of recipients. These include: pregnant women, women, injecting drug users, clients and staff at risk of tuberculosis, and early intervention for individuals with or at risk for HIV disease. The Block Grant requires a minimum of twenty (20) percent of federal funds be used for prevention services to reduce the risk of alcohol and other drug abuse for individuals who do not require treatment for substance abuse.

Federal Mental Health Block Grant

The federal Mental Health Block Grant (MHBG) is awarded to states to establish or expand an organized community-based system for providing mental health services for adults with serious mental illness (SMI) and children with serious emotional disturbance (SED). The MHBG is also a vehicle for transforming the mental health system to support recovery and resiliency of persons with SMI and SED. Funds may also be used to conduct planning, evaluation, administration and educational activities related to the provision of services included in Ohio's MHBG Plan.

Environmental Context of the Community Plan

Economic Conditions and the Delivery of Behavioral Health Care Services

Question 1: Discuss how economic conditions, including employment and poverty levels, are expected to affect local service delivery. Include in this discussion the impact of recent budget cuts and reduced local resources on service delivery. This discussion may include cost-saving measures and operational efficiencies implemented to reduce program costs or other budgetary planning efforts of the Board.

Due to the recent funding reductions from the state department, higher than anticipated Medicaid growth and higher than projected inpatient hospitalization costs, our Board had to reduce its provider allocations by over \$15 million dollars in 2009 and 2010. Using our ASP/Budget planning process in conjunction with our contract providers, we noted that most providers took these allocation reductions first out of prevention and training programs. This resulted in a significant reduction in the numbers and quality of prevention programming throughout our system. If necessary, providers then applied reductions to treatment programming.

Many providers altered their mix of client funding. Older adults, being receivers of Medicare coverage, were referred out to their primary care physicians. Those with no funding coverage at all have been seen much less frequently, and then only after a substantial wait for services.

At the time of the funding reductions, the Board made the decision to hold harmless all crisis-related services and programs. This included our two community based 24/7 crisis sites operated by NetCare available to all populations, child and adolescent crisis beds operated by Buckeye Ranch, detoxification services provided by Maryhaven and medically assisted alcohol and other drug treatment provided by CompDrug and Maryhaven (e.g., methadone).

AOD Prevention:

Our board area's alcohol and other drug prevention providers were severely impacted by the recent budget crisis. Many of our prevention providers count on United Way, City of Columbus, ODADAS pass-thru and other funding to operate. These agencies received disproportionate reductions from all of these funding sources, which will impact their ability to continue serving the same number of children and families. The providers also experience -limited access to school age youth during the school day due to emphasis on academic improvement and test scores. School Age Youth//School Based Services – limited access to services at charter schools in Franklin County School Age Youth/ Limited access to services during out of school time: summer, after-school, school breaks.

Access to Mental Health Prevention, Recovery Support, and Treatment Service:

Our Board area's mental health prevention programming received significant reductions as a result of the last round of budget reductions which impacted its ability to continue serving the same number of children and families. School age youth have limited during out of school time: summer, after-school or school breaks.

Implications of Health Care Reform on Behavioral Health Services

Question 2: Based upon what is known to date, discuss implications of recently enacted health care reform legislation on the Board's system of care.

Creating an environment in which all have health care coverage is likely to significantly increase the demand for behavioral health services from the public system. The ADAMH Board is committed to embracing a system in which behavioral health care is seen as an integral part of general health care, and anticipate the need to plan for service delivery that blends closely with clients' primary care. We understand the need to be both creative and flexible in our expected behavioral health service delivery models as we plan for the implementation of the reform legislation.

Key Factors that Will Shape the Provision of Behavioral Health Care Services in the Board Area

Question 3: Discuss the change in social and demographic factors in the Board area that will influence service delivery. This response should include a description of the characteristics of customers/clients currently served including recent trends such as changes in services (e.g.,

problem gambling) and populations for behavioral health prevention, treatment and recovery services.

The 2008 Ohio Family Health Survey, Franklin county level data estimates that 26,722 children that have health insurance, have no mental health coverage (9.82%), and another 13,099 have no health or mental health coverage (4.5%). It further estimates that there are 139,193 (18.88%) Adults ages 18-64 in Franklin County who are uninsured, and 183,589 (24.9%) with no mental health coverage. In addition, an estimated 44,396 adults (7.42%) with health insurance have no coverage for mental health, and another 25,786 (4.31%) insured adults have no benefits for needed prescription drugs. An estimated 146,553 (19.88%) of adults reported that they could not afford the cost of needed prescription drugs even with health insurance coverage. This is the primary population that the ADAMH Board of Franklin County has and will be serving in the foreseeable future, and given National prevalence data for mental illness and drug/alcohol addiction, we would estimate that at least 11,000 children ages 0-17, and more than 55,000 adults ages 18-64 could benefit from ADAMH services.

Since this survey was completed economic conditions have deteriorated, causing both an increase in the numbers of families and individuals without health coverage and a reduction in available Board funding. As discussed in Question 1, providers have made substantial cuts to their prevention programming as well as limited service access to those with no health coverage. Unfortunately this comes at a time when many are particularly vulnerable to behavioral health problems of anxiety, depression and substance abuse.

Major Achievements and Significant Unrealized Goals of the SFY 2010-2011 Community Plan

Question 4: Describe major achievements.

Treatment services to the most vulnerable (i.e. SMD, SED, pregnant and IV drug users), legislatively mandated populations were maintained.

Crisis Services in Franklin County were maintained in 2010 and 2011. This includes both mental health and AOD crisis care and specifically includes 24/7 crisis intervention, sub-acute detoxification, methadone/buprenorphine programming, engagement services for homeless, publically inebriated adults.

Please see the following chart of access and costs of care provided to **ADAMH Board Priority Client Population** by our contract, in-network providers in recent years, even with the reductions in discretionary revenue stemming from increased Medicaid match costs and state GRF reductions:

Access to Care 2008-2010

ACCESS TO CARE: CLIENT COUNTS AND EXPENDITURES FOR ADAMH BOARD PRIORITY POPULATIONS		ADAMH In-Network Contract Providers		
		Num Clients	% of Total MCD and NON MCD Clients Treated	Total Cost / Client
AOD Criminal Justice	2008	5,246	13.4%	\$1,539
	2009	4,871	11.9%	\$1,706
	2010	3,838	10.1%	\$2,078
MH SED	2008	4,452	11.3%	\$2,788
	2009	7,683	18.7%	\$3,503
	2010	7,997	21.1%	\$3,475
MH SMD	2008	10,862	27.7%	\$4,144
	2009	11,252	27.4%	\$4,324
	2010	10,354	27.3%	\$4,283

ADULTS WITH AT LEAST 1 ODMH REGIONAL PSYCHIATRIC HOSPITAL ADMISSION DURING THE 3 PRIOR YEARS		ADAMH In-Network Contract Providers		
		Num Clients	% of Total MCD and NON MCD Clients Treated	Total Cost / Client
HOSPITAL (Unduplicated clients admitted to RPH during the CY; net day per diem cost during CY)	2007	322	0.8%	\$21,113
	2008	756	1.9%	\$16,751
	2009	837	2.0%	\$15,989
	2010	820	2.2%	\$16,673
OUTPATIENT (Unduplicated clients served receiving outpatient care during CY who had been admitted to RPH <i>anytime in prior 3 years</i>)	2007	954	2.5%	\$5,597
	2008	1260	3.2%	\$5,662
	2009	1590	3.9%	\$5,552
	2010	1694	4.5%	\$5,502

Source: Claims Rcvd by 7-29-11 and PCS thru 6-30-11

Prevention Services

The ADAMH Board of Franklin County, in collaboration with Community for New Directions, Columbus Public Health and Urban Minority alcohol and Other Drug Prevention Program was awarded by ODADAS a three year coalition grant to build a sustainable, culturally and linguistically competent infrastructure that will focus on delaying the onset of AOD use and reducing substance-related problems in young adults in the urban core of Columbus: the Near Eastside, Near Westside (Franklinton and Hilltop), Northside (South Linden Area), and Southside. The coalition expects to see the implementation of the Strategic Prevention Framework on a community level that ultimately results in residents examining their norms around alcohol and marijuana use and choosing to engage in environmental strategies that will reduce alcohol consumption and marijuana use in the 18-25 age group.

SPF SIG Goals

- Decrease the number of 18-25 year olds engaged in high risk use of alcohol.
- Decrease the number of 18-25 year olds engaged in the use of illicit drugs.

Faith-Based Summer Pilot Project

The ADAMH Board of Franklin County, in collaboration Community for New Direction, The Shalom Zone, Family Missionary Baptist Church, The Church of Christ of the Apostolic Faith and Children Defense Fund implemented summer day camps in three Columbus neighborhoods to increase protective factors. Over two hundred youth who reside in live in families with alcohol/drug problems and reside in high crime areas benefited from the summer programs that help them improve academic skills, develop day-to-day coping strategies, and strengthen bonds with peers and caring adults.

Behavioral Health Juvenile Justice Initiative-Youth MH Treatment

The ADAMH Board of Franklin County, in collaboration with Franklin County Children Services, Franklin County Common Pleas Court, Division of Domestic Relations and Juvenile Branch, and Franklin County Family and Children First Council, has developed, implemented and expanded a model to meet the treatment and support needs of youth and their families who, at a minimum, are seriously emotionally disturbed, substance abusing, serious juvenile offenders and may be involved in the child welfare system.

The model moves a youth from the Franklin County Juvenile Court Pre-Sentence Investigation through a screening and assessment process that involves a care coordinator who facilitates the delivery of service throughout the program. Care coordinators engage families and provide linkage and bridging to evidenced-based treatment services including MST, FFT, and MDFT. The service delivery team includes the youth and family, probation officer, school, family defined support, treatment providers and other system representatives as necessary. This model will continue to improve intersystem communication and shared outcomes among the behavioral healthcare, juvenile justice, and child welfare systems.

Question 5: Describe significant unrealized goals and briefly describe the barriers to achieving them.

Our primary unrealized goal has been access to services by two large populations – non-SMD/SMI/SED clients and those without any healthcare coverage whatsoever. General and older adults who are not SMD/SMI have been given the lowest priority for services. Thus, this has been the group with the least access to behavioral healthcare services in the current economy. Unfortunately, this is also the population that requests services in the greatest number. The primary barrier to serving this population has been the funding levels.

II. Needs Assessment

- A. Needs Assessment Process**
- B. Needs Assessment Findings**
- C. Access to Services: Issues of Concern**
- D. Access to Services: Crisis Care Service Gaps**
- E. Access to Services: Training Needs**
- F. Workforce Development & Cultural Competence**
- G. Capital Improvements**

SECTION II: NEEDS ASSESSMENT

Process the Board used to assess behavioral health needs

Question 6: Describe the process the Board utilized to determine its current behavioral healthcare needs including data sources and types, methodology, time frames and stakeholders involved.

The Board employs all standard approaches in determining current and future needs for services and care in the Franklin County public care system (focus groups, key informants, surveys, penetration rates, demographic and social indicators, etc.). The Board's 2005 Levy Plan is a ten year plan through 2016 which included the board's process for determining current and future treatment needs. The needs assessment process began with using national epidemiologic data on prevalence and demographic, poverty and social data to arrive at the number of people most likely to be in need of our services in Franklin County. The ten-year Levy Plan summarized the treatment needs and priorities for services over the ten year span of 2007 to 2016.

All planning efforts include input from key stakeholders, consumers and family members through various interviews, task forces, educational group meetings, and surveys. Our planning and needs assessment process incorporates educational stakeholder focus groups (including consumers and family members), and interviews to determine more specific service and program needs for the next three to five years. In previous Community Plans we included several Board documents which explain our needs assessment, planning and allocations processes entitled "Request for Results," and resulting Board Action of August, 2006. It included a description and input from stakeholders and focus groups (including consumers and family members) conducted in 2006 for the RFR process and decisions.

The needs assessment and planning process culminates with our annual Strategic Business Plan which lays out specific desired measurable results and strategic goals. The Strategic Business Plan also includes several Key Strategic Results which are three to five year goals formulated by our Board.

The strategic results (goals) were updated in 2010 for the last five years of the 10 year plan. The plan is available for review on our website at, http://d3b57b9524af4a17ecb75baf97947d6dfb047a4e.gripelements.com/pdf/ADAMH_Accountability/Managing_For_Results/2011_mfr_performance_plan.pdf

The 2010 Plan (Calendar Year, thus first six months of SFY 2011) is summarized as follows:

2010-2015 STRATEGIC RESULTS

Access to Service By January 2015, ADAMH will seek to ensure access to service for non-Medicaid individuals to help achieve identified outcomes and recovery.

Community Support By January 2015, Franklin County residents will sustain their support of the ADAMH system of care as evidenced by continuing financial support for the Board's mission.

Discretionary Resources By January 2015, ADAMH will protect local discretionary resources needed for increased demand for service.

Expanded Revenue By January 2015, ADAMH will expand sources of revenue for local behavioral healthcare services and supports.

Service Delivery By January 2015, ADAMH will streamline service delivery to increase system efficiencies and sustain clinical quality and cultural competency through performance accountability.

The major issues affecting individuals attempting to access our network for services are summarized in the Board's Strategic Business Plan for 2011 in the Business Environment section, and are as follows:

BUSINESS ENVIRONMENT (Updated August, 2011)

Consumers:

1. Changing community demographics, continuing severe economic stressors and increased complexity of consumer and family needs will challenge ADAMH to provide culturally competent services, delivered by culturally capable professionals that address the following socioeconomic and health factors:
 - Sustained levels of unemployment and associated fall-outs
 - Increased numbers of uninsured citizens

- Increased poverty
- People exposed to trauma (neighborhood, war etc)
- Children and families at risk
- Emerging immigrants
- Stigma
- Aging population & caregivers
- Integration of increased numbers of ex-offenders into community
- Diversion from jails/prisons
- Increasing acuity of consumers at time of entry into system
- Homelessness

2. An increasing number of diverse healthcare plans & benefits will challenge consumers and families in meeting their expectations from multiple public payer systems.

3. A significant increase in the need for intensive and specialized treatment for individuals with dual disorders (i.e. both mental health and substance abuse disorders) and high use of psychiatric beds.

4. Integration of primary & behavioral healthcare

Provider Network:

1. Ability of providers to meet the demands of consumers will be challenged by:

- Rapidly changing reimbursements environment by multiple healthcare plans for insured & non-insured consumers
- Increased demand for price, quality transparency and performance reimbursements
- Insufficient cultural diversity in the workforce

2. Opportunity or Requirement (?) to partner with primary healthcare providers to develop integrated systems of care that address both the behavioral and physical healthcare needs of the patient.

3. Sustainability of the current provider system (e.g. network of providers) in light of changing reimbursement structures

Community:

1. Availability of discretionary funds (resources available) is uncertain due to the:

- Reduction in local levy funds due to slowed housing starts or de-valuation of property
- Uncertainty of community support of the local levy due to continued economic uncertainty
- Reduction of non-levy discretionary funds as a result of economic recession
- Elevation of Medicaid match financing to the State of Ohio

New #: Re-definition of Board's relationship with the State's hospitalization program

2. Increase proportion of consumers who are Medicaid eligible will require the Board to:

- Re-define its relationship with the Medicaid program
- Evaluate the impact of the State's Medicaid cost-containment, including the possibility of managed care

3. Impact of Federal Affordable Healthcare Act on the ADAMH system of care from 2014 and beyond is uncertain due to the:

- Development of medical home models
- Growth in Medicaid Eligibility
- Development of Health Care Exchanges
- Employer choice to opt-in/out
- Continuing political/legal challenges to implementation
- Health Information Technologies

4. Changing community expectations for priority prevention and treatment services that will be available within the new business environment:

- Increased demands on schools to restructure their core learning and instruction time may require prevention services to be delivered with new partnerships during non-schools hours such as after-school or summer learning programs.

5. Increased & disparate levels of poverty throughout Franklin County

6. Increased expectations among all funders for systems to collaborate.

Findings of the needs assessment

Question 7: Describe the findings of the needs assessment identified through quantitative and qualitative sources.

For people hospitalized at regional campuses other than TVBH, discharge planning has been difficult. Providers find it problematic to provide the needed transportation back to Franklin County, hampering the transition out of the hospital.

The Board has continued to partner with Franklin County Children Services, Family and Children First Council and Juvenile Court to identify and serve youth with intensive needs using pooled funding. We now have five MST teams and one MST-PSB team. In 2008, this partnership established a FFT Team which further built our county's capacity to serve families with more severe needs.

The Board and FCFC have been working to standardize criteria for care coordination which has included the capacity to utilize multiple funding recourses. FCFC in partnership with the Board review the utilization of all FAST expenditures to assure appropriateness.

In CY2007, the Franklin County ADAMH Board conducted an analysis of its adult, high utilizer, inpatient hospital population. We posed the following questions: Why are we experiencing an increase in demand and/or volume and what are the potential causes? Which groups or specific individuals are presenting with the highest clinical risk? Which groups of specific individuals are creating the highest financial risk? Which services and/or strategies, if employed, would potentially improve key clinical and financial indicators?

After analyzing the data we discovered that a large percentage of individuals that were utilizing crisis and inpatient hospitals were presenting with co-occurring disorders. As a result, the IDDT/ACT teams that are mentioned throughout this plan were funded to target the specific needs of this highly vulnerable population. Early results look extremely promising. Four teams were created at four large comprehensive centers.

ADAMH estimates that approximately 15,000 adults and older adults will seek outpatient mental health services from the public sector in SFY2010-11. Since many Provider Agencies have many more requests for services than they can handle, more than 1000 persons will not receive services through the public sector annually. With current budget cuts going into effect, we now estimate that for SFY2010-11, only 12,000 will actually receive mental health treatment.

The Board is in year two of a SAMHSA grant implementing Adolescent Community Reinforcement Approach/Assertive Continuing Care (A-CRA/ACC) which is an evidenced based model for youth who are abusing substances. This model is being used by two contract providers with the evaluation portion provided by The Ohio State University College of Social Work. Once completed, we will have the capacity within our county to train and continue the implementation of this model. This is an area in which the county needs more expertise and resources to serve this population effectively.

Access to Services

Question 8:

- a) Identify the major issues or concerns for individuals attempting to access behavioral health prevention and treatment services in the Board area. In this response please include, when applicable, issues that may exist for clients who are deaf or hard of hearing, veterans, ex-offenders, problem gamblers, and individuals discharged from state Regional Psychiatric Hospitals and released from state prisons without Medicaid eligibility.***
- b) Please discuss how the Board plans to address any gaps in the crisis care services indicated by OAC 5122-29-10(B). (ADAMHS/CMH only);***
- c) Please discuss how the Board identified and prioritized training needs for personnel providing crisis intervention services, and how the Board plans to address those needs in SFY 2012-13. (ADAMHS/CMH only);***

Our board areas' general adult outpatient care resources were severely impacted by the budget reductions at the end of 2009 and through 2010. Our local system of care has been seeing the impact of the many individuals who do not fall into ADAMH's priority populations for treatment services. Persons with routine care needs that are not listed in prioritized or mandated population categories may have to wait longer for services or may not receive services at all in our system. The ADAMH Board of Franklin County adopted the following service delivery strategic investment objectives which include maintaining services to most vulnerable, legislatively mandated populations (e.g., SMD, SED, pregnant and IV drug users). In addition, ADAMH contractually requires of its Lead agency providers to accept the following individuals into care regardless of payor source: individuals who are released from a State BHO, Private inpatient psychiatric units and/or a multi-day holdover crisis stabilization service through our local crisis provider. Some of our major alcohol and other drug treatment providers received substantial budget cuts from both the City of Columbus and the Central Ohio United Way. As the board has to restrict care to non-mandated, priority populations that we are legally mandated to serve, some populations, although in great need, may not fall into these prioritized categories. We have continued to be vigilant about looking for and have been successful in obtaining, alternative funding sources for ex-offenders, veterans and youth involved in the criminal justice system through state and federal grants. Increased numbers of individuals re-entering and newly entering Franklin County after being incarcerated continues to be an issue of great concern. Many of these individuals return to the community without any support system and end up being diverted to our community-based crisis sites with long term care needs that we do not have the resources to fully provide the care they need.

Gaps in crisis care services

Due to the funding reductions from the state department, higher than anticipated Medicaid growth and higher than projected inpatient hospitalization costs, our Board has had to reduce its provider allocations in the last two years. As a result of data analysis and needs assessment the Board made the decision to hold harmless all crisis-related services and programs from any of the 2009/2010 reductions. This included our two community based 24/7 crisis sites operated by NetCare available to all populations, detoxification services provided by Maryhaven and medically assisted alcohol and other drug treatment provided by CompDrug and Maryhaven

(e.g., methadone). ADAMH reviewed the capacity and utilization for the ADAMH funded Crisis Beds located at the Buckeye Ranch and will be reinvesting these dollars into a medically integrated, youth Crisis Stabilization service vs. the crisis support services that previously existed. Our hope is that this reinvestment will increase hospital diversions.

How Board identified and prioritized training needs for personnel providing crisis intervention services and how the Board plans to address those needs

Netcare, our local 24/7 Crisis Service provider, has an established staff development training program that assures all individuals providing crisis intervention services receive the appropriate training to meet certification standards. These include: First Aid/CPR, non-violent crisis intervention and verbal escalation skills, etc. In addition, our Client Rights officer and members of our Consumer and Family Advisory Council participate in Crisis Intervention Training for area police officers.

Workforce Development and Cultural Competence

Question 9: Workforce Development and Cultural Competence*:

- a) Describe the Board's current role in working with the ODMH, ODADAS and providers to attract, retain and develop qualified direct service staff for the provision of behavioral health services. Does the local service system have sufficient qualified licensed and credentialed staff to meet its service delivery needs for behavioral health services? If "no", identify the areas of concern and workforce development needs.*

The current economic environment has had an impact on the workforce of the ADAMH system. Significant budget reductions from the state forced the ADAMH system to make adjustments to accommodate the cuts and forced layoffs at both the board and provider levels. Consequently, new hiring has been limited and retention of qualified staff has been less of concern in this economic environment

The ADAMH Board has had no working relationship with ODMH or ODADAS as it pertains to workforce development plans to attract, retain, and develop qualified direct service staff. However, the Board has provided assistance noted below to our providers in order to increase the systems' overall talent pool and to assist with retention efforts. The ADAMH Board realizes that in a slow economy that it must find unique ways to sustain its workforce while building the capacity of its workers, particularly credential direct service staff. Growing the workforce from within is one way we support employees when selective turnover is low. The board has instituted some internal strategies to support the system workforce:

- 1) The ADAMH Board of Trustees included in its Strategic Business Plan a result to become the "Employer of Choice" among behavioral health care professionals who seek to deliver clinically and culturally appropriate services to consumers. To this end, the ADAMH Board staff, in partnership with the Provider Leadership Association, determined that the most effective workforce retention and development strategy that would be mutually beneficial to the system of care was to increase the number of master's level clinicians available to provide billable care and supervision.

OSU College of Social Work / ADAMH Academic Partnership (Master of Social Work Degree Program)

The ADAMH Board worked with providers and The Ohio State University College of Social Work to implement an ADAMH system Master's Degree in Social Work program. The impetus behind this program was to establish ways to grow and retain the system's workforce by creating a program that was low-cost and convenient. Those who are participants in the MSW cohort will increase their employment options, while providing employers with a growing pool of master's level clinicians and administrators. This program is offered at the ADAMH Board's office at 447 East Broad Street so that students have a central location off-campus to attend classes in an attempt to accommodate those that work full-time. The providers support the selected students through provision of fee waivers, flexible work schedules, tuition reimbursement and opportunities for shared internships. This is a four-year, part-time program with a minimum of 15 students, although 25 students are currently enrolled. The program began in the autumn of 2009 and classes are held two nights weekly. Furthermore, several ADAMH staff members teach within this program at The Ohio State University. ADAMH staff members also serve as curriculum advisers to Columbus State Community College (CSCC) students enrolled in the MA/SA/DD program. CSCC is preparing students to seek employment within the ADAMH system or are directing them to enter four-year programs in social work at surrounding universities.

Human Resource Technical Support / HR Workgroup

2) The ADAMH Board also provides HR technical assistance to ADAMH providers and leads an HR Provider group which meets quarterly. This group shares pertinent HR information across the system. The Board also posts jobs on the organization website and provides a resume referral service for employees within the system to fill open positions within the ADAMH system. Because of the economic downturn during the last few years, it is not as difficult as it had been to find licensed and credentialed staff for existing jobs within the system. However, this is still an area of focus for the Board in terms of recruiting and retaining and growing talent within the system overall.

3) In the future, ADAMH will also need assistance from ODMH and ODADAS to identify additional training and development resources for staff. As a cost saving measure, ADAMH would like to look at on-line and other technologically enhanced methods to provide such training. ADAMH would also like to assist in increasing system-wide collaboration among our providers and those agencies external to our system with providing complementary staff trainings.

b) Describe the Board's current activities, strategies, successes and challenges in building a local system of care that is culturally competent. Please include in this response any workforce development and cultural competence issues, when applicable, related to serving the deaf and hard of hearing population, veterans, ex-offenders, problem gamblers and individuals discharged from state Regional Psychiatric Hospitals and released from state prisons without Medicaid eligibility.

The ADAMH Board of Franklin County continues to build on the tenets of cultural competence, which we established in 1990 after responding to a statewide Minority Concerns Report published by the Ohio Department of Mental Health (ODMH, 1989 & 1991). That report illustrated the disparities impacting ethnic minorities in the state of Ohio (i.e., misdiagnose, over-medication, over-hospitalization, under-utilization of community based care, etc.). As a result, the Board used that report along with its previous work in cultural training in the late 1980s to establish a principled approach to continuously address the needs of underserved diverse populations. We clearly recognized this Sisyphean challenge of sustaining cultural competence in our system since there were so many variables influencing underserved diverse communities.

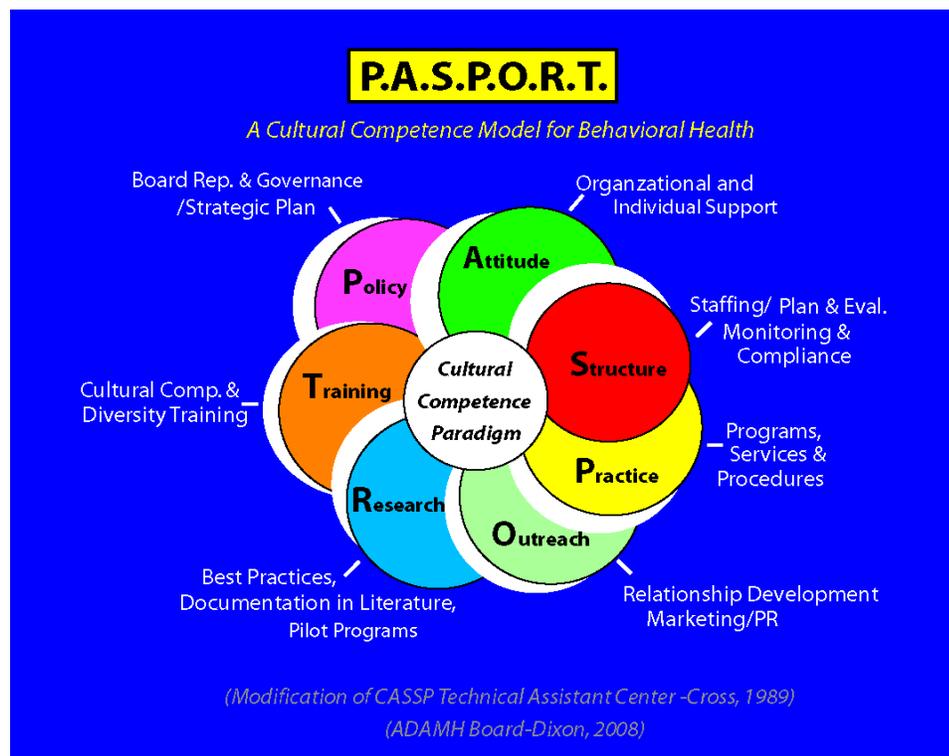
Since the 2010-2011 Community Plan submission, our system experienced significant cuts to the budget. Those cuts impacted cultural competency efforts in several ways, which caused ADAMH to eliminate and modify some of its planned initiatives. Primarily, cuts eliminated cultural competency training at the system's level. This was particularly concerning since there is evidence to show cultural competence training leads to better outcomes for clients, thus reducing costs. Additionally, cuts eliminated the initial partnership between ADAMH providers and Columbus Neighborhood Health Center on the west side to provide behavioral health services to Latino/Hispanic and other Westside residents who also sought primary healthcare (Note: there now is a mental health provider housed in CNHC Westside clinic, but full integration as we planned has not occurred). Reductions also ended the board's own innovation grants to providers designed to stimulate new services, including cultural specific – thus limiting many new initiatives.

The ADAMH Board continues to find new ways of addressing cultural competency efforts during these difficult times – realizing the importance of serving all diverse communities. The Board is partnering with organizations to address the multiple needs of diverse communities. The board plans on working with providers to identify culturally situated grants to address issues regarding disparities and related monitoring/assessment tools, professional development, interpretation and translation supports, material development, and other supports. The goals for 2012-13 will be built upon provider cultural competency plans recently developed. As a part of the cultural competency plan development process, providers were required to conduct a comprehensive self-assessment of 11 key culturally competent standards. The Board will be reviewing provider plans and conducting site visits to ensure both compliance and technical capacity to address the needs of diverse populations. These plans are built upon the overall structure of ADAMH's cultural competency initiatives outlined below.

Background:

The context for the Board's cultural competence initiatives is grounded in a model that was adopted and modified for use by our system of care. The modification of the CASSP Technical Assistance Model (Cross, 1989) extends the cultural competency basics of policy, practice, structure, and attitude to incorporate key elements that support research, outreach/engagement, training, and quality assurance. Although the Cross model provides a solid grounding for systemic praxis, it needed to be adjusted to meet the unique needs of Franklin County – particularly with our emerging populations (i.e., Somali, Latino/a, Iraqi).

Additionally, it helps support the needs of other key populations of need that include veterans, ex-offenders, and deaf/hard of hearing. The underpinnings of this model illustrated in the diagram below are enhanced with other elements that further define our operational use. This model will help explain the Board’s current activities, strategies, successes and challenges for sustaining a culturally competent system of care. In addition, ADAMH’s Board of Trustees has incorporated cultural competency into their system strategic goals in terms of treatment services, system development, funding and grant opportunities, and workforce diversity.



Below is an overview of the Board’s responsibility associated with the P.A.S.P.O.R.T. model for Franklin County:

A. Policy

- a. ADAMH’s Board of Trustees ensures the need for culturally competent services in their overall strategic results for the Board and system.
- b. ADAMH articulates the importance of having Board representation that reflects the population that is served in terms of race and gender.

- c. Several ADAMH Board members have expressed their personal interest in cultural competence and offered their active support and involvement.
- d. Board internal and system policies are reviewed to ensure they support cultural efforts (reviewed in 2010).

B. Attitude

- a. ADAMH's CEO has been a strong advocate for cultural competency within our system – as well as through statewide associations (i.e., Board Association, MACC, local leadership, etc.). According to research and diversity literature (Thomas, 1994), the CEO is a critical component in moving cultural competency initiatives forward and ensuring that the agency overall, and individual staff, take it seriously. Monitoring the cultural climate through self/organizational assessments is an important mechanism required by the Board's Cultural Competency Plan.
- b. ADAMH's senior leadership regularly questions issues and concerns regarding cultural competence impacting diverse populations.

C. Structure

- a. The Board ensures that the key structural components of cultural competence are addressed/developed through the submission of provider Cultural Competency Plans (last submitted Fall 2010), Agency Service Plans (Identification of 2-3 key annual goals in off years when the full plan is not submitted), ProviderStat Reviews (Cultural Plan Issues Addressed), System Quality Indicator Monitoring, and Consumer Satisfaction reports. Utilizing these monitoring and compliance methods support our efforts to improve quality and address disparities.
- b. Board and system staff reflective of the population served is monitored and discussed in the system within our ProviderStat framework.

D. Practice

- a. The Board strongly supports and funds culturally competent behavioral health services and monitors funded services that target diverse communities.
- b. The Board recognizes all providers have both similarities and differences in terms of populations they serve – and must create practices that best meet the unique needs of various communities (i.e., no one cultural competency practice meets the needs of all).
- c. Up through 2008, the Board provided stimulus and innovation funds to allow providers to address the needs of diverse and emerging populations – requiring they utilize evidence-based (if they exist). We are encouraging providers to redirect existing resources and/or partner with other entities to continue to develop services unique to diverse communities since cutting funding for new initiatives.
- d. The Board wants to ensure that services to diverse communities are aligned with best and promising practices for optimal quality.

E. Outreach

- a. The Board is collaborating with several health and human service organizations (i.e., Columbus Public Health, United Way of Central Ohio, Multi-Ethnic

Advocates, OSU College of Social Work, AccessHealth Columbus, Columbus Neighborhood Health Centers, etc.) to support a more comprehensive and integrated strategy for minority populations and others.

- b. The Board built and continues to sustain healthy relationships with organizations and leaders in the Latino, African American, Somali (African), Asian, Native American and other communities (i.e., newest group - Iraqi/Middle Eastern) to ensure our goals and objectives are consistent with meeting their needs.
- c. The Board is participating with a number of initiatives that are addressing the needs of veterans (i.e., Ohio Suicide Prevention, MACC Veteran Survey, Educational and Training Efforts, Local VA Support Initiatives).
- d. The Board supports community-based initiatives that address the needs of diverse communities such as Juneteenth, Ohio Psychological Association Cultural Symposium, and Just for Today event to name a few. Due to limited resources, ADAMH continues to serve on multiple committees, boards, and collaboratives that address the needs of diverse communities (i.e., Faith-based, Violence Prevention, Family Violence)
- e. Marketing to minority communities through print and electronic media was cut in 2009-10 because of budget reductions. ADAMH's public affairs department will seek earned minority media opportunities. Although, current plans are underway to re-initiate some targeted marketing opportunities in printer and electronic media.

F. Research

- a. It is the intent of ADAMH to work with institutions of higher education to co-create research initiatives to address issues of disparities in mental health (e.g., ADAMH completed a research project with Dr. Charles Partridge examining the effectiveness of intervention services for Somali youth at Mifflin International Middle School funded by the Columbus Foundation).
- b. The Board also lends its grant writing expertise to MACC – realizing the importance of supporting statewide initiatives to further support local cultural competency efforts. The Board is supportive of any state initiative designed to improve care to diverse and underserved populations.
- c. During 2012-13 the Board will seek funding to develop an instrument to monitor and inform providers about disparities in services. Additionally, finding integrative service models (i.e., health / behavioral health) that we can consider may help address stigma that impacts various minority populations who do not access care. The Board did apply for system transformation grants from ODMH to implement mechanisms to identify, monitor, and address disparities, but was not funded.

G. Training

- a. Due to the budget reductions, the Board eliminated funds for system-wide training. Culture training sessions are being provided at the individual provider level (in-service), local conferences, as well as sessions offered by MACC and United Way. We realize that our cuts will limit cultural training opportunities for system staff and board members.

- b. The Board encourages providers who are able to provide training to allow other providers to attend – and also seek other fee and free cultural training opportunities across disciplines (i.e., Columbus Public Health, Ohio Commission on Minority Health, College of Public Health). Since the 2010-11 Community Plan ADAMH has partnered with Columbus Public Health and MACC to offer free and low cost training to providers.
- c. ADAMH will explore or design possible online, computer-based cultural training options so that providers will have low cost and convenient options.

Key Monitoring Updates:

Agency Service Plans

Agencies are required to address their annual cultural competency plans during years the full Cultural Competency Plans are not submitted. Those plans identify two or three key areas that the agency will address outside of training (e.g., translating material into foreign languages, tracking disparities, etc.) for the following service year. A review of the 2009 Agency Service Plans indicate that providers are clearly moving into niche’ cultural competence areas that we did not see with earlier reports in 2006-8. ADAMH CEO David Royer understands that cultural competency is not a wholesale movement of a system, but both individualistic and collective movement through incremental shifts and patterns that are engrained into the particular consumer base providers serve. What we found was that each provider was unique – and that agency cultural initiatives varied based on provider size, population served, outcomes, and geographic region where the provider was located (e.g., providers on Westside may offer more after-school AOD prevention programming to avoid increased violence in that area). What we have seen through the 2009 ASP reports are providers who are moving beyond the basics of training and awareness/tolerance activities – to one where their cultural competence goals are specific to the needs of the diverse populations they are serving. This is a huge development in terms of ownership and creating provider specific systems of continuous quality improvement.

Cultural Competency Plan

The ADAMH Board clearly understands the importance of providing culturally competent care for the benefit of consumers, families and overall system competence. Each provider monitors overall cultural competence through the completion of their Cultural Competency Plan that targets 11 key standards (over 60 result areas) that support the P.A.S.P.O.R.T. model illustrated above. Providers submitted Cultural Competency Plans with their 2010 Agency Service Plans. Because of the uniqueness of providers, plans range widely – as expected. Individual provider plans and service issues impacting diverse populations will be assessed and discussed during their 2011 ProviderStat sessions. The initial review of plans revealed that providers needed support in training, valid agency culturalogical assessment /monitoring tools, recognizing disparities, interpretation supports and funding, and general technical assistance.

11 Cultural Competence Standards

The eleven Cultural Competence Standards below are the key areas that are assessed in the Cultural Competency Plan providers submit every three years. They represent the detailed areas that are identified in the P.A.S.P.O.R.T. model and help guide providers when examining their levels of cultural competence.

1. Access to Services
2. Assessment
3. Case Management
4. Cross-Cultural Linguistics and Communication Support
5. Cultural Competence Planning
6. Governance
7. Human Resource Development
8. Management Information Systems
9. Prevention/Education/Outreach
10. Quality Monitoring and Improvement
11. Treatment Plan/Individual Service Plan.

Current activities, strategies, successes and challenges

Strategies:

The overall strategy for Franklin County is outlined above through the P.A.S.P.O.R.T. program. This model helps to ensure that all cultural competency areas are addressed in the system of care. One unique difference that we have providers address in their ASPs is for them to focus on two or three key improvement/result areas per year (generally outside of training itself). The reason for this is to provide focus and attention on critical niche areas of each provider. We also recommend that providers continuously seek out best and better culturally competent practices within their mental health/behavioral health service delivery paradigm. This strategy is beginning to pay off in terms of providers sharing their expertise with other agencies in the system. Another key strategy that will emerge with serving diverse and underserved communities is finding better ways to integrate health and behavioral health services. We are learning that integrating services will provide for a more holistic and efficient way serving underserved and diverse communities, hopefully leading to better outcomes and cost savings to multiple systems. The recently was invited to participate in the 2011 SAMHSA Community Leader and Interfaith Partnership Summit designed to have partnerships with faith communities as another resource and repository for service needs.

Current Activities (Board Focus):

The Board identified a few key cultural competence areas to focus on during the next two program years. Those areas include: Faith-Based Outreach Initiative; Community Engagement/Relations; Grant Submissions for key Cultural Areas (i.e., Disparity Monitoring, Faith-Leaders Symposium, etc.); and system monitoring.

1. Faith-Based: The Board recently established a Faith Leader Advisory Council to provide input about the kinds of challenges they are experiencing with behavioral health issues. We learned that with the downturn in the economy – there is a significant increase of behavioral health issues experienced by the faith community (i.e., domestic violence, alcohol drug use, depression, youth and gang violence, etc.) due to lost employment, foreclosures, etc. Some recent activities and future include:

- a. Faith-Leaders Behavioral Health Information Breakfast – Spring 2010
 - b. Faith-Leader Alcohol and Drug Training – Fall 2010
 - c. Faith-Leader Advisory Council Formed (meeting quarterly) – Fall 2010
 - d. Violence Prevention Partnership with Faith Community – Summer 2011
 - e. Faith Leader Symposium – Fall 2011 (To identify future activities/projects)
2. Community Engagement (VP for Cultural Competency): Designed to establish partnerships with other systems and organizations to address community-based issues related to behavioral health for improved integration, partnerships, collaborations, and communications.
 - a. Service on various boards and committees to address issues related to services to various populations (i.e., Columbus Neighbor Health Center Board, AccessHealth Columbus Board, Franklin Co. Commissioner Multicultural Workgroup, Columbus Public Health Minority Affairs Advisory, Coalition Against Family Violence Community Advisory, Commission on African American Males, Multiethnic Advocates for Cultural Competence, Our Optimal Health, Ohio Latino Mental Health Network, OSU Youth Violence Initiative, etc.).
3. Grants:
 - a. Submit grants to support cultural competence initiatives.
 - b. Continue partnerships with other organizations to support better integration of services (i.e., Health/Behavioral Health). Seek future grants to address key areas identified in provider Cultural Competency Plans: Culturalogical Assessment Tools, Training, Material Translation, and Disparity Monitoring.
 4. System Monitoring:
 - a. Technical Supports for Providers.
 - b. ProviderStat review sessions for examining Cultural Competency Goals/Issues.
 - c. Exam key system quality indicator (SQI-Data) to help identify disparate care.
 - d. Identify best and better practices that are or can be identified and replicated.
 5. Marketing:
 - a. Identify earned media opportunities to help communicate behavioral health information to diverse communities (i.e., Latinos, Deaf and Hard of Hearing, Somalis, etc.).
 6. Training:
 - a. Partner with Multiethnic Advocates for Cultural Competence to plan future trainings that system providers can participate.

Current Activities (Provider/System Focused)

The following is a summary of current activities by cultural competency categories (P.A.S.P.O.R.T.) to fully understand ongoing activities unrelated to specific cultural competency goals and objectives set forth by ADAMH. The diversity of activities is enormous amongst provider agencies – and unique to their target populations.

Policy (Governance): Each provider submits a racial/ethnic composition of their board of trustees in the ASP and is prepared to discuss board composition if it does not reflect the population

served during ProviderStat reviews.

Attitude (Organization and Individual Support): ADAMH's CEO has been a strong advocate for cultural competency within our system – as well as through statewide associations. As a result, many providers have also model similar leadership within their agencies and support many of the cultural competency initiatives within their organization. Several provider agencies require internal staff climate audits, performance appraisals, diversity councils, affinity groups, and other methods to create a culturally supportive environment. In addition, some agencies have designed their waiting areas to be culturally sensitive motif through diverse artwork, magazines, artifacts and other methods to make consumers feel welcome. Most providers realize their front-desk staff must also express a level of understanding and sensitivity when working with diverse populations who seek care.

Structure (Staffing/Plan&Eval./Monitor/Compliance): Providers are addressing their staff diversity based on the population they serve through ADAMH's ProviderStat review meetings. Any variance above 10% with respect to racial / ethnic disparity must be addressed by providers. During the last 2010-11 community plan, overall system staff reflected the population served (2011 will earmark another review of system employees since significant cuts occurred during this period). The Board continues to examine outcomes data to ensure there is consumer satisfaction based on race/ethnicity. ProviderStat is the forum to monitor compliance.

Practice (Programs/Services/Procedures): There are several unique programs in place that target cultural uniqueness and unicity. Prevention and treatment programs / services that target African Americans, Somalis (e.g. Rosemont, Southeast), Latinos (e.g, North Community Counseling in collaboration with Columbus Neighborhood Health Center), Gays and Lesbians (e.g. North Central), Deaf and Hard of Hearing (Southeast, House of Hope, Buckeye Ranch, and St. Vincent Family Center) – as well as those persons homeless (i.e., living on the land), and other special populations. Each agency continues to develop their cultural uniqueness based on the populations they serve.

Outreach (Relationship Development / Marketing): Most agencies who serve diverse populations have established relationships with faith-based institutions, community organizations, and other entities that represent diverse racial and ethnic populations and cultures. In addition, several providers have developed their brochures and other marketing materials in Spanish and Somali. Many agencies display artifacts, art, reading materials that reflect the diverse populations they serve. The Board's development of a Somali video will also be well marketed within the community to help address stigma and improve access to services.

Research: Some providers have used their experiences working with diverse communities to develop or refine how they assess their organization's cultural competence. In addition, some have used their own research and data analysis to rethink how they administer services to diverse communities. Rosemont recently completed work to further examine the outcome data (Dr. Partridge OSU College of Human Ecology) regarding their involvement with the Mifflin International Welcome Center Somali student population. Other providers used their research to redesign or implement new cultural assessment tools.

Training (Learning): The cancellation of the Maryhaven/ADAMH Training Academy, due to budget reductions, has limited one key learning option for some providers since 2009. Many providers already had multiple cultural competency learning options targeted – but this particularly impacts smaller organizations. Providers are utilizing the following ways to ensure their staff/ organizations are moving toward cultural competence.

1. Methods and Learning/Training Options used by providers:
 - a. Cultural Competency Monograph Learning
 - b. E-Learning Training Options / Computer-based Instruction Modules
 - c. Video / DVD Training
 - d. Cultural Affinity Groups / Cultural Competency & Diversity Committee
 - e. Racial Justice Dialog Groups
 - f. Partnerships with local Emerging Population Groups (i.e., LEON, Somali Community Association, Ohio Latino Mental Health Network, Asian Community Services, Ohio Hispanic Coalition, etc.) to provide speakers and learning options.
 - g. Use of MACCs Resource Center
 - h. Required Reading on Cultural Issues
 - i. Use of Internal & External Cultural Consultants & Informants
 - j. Conferences, Seminars, Workshops, Learning Communities – based on resources

Successes

The ADAMH Board is proud of our system transformation beyond cultural awareness and sensitivity training to one that is beginning to address substantive needs of diverse communities through service design, delivery, and outcomes. The CEO and Board understand the importance of this work even more during this current economic downturn. Many of the successes are noted above through the volume of work within this system around cultural competency – and under each population area. Below are some key successes that should be noted:

1. Ardent support of a diversity of faith community leaders around partnering to address behavioral health concerns (i.e., educating faith leaders about recognizing, advising, resource access, and referring for treatment).
2. Partnering with MACC to provide statewide training opportunities for behavioral health, health, and human service professionals.
3. Well established relationships with the Somali and Latino communities to address their behavioral health needs.
4. Established strong relationships and partnerships with multiple community organizations addressing health related issues.
5. Provider awareness and attentiveness to cultural competence efforts at the service level.

Challenges

1. Elimination of system-wide cultural competency training due to budget reductions. This training provided best practice information for service diverse communities – as well as cross agency networking on related matters.

2. Funding to support the development of a valid and reliable disparity tracking tool at the Board and provider level to easily identify, monitor and adjust for identified disparities (beneficial to partner with ODMH to examine statewide).
3. Funding needed to support costs related to interpretation and translation services (language and deaf/hard of hearing populations). The identification and utilization of new technology that can support video interpretation and other options.
4. Ensuring that staff diversity is utilized to tap the talents, skills, abilities, ideas, solutions, strategies, of 100% of the workforce – whereby no one is advantaged or disadvantaged in the process. In essence, using/enhancing the power of diversity beyond the achievement of people in positions to address problems from a variety of perspectives – utilizing TQM principles.
5. Resources to better integration and collaboration of behavioral health, health, and human services – to reduce costs, create better outcomes, reduce stigma, and designed for client/patient convenience.

Capital Improvements

Question 10: Capital Improvements: For the Board's local behavioral health service system, identify the Board's capital (construction and/or renovation) needs.

At this time, ODMH has just released the instructions for submitting state capital funds proposals for the three biennia FY 13-14, 15-16 and 17-18. Providers have been notified and are currently in the process of preparing their requests. Capital plans will be considered only with evidence of a planning process that ensures input from consumers, family members and providers and that is consistent with the capital needs as outlined in the Board's Strategic Housing Plan and the Community Plan.

III. Priorities, Goals and Objectives for Capacity, Prevention and Treatment and Recovery Services

- A. Determination Process for Investment and Resource Allocation**
- B. Goals and Objectives: Needs Assessment Findings**
- C. Goals and Objectives: Access and State Hospital Issues**
- D. Goals and Objectives: Workforce Development and Cultural Competence**
- E. Goals and Objectives: ORC 340.033(H) Programming**
- F. HIV Early Intervention Goals**
- G. Civilly and Forensically Hospitalized Adults**
- H. Implications of Behavioral Health Priorities to Other Systems**
- I. Contingency Planning Implications**

Section III: Priorities, Goals and Objectives for Capacity, Prevention, Treatment and Recovery Services

Process the Board used to determine prevention, treatment and capacity priorities

Question 11: Describe the process utilized by the Board to determine its capacity, prevention, treatment and recovery services priorities for SFY 2012 – 2013. In other words, how did the Board decide the most important areas in which to invest their resources?

The Board's planning process began with a ten year Levy Plan 2005-2015 (attached for more information) and includes a Needs Assessment of public sector behavioral health needs and current trends and service patterns. With the success of the Levy, the Board was able to invest additional funding, and updated the Needs Assessment in addition to completing focused stakeholder interviews and focus groups for the purpose of determining priority service needs. Unfortunately, the Board had to reduce funding by more than \$4 million dollars since July, 2008, which has made it necessary to adjust the original ten year plan for treatment and prevention priorities. The ADAMH Board of Franklin County has prioritized the following service delivery strategic investment objectives;

- Maintain services to most vulnerable, legislatively mandated populations (e.g., SMD, SED, pregnant and IV drug users).
- Purchase services from providers that demonstrate the best quality, most efficient and cost effective use of non-Medicaid funds.
- Maintain geographical presence.
- Maintain current ratio of treatment and prevention services.
- Maintain culturally competent services that meet the diverse needs of Franklin County.
- Leverage investments where initiatives are consistent with ADAMH priorities. Given these priorities, the Board's current investments in both prevention and treatment services have been developed with these strategic investment objectives in mind. Allocation reductions,

increases and realignments have been instituted with these core service strategies as our overarching guide. Our most recent local allocation reductions resulted in the following impact on our system of care:

- Service system remained intact with full compliment of providers, but some services and programs were reduced.
- Current geographical presence was maintained.
- Crisis services maintained at current levels (e.g., 24/7 crisis services intact, detoxification services intact, methadone/buprenorphine programs intact, engagement services for homeless, publicly inebriated adults intact).
- Service reductions focused on non-direct service supports, areas of low performance and future innovation programs that would have been funded with system innovation funds supported by local levy.
- Maintained services to most vulnerable, legislatively mandated populations (e.g., SMD, SED, pregnant and IV drug users).
- Maintained pledge that 95% of all revenues are at the service level by reducing both Board administrative and provider allocations simultaneously.

As noted above, our community is extremely fortunate to have been able to maintain a full compliment of services targeting individuals in need of behavioral health care interventions even after extensive budgetary reductions were instituted in the past 12 month period. This ability is largely due to our local levy and the acquisition of some large federal, state and local grants which we have aggressively pursued. We will be faced with more comprehensive system restructuring should there be additional reductions to our local behavioral health care budget from the state. We have attempted to keep our system of care intact to the greatest degree possible, but understand that adjustments will have to be made as we respond to deeper cuts. Other drivers impacting our budget include the increase in state hospital utilization, Medicaid match requirements and reductions from other funding sources historically utilized to augment our system provider's budgets (e.g., United Way, City of Columbus).

Behavioral Health Capacity, Prevention, and Treatment and Recovery Support Goals and Objectives

Question 12: Based upon the Departmental priorities listed in the guidelines (and/or local priorities) and available resources, identify the Board's behavioral health capacity, prevention, treatment and recovery support services priorities, goals and objectives for SFY 2012—2013.

- ***PRIORITY: Promote integration of behavioral healthcare and other physical health services:***

Continue to plan, support, and where feasible fund providers' efforts to identify medical co-morbidity among their SMD and elder consumers; to increase the utilization of mobile/community-based RNs and APNs in delivery of mental health care (e.g. ADAMH's IDDT-ACT initiative; North Central MHS's Nurse Outreach Team, Southeast's Homeless PATH Program); and increase bi-directional co-location (e.g. Southeast SAMHA-funded primary care clinic; North Community Counseling's entire West Side practice moving into

the Westside Wellness Center of the Columbus Neighborhood Health Centers; Concord’s and Northwest’s outreach and care coordination with elders’ primary care providers).

- ***PRIORITY: Promote and sustain the use of “evidenced-based” policies, practices, strategies; increase the hiring of peers; and increase competitive employment.***

Continue planning, funding and evaluating Evidence Based Practices. ADAMH conducted extensive data analysis of the adult high-risk/high-cost adult clients who disproportionately use Regional Psychiatric Hospital, residential and crisis care. We engaged with stakeholders to identify and prioritize opportunities for improvement. In response, the Board made a sizeable new levy investment in the **evidence-based practices of Integrated Dual Diagnosis Treatment (IDDT) and Assertive Community Treatment (ACT).** We are implementing four IDDT-ACT Teams with capacity to serve 325 of our most vulnerable consumers. The Board continues to collaboratively plan, fund and evaluate this initiative with Columbus Area, North Central, TVBH-CSN and Southeast. ADAMH contracts with both the Ohio SAMI CCOE and the Ohio Coordinating Center for ACT for consultation and training. The Teams are achieving positive results and increased fidelity to the two models. Comparing consumers’ baseline to their first and second years on the Teams:

Service	Reduced Usage From Baseline, First Year	Reduced Usage From Baseline, Second Year
ODMH Regional Psychiatric Hospitals (N Days)	-44%	-72%
Netcare Crisis Episodes	-24%	-57%
Residential Care (Days)	-2%	-27%

Source: Claims Rcvd by 3-2-11 and PCS thru 1-31-11(MFR A5, 3-9-11)

ADAMH pursued and provided levy matching for Ohio Rehabilitation Services Commission investments in 2008 (Pathways II initiative - Central Ohio Supported Employment Collaborative or COSEC) and in 2011 (VRP3) to enhance vocational opportunities for persons with severe mental disabilities and addictions. COSEC is a systems’ change initiative, melding the **evidence-based practice of Supported Employment** with the traditional vocational rehabilitation structures and processes of BVR, as well as two other EBPs of IDDT and ACT.

The project includes the Franklin County, Delaware/Morrow and Fairfield County Boards; our primary vocational provider, Center of Vocational Alternatives; and our four providers implementing IDDT-ACT Teams. Consultation and training is provided by the Ohio Supported Employment CCOE. The project embeds trained Vocational Counselors with our IDDT-ACT Teams and four other Community Treatment Teams at these agencies. During 2010, 311 Franklin County clients with SMD were actively engaged in vocational rehabilitation and/or working where jobs were available. COSEC’s competitively employed consumers earned an average hourly wage of \$8.34 and worked an average of 33 hours per week, exceeding the goals of \$8/hour and 20 hours/week.

The ADAMH Board is continuing its commitment to promote, invest in and evaluate the **evidence-based practice of Consumer-Operated Services**. Our largest single-program replacement levy investment was the creation of **Peers Enriching Each others' Recovery** - now commonly known as the PEER Center - in January 2007. Of particular note, 97% of the PEER Center participants report that the Center's services have helped them deal more effectively with their problems.

The Center at 1221 East Broad Street is open Monday-Friday 7 AM - 11 PM, Saturday-Sunday 9 AM - 7 PM, and all Holidays 9 AM - 7PM. The Center is staffed 100 percent by peers, both paid and volunteer, who are in mental health, addiction and trauma recovery. With its mission "to provide a safe place where individuals receive support toward hope and mental health recovery," PEER Center offers a robust calendar of activities and services, e.g. one-on-one and group peer support, recreational activities, a resource center and computer lab, a media center and other programs decided upon by Associates. One of the options available to participants is **WRAP - just officially recognized as an evidence-based practice** in SAMHSA's registry.

As planned from the outset, in January 2010, the PEER Center is successfully evolved from a consumer-operated program "incubated" within a traditional, comprehensive behavioral healthcare provider to a fully independent non-profit agency, with persons in recovery comprising a majority of the Board of Directors.

Effective May 2011, the PEER Center expanded operations to a second location by incorporating the services, staff and facility formerly known as Partners in Active Living Through Socialization, Inc. (Partners). Now called PEER Center-North, the site is located at 15 West 5th Avenue near North High Street.

This latest evolution, actively supported by ADAMH, began in June 2010 with representatives of the Boards of Directors of the two consumer-operated providers considering ways to increase their cost-effectiveness through collaboration. The providers determined that they shared common missions, values and services that support consumers' recovery. On April 30, 2011, the Board of Directors of Partners voted to dissolve and merge its operations immediately into the PEER Center. ADAMH is assisting this merger through supplemental allocations for staffing, improved information technology, consultant-facilitated strategic planning, and staff cross-training/culture integration. This merger will strengthen the business/operational position of consumer-operated services, and as the Executive Director Juliet Dorris-Williams stated, "peers across all of Franklin County will have choice, options for self-directed recovery, and a variety of programming."

Prevention Services:

- The ADAMH Board is continuing its commitment to promote and to invest in Providers who offer evidence-based prevention practice programs in ADAMH Target Areas.
- The ADAMH Board is continuing its commitment to assess prevention programs to determine the program effectiveness and the cost efficiency in delivering services to youth and adults. The Prevention System Quality Indicators are MH & AOD Prevention

Categories (Universal, Selected or Indicated), Level of Risk (ODE School Designation and Economic Disadvantage Status), Cost Per Client and Outcomes Achieved.

Investor Targets	ADAMH Target Areas
1. Increase the number of customers who perceive AOD use as harmful and non-use as the norm.	a. Increase in the number of customers who avoid AOD use. b. Increase in the number of customers who change their AOD use behavior related to increase in knowledge of risk and harm of AOD use, abuse and pregnancy. c. Increase the number of customers who perceive an AOD using or abusing lifestyle as unacceptable. d. Increase involvement of customers engaged in alcohol, tobacco and other drug-free alternative activities. e. Increase the number of customers who perceive alcohol and other drug use as harmful. f. Increase the number of customers who delay the first use of alcohol and other drugs. g. Reduce the number of customers who engage in high-risk use of alcohol h. Reduce the number of customers who misuse prescription and/or over-the-counter medications.
2. Increase the number of customers who have positive family management and communication.	a. Increase the number of customers who experience positive: <ul style="list-style-type: none"> • Adult support • Peer support • School/community support.
3. Increase the number of customers who demonstrate school bonding and educational commitment.	a. Increase the number of customers who demonstrate school bonding and educational commitment b. Decrease school suspensions and/or expulsions
4. Decrease in the number of HIV/AIDS/STD/TB and Hepatitis C infection and an increase in those with HIV/AIDS/STD/TB/HEPC receiving treatment.	a. Increase in the number of customers who reduce risk of infection or transmission. b. Increase in the number of customers who are properly diagnosed and linked to proper treatment.
5. Increase the number of customers who improve their quality of life and live in a safe environment.	a. Increase the number of customers who demonstrate stability of life factors, i.e. employment, income, housing, education, health, etc. b. Increase the number of customers who reside in a safe, stable home environment.
6. Increase the number of customers who adopt a drug-free workplace policy.	a. Increase the number of customers who adopt a drug-free workplace policy. b. Decrease the number of customers who use alcohol and other drugs in the workplace
7. Decrease criminal justice involvement	a. Decrease criminal justice involvement
8. Increased access to services (services capacity)	a. Increased access to services (services capacity)
9. Increase retention in prevention programs	a. Increase retention in prevention programs.

- ***PRIORITY: Adult and family of youth consumers report that they are satisfied with the quality of their care and participate in treatment planning***

Consumer Satisfaction—The Board assesses each provider’s consumer satisfaction through the employment of consumer interviewers who assess a representative sample of more than 2,500 consumers from all treatment providers on an annual basis using the CSQ–8 item survey in a telephone interview. Results are scored for each provider and compared to system averages by population served and benchmarked to national studies of behavioral health consumers.

We compile data from consumers responses in order to determine our system average as well as the typical responses from consumers at each agency. This enables us to compare the quality of our consumers’ experience in treatment across providers.

For SMD and GAOA clients, please refer to Adult Consumer forms

Item #15 in Consumer A & B forms asks: “I have been treated with dignity and respect at this agency.” If the client answers 4 or 5, then this client is counted as being treated with adequate dignity and respect. If the client answers 1 or 2, then this client is counted as not being treated with adequate dignity and respect. If the client answers 3, then this client is counted as being treated with average/mediocre dignity and respect.

For SED & Children & Adolescents (C&A) clients, please refer to Parent Forms

Item #2 in the Satisfaction section asks: “To what degree have you been included in the treatment planning process (for your child)?” If the client answers 1, 2 or 3, then this client is counted as having a positive view of being involved in his/her (child’s) treatment. If the client answers 4, 5 or 6, then this client is counted as having a negative view of being involved in his/her (child’s) treatment.

- ***PRIORITY: Increase the number of consumers reporting positively about social connectedness and functioning and client perception of care.***

System Quality Improvement (SQI) Indicators—Consists of 15 measurable indicators of client access, appropriateness (process measures) and client outcomes, using provider submitted data from our data warehouse, including claims data, behavioral health data, and client outcomes, all required by contract. Providers are assessed and compared to system averages and set thresholds for performance.

We used the the following in our comparative analysis across providers regarding the consumer outcomes from treatment:

Number of people who experience an increased level of functioning

- For SMD & GAOA clients, Quality of Life Subscale (QOL) is taken as the proxy of level of functioning.
- For AOD clients, Employment Condition and Family Relationship are taken as the proxy of level of functioning.

- For SED and *Children & Adolescents (C&A)* Clients, Functioning Subscale is used to indicate the level of functioning.

- ***PRIORITY: Decrease homelessness.***

Continue planning, funding and evaluating interventions that decrease homelessness. In collaboration with ODMH and Southeast, Inc., ADAMH funds and monitors the PATH Program (Projects for Assistance in Transition from Homelessness), locally known as the Project Liaison/Mobile Psychiatric Van. This program serves persons who are homeless who are also severely mentally disabled or have co-occurring addiction disorders. Southeast’s program provides assertive outreach on the streets and in the shelters; builds authentic relationships through engagement and emergency material assistance; delivers behavioral health and medical services, and facilitates linkages to benefits, ongoing treatment and housing. In 2010, the program hired a peer veteran to reach out to this priority population and increase access to VA benefits. The newest developments include hiring an another peer outreach worker; building in more opportunities for consumer input into the program design and operations; significantly increasing planned volume of clients; the purchase and retrofitting of a larger replacement for the older van which was having major mechanical problems; and enhancing client-specific enrollment and claiming.

- ***PRIORITY: Decrease re-hospitalization at Regional Psychiatric Hospitals in 30 and 180 days***

Continue decreasing re-hospitalization. ADAMH, our Lead Agencies for persons who are SMD, and TVBH are achieving important reductions in one of the Board’ highest priority outcome indicators. Please see the improving percent and volume of people discharged from a Regional Psychiatric Hospital who remained in the community over 30 days without readmission:

	2007	2008	2009	2010	Thru June 2011
Percent	86.5%	87.3%	90.1%	90.5%	92.3%
N Discharged	995	1,124	1,148	1,146	627

Source: Claims Rcvd by 7-29-11 and PCS thru 6-30-11 (SQI Outcome #1, 8-4-11)

Access to Services

Question 13: What are the Board’s goals and objectives for addressing access issues for behavioral health services identified in the previous section of the Plan?

In line with the Board’s objective of maintaining services to the most vulnerable, legislatively mandated populations (e.g. SMD, SED, pregnant and IV drug users), the ADAMH Board of Franklin County, in collaboration with Franklin County Children Services, Franklin County Common Pleas Court, Division of Domestic Relations and Juvenile Branch, and Franklin County Family and Children First Council, has successfully leveraged state and federal grant monies for the purpose of developing, implementing and expanding our Behavioral Health/Juvenile Justice model to meet the treatment and support needs of youth and their families who, at a minimum,

are seriously emotionally disturbed, substance abusing, serious juvenile offenders and may be involved in the child welfare system.

The proposed model will move a youth from the Franklin County Juvenile Court Pre-Sentence Investigation through a screening and assessment process that involves a care coordinator who facilitates the delivery of service throughout the program. Care coordinators engage families and provide linkage and bridging to evidenced-based treatment services including MST, FFT, and MDFT. The service delivery team includes the youth and family, probation officer, school, family defined support, treatment providers and other system representatives as necessary. The development of this initiative reflects the cooperative atmosphere and willingness to work together by members of different systems with interests in increasing access to services for this target population. It is a shared goal of our community partners to maintain this service in future years.

As part of the aforementioned Behavioral Health/Juvenile Justice model, ADAMH and the system partners will continue to jointly plan, fund and evaluate the evidence-based practices that provide the treatment portion of the model. These practices include six MST teams that are provided across three separate agencies and one FFT team.

Workforce Development and Cultural Competence

Question 14: What are the Board's goals and objectives for SFY 2012 and 2013 to foster workforce development and increase cultural competence? Please discuss the areas of most salience or strategic importance to your system. What are the Board's plans for SFY 2012 and 2013 to identify, increase and assess cultural competence in the following areas: Consumer satisfaction with services and staff, staff recruitment (including persons in recovery) staff training, and addressing disparities in access and treatment outcomes? (Please reference Appendix D for State of Ohio definition of cultural competence.)

Cultural Competence Goals and Objectives 2012-13: The ADAMH Board of Franklin County clearly understands the importance of ongoing and continuous activities associated with cultural competence. The Board has and continues to fund and support efforts that increase the awareness, sensitivity, and competence of our system to serve diverse and underserved clients. Providers are also well aware of the emphasis the Board places on cultural initiatives. What is important to the Board is to ensure that a comprehensive and well-constructed cultural competence program be in place for the system. The Board is also mindful of that cultural competence is not a destination, but an ongoing process. That said, the Board must understand and be flexible to environmental changes such as new emerging populations, shifts in outcomes and disparities in care, programs and services that reflect the needs of populations served, and other key components outlined in the P.A.S.P.O.R.T. model illustrated above.

1. Faith Community Partnerships: to develop strong and sustaining partnerships with faith community leaders to support system treatment and prevention efforts.
 - a. 2011-2013 Summer Youth Safety Prevention Program in areas where youth are high risk for use of AOD, exposure to violence, paucity of structured summer programming, and communities with schools on academic emergency (Children's Defense Fund Model in collaboration with Faith Community/Shalom Zone).

- b. 2011 Fall Faith Leader Symposium designed to share existing models within these institutions that address counseling, AA, prevention, and other support services. Issues identified as a result from this symposium will be addressed in 2012-13.
- 2. Community Engagement and Relations
 - a. Serve on organization boards, committees and workgroups designed to establish supports for our diverse consumers.
 - b. Seek out community partnerships and collaborations that further the support of the holistic needs (i.e., health, behavioral health, social issues, etc.) of ethnic minority and emerging populations (i.e., Somalis, Iraqis, etc.). Additionally, seek ways to address the issues associated with stigma related to seeking / accessing treatment.
 - c. Continue legislative support efforts that will benefit all populations, but inform them about the unique needs for diverse communities.
- 3. Grant Development
 - a. Partner with providers seeking grants to address the needs of diverse communities (e.g., Mental Health Services for Somalis, Substance Abuse/Domestic Violence within Latino Community, etc.).
 - b. Draft specific grants by ADAMH to explore disparity identification, reduction and monitoring at both the system and provider level. One goal is to partner with or seek funding support from ODMH to begin work to develop a model that can be implemented statewide to address disparities impacting minority populations.
 - c. Partner with MACC provide grants for cultural competence development.
 - d. Seek funding supports for new technologies for interpretation (poss. video) and translation services.
- 4. Training and Education Supports
 - a. Provide information and resources to ADAMH providers around new developments in serving diverse populations.
 - b. Support efforts of MACC to offer basic training to health/human service staff.
 - c. Find low cost and productive (i.e., online) ways to institute training.
- 5. Cultural Competency Extranet for Provider and Community Supports
 - a. Build a solid online resource for provider system regarding best practices in cultural competence.
 - b. Establish an online resource (clearinghouse) for local faith leaders (regardless of religion) that provide information from behavioral health issues to training we offer on recognizing, addressing, counseling options, and referral to system services.
 - c. Establish a community section on the web for diverse communities with issues and challenges to accessing services and how to over barriers.
- 6. Marketing and Outreach to Minority Community
 - a. Establish ways to keep diverse communities informed about specialized services.
 - b. Coordinate with local media outlets to obtained earned media and public service announcements to better inform minority communities about behavioral health (i.e., anti-stigma, prevention, treatment, etc.).
 - c. Serve on committees, planning workgroups and organizations of representing diverse communities to be better informed about needs and solutions.

The Board ensures that consumers representing diverse populations are identified for ADAMH's consumer satisfaction surveys. Previous evaluations of services have shown no statistical difference between minority populations and non-minority in terms of levels of satisfaction.

Staff Recruitment:

ADAMH ensures the hiring of diverse staff in the system of care. As indicate earlier, minority staff represented the population that was served in our system of care during the last review. What is needed for future assessments will be to examine staff in the context of employment classification (i.e., executive, professional, administrative, etc.). The importance of employing mental health, alcohol and drug consumers is important. Many providers employee consumers in a variety of ways, particularly consumer operated services. Many AOD treatment providers benefit greatly by employing persons in recovery to serve in various treatment roles. The ADAMH Board itself contracts with consumers administrating consumer satisfaction surveys.

Staff Training

Cultural competence training is critically in terms of staff development in the system. Unfortunately, funding cuts will impede the system's ability to adequate provide consistent training to a wide range of individuals who provide services to diverse communities. Providers are responsible to provide their own training in this area since our system wide training efforts ended. The Board will continue to identify ways to support both individual and collective cultural competency training through individual provider efforts, Multiethnic Advocates for Cultural Competence, and low cost online forums.

Disparities in access and Treatment Outcomes:

The Board monitors system quality indicators in terms of identifying disparities among service demographics. In particular, data is examined by race, ethnicity, age and gender to determine if significant differences exist in access and treatment domains. ADAMH will continue to address system access issues by identifying areas of concern and utilizing the ProviderStat format, clinical director meetings, and other methods to pinpoint areas of concern. Additionally, ADAMH will work with SAMHSA, Office of Minority Health, and other local and regional office who also seek to address disparities based on access, quality, and outcomes.

Ultimately, the ADAMH board will continue to address cultural competency in all aspects of our business, as illustrated in the P.A.S.P.O.R.T. model above. More importantly, we will provide encouragement, incentives, supports and offer other methods to providers to encourage their staff to identify, understand, and respect the uniqueness of culturally diverse communities in order to provide the best quality care in meeting the individual and collective needs of those who are served. Since our Consumer Satisfaction surveys indicate no statistically significant difference between minority and non-minority consumers regarding satisfaction with services, we consider this aspect of our work quite successful.

ORC 340.033(H) Goals

Question 15: To improve accountability and clarity related to ORC 340.033(H) programming, ADAMHS and ADAS Boards are required to develop a specific goals and objectives related to this allocation.

ADAMH's Managing For Results system is designed to ensure that public resources are being used in the most efficient and effective manner to serve as many consumers as possible with quality alcohol/drug and mental health treatment and prevention services. Our current goals are as follows:

1. 85% of adults receiving abstinence-based AOD treatment (non-medically assisted services) will show improvement in at least four areas of recovery.
2. 90% of consumers who receive medically assisted treatment services (methadone and Buprenorphine only) will show improvement/stability in at least four measures of recovery.
3. 45% of consumers receiving sub-acute and ambulatory detoxification services from Maryhaven will show linkage and continued treatment at Maryhaven or another ADAMH service provider within 7 days of discharge.
4. 80% of consumers receiving Engagement Center services will engage in AOD treatment, not including assessment, within 60 days of discharge.
5. 33% of ADAMH AOOD funding for adults will be invested in services and supports for persons involved in the criminal justice system.

We are on track to meet these goals, and will be developing new goals through our Managing For Results process later this calendar year.

HIV Early Intervention Goals-

Question 16: ADAMHS and ADAS Boards receiving a special allocation for HIV Early Intervention Services need to develop a goal with measurable objective(s) related to this allocation.

The ADAMH Board is continuing its commitment to invest in HIV/AIDS/STD/TB and Hepatitis-C education, outreach and testing services to reduce the spread of HIV/sexually transmitted diseases in high risk populations.

This strategy establishes or changes written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of substance abuse in the general population – (an ATOD prevention strategy that represents a broad range of activities geared toward modifying systems in order to mainstream prevention through policy and law. The environmental strategy establishes or changes written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of alcohol and other drug use/abuse in the general population).

Addressing Needs of Civilly and Forensically Hospitalized Adults

Question 17: ADAMHS and CMH Boards only: Address how the Board will meet the needs of civilly and forensically hospitalized adults, including conditional release and discharge planning processes. How will the Board address the increasingly high number of non-violent misdemeanants residing in state hospitals?

ADAMH Franklin County continues to have an assertive role in working with the state hospital and provider agencies around hospital utilization management which includes civil and forensic patients. Representatives from the Board and Community Housing Network meet weekly with TVBH staff to review every patient that has been in the state hospital for 14 days or longer in order to identify and then address barriers to community placement.

The Board has developed a program to authorize and fund placement of homeless men in the local YMCA temporarily while awaiting more permanent housing options. Franklin County received federal stimulus dollars for housing homeless individuals as well and all of the money was targeted to homeless patients in the state hospital. Neither TVBH, the Board or providers restrict the use of these funds based on a patient's legal status – only clinical need is considered.

The Board works closely with the state hospital and forensic monitors in developing discharge plans for persons entering the community on conditional release. The Board is represented at discharge planning meetings as necessary in addition to the weekly utilization management meetings. The majority of patients leaving the state hospital on conditional release are linked to CSN as the provider agency and team with the additional skill set and expertise to deal with both the patient's clinical needs (small caseload, frequent contact) and the legal system requirements (regular reporting to the courts, monitoring, etc.) If patients have a pre-existing relationship with another provider and wish to continue it, the Board honors that request and assists the provider agency with meeting the court's expectations and legal requirements associated with conditional release. The Board CCO stays in close communication with the county forensic monitors and actually conducts the mandatory evaluations of patients on conditional release in the community providing direction to the provider as well as updates to the court on the patient's condition.

With respect to non-violent misdemeanants in the state hospital, the Board embraces a three-pronged approach: diversion, assertive utilization management/discharge planning and community resource development. Data published by ODMH regarding hospital utilization by non-violent misdemeanants in Franklin County demonstrates that this approach is quite effective when numbers of patients and lengths of stay are compared across the state, particularly with urban counties.

Diversion: In collaboration with the Columbus Police Department, NAMI and other community stakeholders, the Board has resumed CIT training for law enforcement and first responders occurring three times per year in attempts to divert non-violent misdemeanants with mental illness into community treatment rather than jail or admission to the state hospital.

Assertive utilization management/discharge planning: As described above, the Board is represented at weekly utilization review meetings with hospital staff and a housing provider

reviewing all patients that have been hospitalized for two weeks or longer in order to identify and then address barriers to discharge. Temporary housing subsidies have been developed by the Board and received from the federal government and these are targeted to homeless persons in the state hospital. In addition, patients who are high utilizers of inpatient services may be referred to an IDDT-ACT team in the community, all of which are demonstrating a positive effect on reducing criminal recidivism in addition to reducing homelessness, reducing use of the state hospital and crisis services and improving clinical conditions. The Board also works closely with the hospital's Forensic Review Team and the forensic monitors to monitor lengths of stay to ensure that hospital lengths of stay are related to clinical need and not solely an artifact of criminal justice involvement.

Community resource development: These patients are eligible to receive temporary and permanent housing subsidies that have been earmarked for state hospital patients; may be enrolled onto an IDDT-ACT team and/or be transferred from the state hospital into intensive AOD treatment if clinically appropriate and the patient expresses a desire to do so. The Board is also working with community stakeholders including the community shelter board and various components of the re-entry task force to seek demonstration project grant funding to expand IDDT-ACT capacity to encompass high utilizers of the shelter system, jail, mental health and AOD systems.

Implications of Behavioral Health Priorities to Other Systems

Question 18: What are the implications to other systems of needs that have not been addressed in the Board's prioritization process?

We have already seen the results of budget cuts to Behavioral Health services in our community, as evidenced by the following:

- Persons with routine care needs that are not listed in prioritized or mandated population categories wait longer for services and are likely to not receive services at all in our system.
- Local emergency rooms have been receiving a higher number of uninsured persons with mental health and substance abuse service needs.
- Many of our Medicare recipients have been referred to primary care physicians, many of whom are reluctant to be responsible for managing psychotropic medications and other needs of this population.

Contingency Plan: Implications for Priorities and Goals in the event of a reduction in state funding

Question 19: Describe how priorities and goals will change in the event of a reduction in state funding of 10 percent of the Board's current annual allocation (reduction in number of people served, reduction in volume of services, types of services reduced, impact on monitoring and evaluation etc). Please identify how this reduction in services affects specific populations such as minorities, veterans and "high-risk" groups.

Our priority will remain to serve the legally mandated populations and attempt to minimize the negative effects of lack of services on other populations. Further budget cuts will, of course

make this effort much more difficult. The ADAMH Board of Franklin County has prioritized the following service delivery strategic investment objectives;

- Maintain services to most vulnerable, legislatively mandated populations (e.g., SMD, SED, pregnant and IV drug users).
- Purchase services from providers that demonstrate the best quality, most efficient and cost effective use of non-Medicaid funds.
- Maintain geographical presence.
- Maintain current ratio of treatment and prevention services.
- Maintain culturally competent services that meet the diverse needs of Franklin County residents.
- Leverage investments where initiatives are consistent with ADAMH priorities.

Given these priorities, the Board's current investments in both prevention and treatment services have been developed with these strategic investment objectives in mind. Allocation reductions, increases and realignments have been instituted with these core service strategies as our overarching guide. Our most recent local allocation reductions resulted in the following impact on our system of care:

- Service system remained intact with full compliment of providers, but some services and programs were reduced.
- Current geographical presence was maintained.
- Crisis services maintained at current levels (e.g., 24/7 crisis services intact, detoxification services intact, methadone/buprenorphine programs intact, engagement services for homeless, publicly inebriated adults intact).
- Service reductions focused on non-direct service supports, areas of low performance and future innovation programs that would have been funded with system innovation funds supported by local levy.
- Maintained services to most vulnerable, legislatively mandated populations (e.g., SMD, SED, pregnant and IV drug users).
- Maintained pledge that 95% of all revenues are at the service level by reducing both Board administrative and provider allocations simultaneously.

As noted above, our community is extremely fortunate to have been able to maintain a full compliment of services targeting individuals in need of behavioral health care interventions even after extensive budgetary reductions were instituted in the past 12 month period. This ability is largely due to our local levy and the acquisition of some large federal, state and local grants which we have aggressively pursued. We will be faced with more comprehensive system restructuring should there be additional reductions to our local behavioral health care budget from the state. We have attempted to keep our system of care intact to the greatest degree possible, but understand that adjustments will have to be made as we respond to deeper cuts. Other drivers impacting our budget include the increase in state hospital utilization, Medicaid match requirements and reductions from other funding sources historically utilized to augment our system provider's budgets (e.g., United Way, City of Columbus).

IV. Collaboration

A. Key Collaborations

B. Customer and Public Involvement in the Planning Process

C. Regional Psychiatric Hospital Continuity of Care Agreements

D. County Commissioners Consultation Regarding Child Welfare System

SECTION IV: COLLABORATION

Key collaborations and related benefits and results

Question 20: What systems or entities did the Board collaborate with and what benefits/results were derived from that intersystem collaboration? ADAMHS and CMH Boards should include discussion regarding the relationship between the Board and private hospitals.

ADAMH participates in a Ohio Hospital Association convened workgroup that brings together leadership of all Franklin County local psychiatric hospitals, including Netcare and Twin Valley Behavioral Healthcare . Through the work of this group the collaborative Hospital Bed Board became available for use by Netcare, TVBH, Ohio State University Medical Centers, Mount Carmel, and Ohio Health hospitals. The availability of this active client-exchange system has greatly improved the transfer of clients needing inpatient psychiatric hospitalization and in achieving the goal of getting the right client to the right location at the right time. Netcare began to participate in daily conference calls with the private hospitals, with the goal of getting the right client to the right location at the right time. This process includes transferring clients to/from Netcare, as well as clients shifting between the private hospitals.

Additionally ADAMH convenes a workgroup that includes representation from three local private hospitals, Netcare and five of our Lead agency mental health providers with the purpose to ensure timely linakge to outpatient care for individuals being dischargd from these acute care settings.

ADAMH sits on the Franklin County Re-Entry Task Force and co-chairs the Housing/Behavioral Health subcommittee of this larger Task Force. This participation has lead to collaborive efforts on several grant proposals, improved communication and problem-solving efforts between our criminal justice and local housing partners, as well as a recent focus on our shared cross system consumers who frequently utilize ADAMH services, local homeless shelters and the Franklin County Jail.

The Franklin County BHJJ Initiative, now in its fifth year, was developed to meet the treatment and support needs of youth who, at a minimum, are seriously emotionally disturbed, substance abusing, serious juvenile offenders and may be involved in the child welfare system. This model has improved intersystem communication and shared outcomes among the behavioral health, juvenile justice, and child welfare systems. This initiative was researched, designed, and will

continue to be implemented by the Cross System Initiative Committee (CSI), a local partnership that includes ADAMH, Franklin County Children Services, Franklin County Common Pleas Court, Division of Domestic Relations and Juvenile Branch (Juvenile Court), and Franklin County Family and Children First Council.

The development of this proposal reflects the cooperative atmosphere and willingness to work together by members of different systems with interests in the same target population. Community partners have designed a program that involves parents, schools, child welfare, behavioral health and juvenile justice systems. Collaboration partners have committed time, resources and funds to the success of the initiative.

ADAMH participates on the Franklin County Family and Children First Financial Oversight Committee. The goal of this collaboration is to assist system partners with increasing the access, capacity and effectiveness for the most vulnerable Franklin County youth and their families whose needs extend beyond any of youth-serving program in the community.

ADAMH participates on Changing Environment and Attitudes for Substance Elimination (CEASE) Prevention Coalition, is a faith-based, culturally specific HIV/AIDS and substance abuse prevention/intervention program designed to establish and strengthen collaboration among faith and community-based organizations, community re-entry and local governments to prevent and reduce substance abuse and HIV/AIDS in the African American community.

ADAMH participates on the Ohio Afterschool Network which supports children, youth, families, and communities by advocating and building capacity with a unified voice for sustainable investments in safe, healthy, and nurturing afterschool experiences. The network of over 600 (and growing) after school advocates serves as a vehicle to bring together a number of systems and stakeholders, including policymakers, educators, parents, and service providers.

ADAMH participates on the Franklin County Suicide Prevention Coalition whose goal is to prevent suicide by increasing public awareness by engaging a wider base of concerned stakeholders, training to gatekeepers and developing public relations/media activities to educate the public at large.

ADAMH and Community for New Directions joined with Franklin County SPF Urban Coalition members from Columbus Public Health, Urban Minority Alcoholism and Drug Abuse Program, Ohio National Guard, Columbus Public Schools, Community Research Partners, Neighborhood House, New Covenant Church and young adults to implement the Strategic Prevention Framework on a community level that ultimately results in residents examining their norms around alcohol and marijuana use and choosing to engage in environmental strategies that will reduce alcohol consumption and marijuana use in the 18-25 age group.

ADAMH participates on the [Ohio Suicide Prevention Foundation](#) (OSPF) whose purpose is to build and support a statewide infrastructure of community programming that promotes suicide prevention, works to eliminate stigma, and encourages early intervention for Ohioans that are suffering from suicidal thoughts, mental illness, and alcohol and drug addiction.

ADAMH participates with the Alcohol and Drug Abuse Prevention Association of Ohio

(ADAPO), a membership-based association that serves as the voice of alcohol, tobacco and other drug prevention in Ohio. The association sponsors training and networking opportunities for alcohol and other drug prevention professionals.

ADAMH serves on the ODADAS Prevention Investment Planning and Reporting System (PIPAR) User Workgroups as a way to gather feedback from the field regarding the PIPAR system implementation process with Boards and Providers.

Involvement of customers and general public in the planning process

Question 21: Beyond regular Board/committee membership, how has the Board involved customers and the general public in the planning process (including needs assessment, prioritization, planning, evaluation and implementation)?

Consumer and Family involvement is an important component of the ADAMH Board's structure and operations. We seek and value input and feedback from consumers through various board activities. This is an essential ingredient to ensure that ADAMH strives to be recovery driven in its mission of improving the well-being of our community by reducing the incidence of mental health problems and eliminating the abuse of alcohol and other drugs in Franklin County. The following are ways that the board seeks to engage and incorporate consumer /family input into its business operations.

Board of Trustees: ADAMH by statute must have a primary (secondary) consumer of mental health and alcohol and other drug services on its Board. The following is also incorporated in ADAMH Policies and Procedures Section 4.1.2. *The ADAMH Board, Provider Leadership Association and the Consumer and Family Advocacy Council shall collaboratively implement strategies to further the involvement of consumers and families in providing recommendations and advice on identifying needs, planning, prioritization, implementation/delivery and evaluation of mental health, alcohol and other drug addiction services.* This is done through a variety of mechanisms that ensures that all the work of the Board has consumer and family participation as sanctioned by the Board of Trustees. Besides the use of consumers, families, and the general public in the formal planning structures as shared above, the Board finds other ways to engage consumers for having their influence on our daily operations.

- a. **Coordinating Committee of the Board:** A committee of the ADAMH Board of Trustees whose purpose is to review, discuss, and recommend actions to the full board for decisions and approval. There is usually a consumer and family member who participates on this committee – to ensure that their perspectives are articulated.
- b. **ADAMH Board Strategic Business Plan:** A process that establishes the strategic direction for board and system services. The plan is evaluated annually and incorporates consumer and family input and feedback into this process. The purpose of this plan is designed to ensure that public resources are used in the most efficient and effective manner to serve as many consumers as possible with quality alcohol/drug and mental health treatment and prevention services. Consumers participate in the Board planning process that is under the auspices of the board of trustees.
- c. **Managing for Results System (MFR):** An outcome of the strategic business plan is the cornerstone of the MFR system, which incorporates both the Strategic Results portion (i.e., longer range/overarching goals and the Operational Results). These results

drive the development of internal lines of business and guide the board annually in its operations. Consumers and Family members are involved in the review and creation of this document and participate actively with an internal process to monitor these results called ADAMH-STAT.

d. **ADAMH-STAT:** The internal performance review platform that monitors all of the annual board results (metrics) in the MFR Performance Plan under all Lines of Business. ADAMH invites consumers to participate (i.e., ask questions / provide input) on these weekly meetings that review all board quarterly results. Consumer input in this process helps board staff understand how recipients of service perceive outcomes and results.

e. **Policy and Procedures:** ADAMH also utilizes consumer and family involvement in the review of both system and internal policies and procedures process. This process is conducted every couple of years and consumer input is critical to ensure that system policies and practices are both consumer centered and recovery focused.

f. **Consumer and Family Focus Groups:** The Board periodically seeks consumer and family input to ascertain opinions about a variety of issues regarding operations. One example is when the board sought feedback regarding the development of Provider Contract language to ensure consumer and recovery centeredness.

CFAC (Consumer and Family Advocacy Council) - Structure ADAMH uses for obtaining consumer/family input.

Mission Statement

The Consumer and Family Advocacy Council (CFAC) is an organization which promotes education, support, empowerment, and activism of consumers and families within the mental health and addiction recovery services of Franklin County.

Vision Statement:

The Consumer and Family Advocacy Council strives to fulfill the right of Franklin County residents requiring mental health and/or addiction recovery services to receive appropriate, accessible, and timely care.

The ADAMH Board established an advisory council to assist in assessing and shaping our community system of care. The council is designed to fully address the advocacy needs of consumers and families in terms of system services. Below is a timeline of the Development of CFAC and below the timeline is the current state of CFAC and the Mission and Vision Statement that was developed.

Consumer Council History

1989 Consumer Advisory Committee established. At that time there were approximately 10 members.

1997 Consumer, Family, Advisory Council (CFAC) was first established. After about a year, we decided we needed to do something to help out the system. We decided to work on a resource booklet for other consumers in need of help. As a result of this effort a Solutions Flyer was developed that is widely embraced and utilized by ADAMH's system of care. Netcare requests Solutions Flyers from CFAC which

- they share with Consumers who are seeking resources.*
- 1999 *The ADAMH Board began to sponsor annual leadership training for consumers and family members.*
- 2000 *CFAC began to do sensitivity training to ADAMH staff on consumer and family issues.*
- 2001 *CFAC successfully advocated for a system Ombudsman (an advocate to help consumers solve treatment and other related problems). Mental Health America of Franklin County employs Central Ohio's only full-time, mental health Ombudsman.*
- 2002 *Ohio State Auditor named the ADAMH Board of Franklin County's CFAC as a best practice in its Performance Audit Report of the Cuyahoga County Community Mental Health Board*
- 2003 *CFAC president instituted a quarterly meeting between the ADAMH CEO and the President of CFAC to discuss the work of the Council and ADAMH staff.*
- 2004 *CFAC began to become very involved in virtually every ADAMH workgroups and committees.*
- 2005 *NAMI – Ohio (National Alliance for the Mentally Ill) honored ADAMH Board and CFAC by presenting the Board of the Year to Franklin County for the consumer and family volunteer involvement at this Board*

Currently CFAC members are involved in several workgroups and committees at the ADAMH Board—Examples are: CIT (Crisis Intervention Training) Agency Services Plan, Consumer/Provider Stat, Visual Performance Management, Clinical Directors, Coordinating Committee, among others.

Below are examples of how CFAC members are interwoven into assisting to improve our System of Care:

CIT (Crisis Intervention Training): Implements training programs to assist police officers to become more competent in working with people with mental illness by increasing their sensitivity and improving their skills. Both a Consumer and Family Panel are utilized to share their perspectives and offer strategies on ways officers should engage consumers during crises.

ASP (Agency Services Plan Review): Provides feedback from the perspective of consumers and family members on services proposed by contract agencies. Goal is to review Agency Services Plan submitted by contract agencies and offer feedback to Network Services in preparation for the new contract year to ensure services are consumer centered and recovery focused. . The Board established consumer/family focus groups through CFAC to obtain feedback on the development of actual contract language.

Grant Development: Over the past several years ADAMH has not only written grants to support consumers and families, but also utilizes their input on the development of funding grants.

Visual Performance Management(VPM): ADAMH utilizes a unique process of posting visuals (i.e., pictures, artwork, and images of consumers), history timelines, performance

data/metrics and other visual aides to communicate visually the mission, performance, and work of ADAMH. A consumer representative participates on this monthly workgroup.

Public Relations / Community: ADAMH consistently utilizes consumer and family members in marketing / advertising campaigns and publications. Consumer and family members also represented at community events such as recovery month and other public gatherings.

Advocacy: Members of CFAC also serves as a voice to other consumers through various committees related to their work. Those include, but not limited to: *Action Committee* – examines legislation that impacts consumers and establishes ways to support initiatives that they perceive as beneficial – up to and including meeting with legislators and providing formal testimony; *Resource Center*- members have access to an office with a computer, literature, books, documents, and other items to help them conduct business both within the board as well as within the provider network and community; *Education* – members plan a variety of speakers, films, document sharing, and training that helps educate other consumers/families and the community about behavioral health. Once a year there is a Saturday training day that is open to the public on a variety of mental health issues.

ADAMH values the importance of consumer and family involvement at all levels of our Board operation. It truly feels natural to have engaged consumers at the table for planning meetings, projects, key document reviews, annual provider reviews, and other key activities of the board. ADAMH also wants to ensure we value consumer input by offering them a survey to tell us how we are doing with the business of consumer involvement on workgroups and committees. We believe this strong partnership with consumers and families ensures better outcomes for consumers system-wide and the community at-large.

Franklin County SPF Urban Coalition

ADAMH partnered with Community for New Directions, Columbus Public Health, the Urban Minority Alcoholism and Drug Abuse Program, to write a proposal to form the Franklin County SPF Urban Coalition which was funded by ODADAS. The Coalition utilizes the Strategic Prevention Framework, a planning process comprised of five phases to assist communities in delivering and sustaining effective substance abuse prevention. Communities assess prevention needs based on epidemiological data, build prevention capacity, implement effective community prevention programs, policies and practices and evaluate their efforts for outcomes. Integral to each step in the framework is cultural competence and sustainability. We are implementing the Strategic Prevention Framework with coalition members from Ohio National Guard, Columbus Public Schools, Community Research Partners, Neighborhood House, New Covenant Church and young adults 18-25 primarily African American or Latino from Columbus neighborhoods. Implementing the Strategic Prevention Framework on a community level ultimately results in residents examining their norms around alcohol and marijuana use and choosing to engage in environmental strategies that will reduce alcohol consumption and marijuana use in the 18-25 age groups.

Faith-Based Summer Pilot Project

As a part of ADAMH's Faith-Based Outreach Initiative, staff met with faith leaders to learn

more about their experiences addressing behavioral health issues within their congregations and community. We learned that faith leaders are confronted with problems associated with youth and gang violence, crime, domestic violence, substance abuse, mental health issues, and other challenges. Faith leaders shared that youth are exposed to a myriad of issues that include, but not limited to, alcohol and other drug use by parents/caregivers, domestic and family violence, open drug trafficking and solicitation, peer pressure to use drugs, and other issues. Youth who are exposed to these problems often exhibit behavioral problems at home, experience academic failure, and find it difficult to navigate peer relationships. Faith communities responded to neighborhood youth by offering them a place to come for spiritual growth and homework assistance to provide some level of support.

Faith leaders also shared that the economy is exacerbating these problems, and, with limited alternatives, they need help to address such problems – particularly among youth. Without the supports of structured summer activities, many youth are most vulnerable to substance abuse, violence, and crime in poor communities. The faith leaders' observations were confirmed by Ohio Department of Education (ODE) School report Cards in regards to school failure and economic disadvantage status in these neighborhoods. It is reported that children of alcoholics start using alcohol or drugs at an earlier ages and are four times more likely than non-children of alcoholics to develop alcoholism and more likely be exposed to family violence. SAMHSA recommends using Evidenced Based Prevention Practices that utilize protective factors that build resiliency in youth and families, as well as mitigate the influence of risk factors. Based on the discussions with faith leaders and community profile data from various sources, we developed in partnership with community and faith partners a summer program for at-risk youth at five sites (50 youth per site a total of 250) throughout Franklin County that Community for New Direction coordinated to increase protective factors in school-age youth (6-18). The Shalom Zone, Westside coalition, Church of Christ of the Apostolic Faith (Northeast) and Family Missionary Baptist Church (Southside) faith based groups' submitted proposals that addressed academic skills primarily reading and computer skills, violence prevention and cultural enrichment. The summer pilot programs engaged youth in key life domains that strengthen their ability to address problems at home, at school, with the family and in the community.

Regional Psychiatric Hospital Continuity of Care Agreements

Question 22: ADAMHS/CMH Boards Only: To ensure a seamless process to access and improve continuity of care in the admissions, treatment and discharge between state hospitals and community mental health providers, describe how Continuity of Care Agreements have been implemented and indicate when and how training was provided to pre-screening agency staff. Please indicate the number of system staff that has received training on the Continuity of Care Agreements.

Our existing COC Agreement is operative on a two year cycle. Every two years we solicit input from Lead agency clinical leadership and Twin Valley Behavioral Healthcare regarding potential changes to the document. The Franklin County ADAMH Board then compiles the suggested revisions/additions and negotiates them as needed through our existing ADAMH provider system Clinical Director's meetings and/or our UM process with TVBH. Each year we may make minor revisions only on an as needed basis.

TVBH and ADAMH host a Case Manager orientation and training at TVBH on a quarterly basis,

required for any/all Franklin County case managers new to the system that are part of the ADAMH provider network. The number of participants for each training varies (typically 8-20), and in 2011 the expected number of trained case managers is projected to be between 35-75. As a part of this training the COC Agreement is reviewed. Additionally, each Lead provider agency in Franklin County employs a designated Hospital Liaison who works closely with hospital staff (particularly social workers) to assure all treatment services for clients are coordinated with the community provider(s). Hospital Liaisons meet with TVBH Clinical Leadership at a minimum of every other week to problem solve challenging cases, coordinate efforts and fine tune discharge planning processes. Having this single point of contact with each Lead Agency has worked well for our System of Care and has contributed to a more streamlined discharge planning process for Franklin County clients.

The Franklin County ADAMH System has one contract agency responsible for all pre-hospital screening services. This agency, Netcare, is involved in the system Clinical Director's meetings, provides input into the agreement and its content, and is as well responsible for ensuring all staff are likewise trained on the contents of the Agreement.

Consultation with county commissioners regarding services for individuals involved in the child welfare system and Funds available for parents/caregivers in the child welfare system

Question 23: ADAMHS/ADAS Boards Only: Describe the Board's consultation with county commissioners regarding services for individuals involved in the child welfare system and identify monies the Board and county commissioners have available to fund the services jointly as required under Section 340.033(H) of the ORC.

The Franklin County ADAMH Board and the Franklin County Children Services Board has implemented an Interagency Agreement which focuses on a commitment to work together to improve the service delivery system on behalf of children and families served by both systems. Our current projects are

- 1) An enhanced Transition-Age Youth Team for children with behavioral health care needs who are aging out/transitioning out of the child welfare system.
- 2) Two Multi-Systemic Therapy Teams (MST) which are targeting adolescent sex offenders and other children actively engaged in the criminal justice system.

V. Evaluation of the Community Plan

A. Description of Current Evaluation Focus

B. Measuring Success of the Community Plan for SFY 2012-2013

C. Engagement of Contract Agencies and the Community

D. Milestones and Achievement Indicators

E. Communicating Board Progress Toward Goal Achievement

SECTION V: EVALUATION OF THE COMMUNITY PLAN

Ensuring an effective and efficient system of care with high quality

Question 24: Briefly describe the Board's current evaluation focus in terms of a success and a challenge (other than funding cuts) in meeting the requirements of ORC 340.03(A)(4) and 340.033(H). Please reference evaluation criteria found in Appendix C with regard to your discussion of successes and challenges with measuring quality, effectiveness and efficiency.

The Franklin County ADAMH Board has an extensive and comprehensive sub recipient monitoring process which provides oversight for the expenditure of over \$140 million in Federal, State and local funds for the purpose of providing needed treatment and prevention services to people in need of mental health and alcohol and drug services. These processes are summarized below and include:

1. Provider STAT reviews—Each agency is reviewed in a face-to-face meeting once a year, using a comprehensive report that includes fiscal, planning and service data and client outcomes based upon provider data that covers the current year and previous two years performance. The data reports include the following key components for contract performance:

a. System Quality Improvement (SQI) Indicators—Consists of 15 measurable indicators of client access, appropriateness (process measures) and client outcomes, using provider submitted data from our data warehouse, including claims data, behavioral health data, and client outcomes, all required by contract. Providers are assessed and compared to system averages and set thresholds for performance.

b. Consumer Satisfaction—The Board assesses each provider's consumer satisfaction through the employment of consumer interviewers who assess a representative sample of more than 2,500 consumers from all treatment providers on an annual basis using the CSQ-8 item survey in a telephone interview. Results are scored for each provider and compared to system averages by population served and benchmarked to national studies of behavioral health consumers.

c. Fiscal Key Performance Indicators—Audit firms performs a ratio analysis for each contract service provider. These ratio analysis are applied to six objectives; 1) Current Ratio, 2) Debt to Equity Ratio, 3) Administrative Cost to Expenses, 4) Revenue to Expenses, 5)

Fund Balance Reserve, 6) Percent of Funding From ADAMH Board. The Board has entitled these analyses —Fiscal Key Performance Indicators and uses them to monitor Providers’ financial performance—in Provider STAT reviews.

d. Agency Service Planning commitments—Each provider submits annual service plans which include service commitments and budgets that are assessed for actual to budget performance.

e. Compliance with Outcomes (80% threshold level) and Behavioral Health data (70% threshold for intake and closure) submission is also measured and part of the performance index for monitoring, quality improvement and evaluation.

Collaboration with Providers in Evaluating Services.

2. The SQI indicators and Client Outcome data are also monitored throughout the year on a quarterly basis and feedback reports are provided to each contract agency for quality improvement purposes. Quarterly meetings are held with evaluation and quality improvement representatives (staff) from each provider for the purpose of ongoing monitoring and quality improvement using the data reports mentioned above. The providers also receive quarterly updates on outcomes compliance. In addition, we produce “benchmarking reports” which “mirror” the Statewide Outcomes reports from ODMH to compare Franklin County system results with the Statewide data, and each provider receives a report which compares their consumer outcomes data to the County and State reports. The quarterly meetings are held with provider evaluation and quality improvement staff by major populations served (SMI Adults, General MH Adults, AOD Adults, and Children and Adolescents), and the sessions are used for troubleshooting, questions and answers, and communications regarding using data for treatment planning and quality improvement.

Services or Programs Having the Highest Priority for the Evaluation of Effectiveness and/or Efficiency

3. The Boards priorities for services are by major population groups, MH SMI Adults, MH SED Children & Adolescents, AOD Adults, and all other MH and AOD populations. The SQI measures, Outcomes and Consumer Satisfaction data/information is broken out by these major populations for performance indexing, scoring and feedback to each provider for quality improvement purposes. The Board promotes and emphasizes "best practice" programs and services, and allocates dollars to these programs, such as those addressed in various previous sections of this plan. We are beginning to evaluate certain programs using the SQI, Outcomes and Consumer Satisfaction data in order to compare program methodologies and achievement of recovery for consumers. In this way, we can confirm the research for best practices through practical application of the recovery measures and direct our resources to the most efficient and effective programs and services.

Using the Results from the Evaluation of Programs/Services

4. As noted above, the primary purpose of the extensive evaluation and results monitoring system is to inform the system, providers and our Board for the purposes of feedback for quality improvement and treatment planning. We are also beginning to use the performance data to index the system of providers as one factor in funding decisions. The ODADAS performance

management system is utilized for Prevention services in order to determine program and provider performance for those programs and services. The information is also used in a similar fashion as treatment outcomes and indicators, for quality improvement and program planning.

Strategies to Evaluate Child & Adolescent Services Versus Adult Services

5. The Board uses similar strategies for evaluation of Child & Adolescent services, however, the outcome instruments (Ohio Scales) are specifically designed for this population. We also use many of the same Access and "process" or Appropriateness measures to assess both adult and child & adolescent services, but some are also different by population. Consumer Satisfaction using the CSQ-8 is also used for all populations, but we survey both the youth and their parents, so that strategy is different in a sense.

Determining Success of the Community Plan for SFY 2012-2013

Question 25: Based upon the Capacity, Prevention Services and Treatment and Recovery Services Goals and Objectives identified in this Plan, how will the Board measure success in achieving those goals and objectives? Identify indicators and/or measures that the Board will report on to demonstrate progress in achieving each of the goals identified in the Plan.

- a. How will the Board engage contract agencies and the community in evaluation of the Community Plan for behavioral care prevention and treatment services?*
- b. What milestones or indicators will be identified to enable the Board and its key stakeholders to track progress toward achieving goals?*
- c. What methods will the Board employ to communicate progress toward achievement of goals?*

Board's Approach to Evaluating the Effectiveness and Efficiency of Services in the Overall System of Care

A - The Franklin County ADAMH Board has an extensive and comprehensive sub recipient monitoring process which provides oversight for the expenditure of over \$140 million in Federal, State and local funds for the purpose of providing needed treatment and prevention services to people in need of mental health and alcohol and drug services. These processes are summarized below and include:

1. Provider STAT reviews—Each contract agency is reviewed in a face-to-face meeting once a year, using a comprehensive report that includes fiscal, planning and service data and client outcomes based upon provider data that covers the current year and previous two years performance. The data reports include the following key components for contract performance:

a. System Quality Improvement (SQI) Indicators—Consists of 15 measurable indicators of client access, appropriateness (process measures) and client outcomes, using provider submitted data from our data warehouse, including claims data, behavioral health data, and client outcomes, all required by contract. Providers are assessed and compared to system averages and set thresholds for performance.

b. Consumer Satisfaction—The Board assesses each provider’s consumer satisfaction through the employment of consumer interviewers who assess a representative sample of more than 2,500 consumers from all treatment providers on an annual basis using the CSQ–8 item survey in a telephone interview. Results are scored for each provider and compared to system averages by population served and benchmarked to national studies of behavioral health consumers.

c. Fiscal Key Performance Indicators—Audit firms performs a ratio analysis for each contract service provider. These ratio analysis are applied to six objectives;

- 1) Current Ratio,
- 2) Debt to Equity Ratio,
- 3) Administrative Cost to Expenses,
- 4) Revenue to Expenses,
- 5) Fund Balance Reserve,
- 6) Percent of Funding

From ADAMH Board. The Board has entitled these analyses —Fiscal Key Performance Indicators[¶] and uses them to monitor Providers’ financial performance—in Provider STAT reviews.

d. Agency Service Planning commitments—Each provider submits annual service plans which include service commitments and budgets that are assessed for actual to budget performance.

e. Compliance with Outcomes (80% threshold level) and Behavioral Health data (70% threshold for intake and closure) submission is also measured and part of the performance index for monitoring, quality improvement and evaluation.

Collaboration with the Agencies in Evaluating Services.

B - The SQI indicators and Client Outcome data are also monitored throughout the year on a quarterly basis and feedback reports are provided to each contract agency for quality improvement purposes. Quarterly meetings are held with evaluation and quality improvement representatives (staff) from each provider for the purpose of ongoing monitoring and quality improvement using the data reports mentioned above. The providers also receive quarterly updates on outcomes compliance.

In addition, we produce “benchmarking reports” which “mirror” the Statewide Outcomes reports from ODMH to compare Franklin County system results with the Statewide data, and each provider receives a report which compares their consumer outcomes data to the County and State

reports. The quarterly meetings are held with provider evaluation and quality improvement staff by major populations served (SMI Adults, General MH Adults, AOD Adults, and Children and Adolescents), and the sessions are used for troubleshooting, questions and answers, and communications regarding using data for treatment planning and quality improvement.

Services or Programs Having the Highest Priority for the Evaluation of Effectiveness and/or Efficiency

C - The Board's priorities for services are by major population groups, MH SMI Adults, MH SED Children & Adolescents, AOD Adults, and all other MH and AOD populations. The SQI measures, Outcomes and Consumer Satisfaction data/information is broken out by these major populations for performance indexing, scoring and feedback to each provider for quality improvement purposes. The Board promotes and emphasizes "best practice" programs and services, and allocates dollars to these programs, such as those addressed in various previous sections of this plan. We are beginning to evaluate certain programs using the SQI, Outcomes and Consumer Satisfaction data in order to compare program methodologies and achievement of recovery for consumers. In this way, we can confirm the research for best practices through practical application of the recovery measures and direct our resources to the most efficient and effective programs and services.

Using the Results from the Evaluation of Programs/Services

D - As noted above, the primary purpose of the extensive evaluation and results monitoring system is to inform the system, providers and our Board for the purposes of feedback for quality improvement and treatment planning. We are also beginning to use the performance data to index the system of providers as one factor in funding decisions. The ODADAS performance management system is utilized for Prevention services in order to determine program and provider performance for those programs and services. The information is also used in a similar fashion as treatment outcomes and indicators, for quality improvement and program planning.

Strategies to Evaluate Child & Adolescent Services Versus Adult Services

E - The Board uses similar strategies for evaluation of Child & Adolescent services, however, the outcome instruments (Ohio Scales) are specifically designed for this population. We also use many of the same Access and "process" or Appropriateness measures to assess both adult and child & adolescent services, but some are also different by population. Consumer Satisfaction using the CSQ-8 is also used for all populations, but we survey both the youth and their parents, so that strategy is different in a sense.

Portfolio of Providers and Services Matrix

TABLE 1: PORTFOLIO OF ALCOHOL AND DRUG SERVICES PROVIDERS

Prevention Strategy and Level of Care	a. Provider Name	b. Program Name (Provider Specific)	c. Population Served	d. Prevention Level (Prevention only)	e. Evidence-Based Practice (EBP)	f. Number of sites	g. Located outside of Board area	h. Funding Source (Check the box if yes)		i. MACSIS UPI
								ODADAS	Medicaid Only	
PREVENTION										
Information Dissemination	Amethyst	Summer Quest, ,	Youth, Adult Women , Adult Men, Youth, (MH/AOD)	Selected / Universal, Indicated	C-POM / CBT /Lifetime Risk Reduction/ Resiliency/	1/	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	1849
	Cols Publ. Health	SAGE, HIV, SOS, YES, HIVEIS				Multi				1175
	Northwest Counseling	HIVEIS				Multi				1195
	UMADAOP	CFRO, After-school, Summer Day Camp, Enhanced Community Based				1				1120
Alternatives	Amethyst	Summer Quest,	Youth, Youth,,Adult Female (MH/AOD)	Selected / Universal	C-POM / CBT / LifeSkills/Asset Development/LifeSkills/Resiliency,	1/Multi	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	1849
	APDS	, Imhotep Summer Day Camp,								2915
	Comm. For New Direct.	Summer Day Camp, After-school, College Tour, Latino, In-School Mentoring, In-School YAP, Vision Conference								6750
	Cols Pub Health	HIV, SOS, YES,								1175
	Directions for Y & F	Shortstop, LifeSkills,								1880
	UMADAOP	Summer Day Camp, After-school, Enhanced Community Based								1120

Education	Amethyst,	Summer Quest, , ,	Youth, Adult Male,Adult Female (MH/AOD)	Selected / Universal	C-POM / CBT / Asset Development/ Risk & Procetive Factors, Lifetime Risk Reduction / LifeSkills /Leadership Resilency/ White Bison/HIP/Resilency T	1/Multi	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	1849
	APDS	Imhotep Summer Day Camp,								2915
	Comm for New Dir	After-school, Summer Day Camp, College Tour, Latino, In-School Mentoring, In-school YAP, Vision Conference								6750
	Cols Urban Lg	Project Survival, Positive								3201
	CompDrug	Peer , BASA, Senior Sense,								1802
	Cols Pub Health	SAGE, HIV, SOS, YES,								1175
	Maryhaven	Rosemore								1183
	NAICCO	White Bison, Talking Circle, Sweat Lodge,								10430
	Proj Linden	PL Summer Day Camp, Women Pregnant Schools, Suburban Schools,								1212
	Southeast	Phoenix Pride,								6723
	UMADAOP	Summer Day Camp, After-school, Enhanced Community Based								1120
Community-Based Process	Amethyst	Summer Quest, ,	Youth, Adult Female (MH/AOD)	Selected / Universal	C-POM / CBT / Friendship Circle/	1/Multi	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	1849
	Cols Pub Health	, HIV, SOS, YES,								1175
	Northwest C ounseling									1195
	Proj Linden	Women Pregnant Prision								1212
	Schottenstein Chabad Hs	Mentoring								1053
	UMADAOP	Summer Day Camp, After-school, Enhanced								1120

		Community Based						<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	1849
Environmental	Amethyst	SummerQuest, HIV, SAGE, SOS, YES, LRP, Afterschool CFRO, After-school, Summer Day Camp, Enhanced Community Based						<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	1849
	Cols Pub Health										1175
	UMADAOP										1120
Problem Identification and Referral	Amethyst	Summer Quest, AFAR, HIV, SAGE, SOS, YES, LRP, Afterschool, HIVEIS	Youth, Adult Female (MH/AOD)	Selected / Universal	C-POM / CBT / Too Many	1/Multi		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	1849
	APDS										2915
	Cols Pub Health										1175
	Northwest Counseling										1195
	UMADAOP										1120
PRE-TREATMENT (Level 0.5)	CPH	SAGE, Women Pre Treatment, Women ATOD	Adult, Adult Female					<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	1175
	Proj Linden										1212
OUTPATIENT (Level 1)											
Outpatient	Amethyst,	STAR/ACES/ Outpatient Treatment Program	Adult Female / Adult		C-POM / CBT / Matrix	2 / 1		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	1849
	APDS	Outpatient Tx	Adult			1		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	2915
	Columbus Pub. Health	Outpatient Tx	Adult			1		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	1175
	CompDrug	Outpatient Tx / Opiate Tx	Adult			1		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	1802
	Concord Counseling	Outpatient Tx	Adult			1		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	1161
	Dublin Counseling	Outpatient Tx/ CAPP	Adult/Adol			1		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	1167
	Dir For Youth & Fam	Outpatient Tx	Youth			1		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	1880
	Neighborhood Hs.	Outpatient Tx	Adult			1		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	1563
	N Central	Soaring Sober	Adult			1		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	1197
	N Community	Outpatient Tx	Adult			1		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	1186
	Northwest	Outpatient Tx	Adult/Adol			1		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	1195
	OSU-TBI	Outpatient Tx	Adult Brain Injury			1		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6707
	Project Linden	Outpatient Tx	Adult			1		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	1212

	Southeast	Outpatient Tx	Adult			1	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6723
	Maryhaven	Outpatient Tx /Opiate Tx	Adult			1	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	1183
Intensive Outpatient	Amethyst	Long Term / Permanent	Adult Female / Adult		C –POM / EMDR	2	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	1849
	House Of Hope	IOP	Adult Female			1	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	1881
	Project Linden	IOP	Adult / Adult Female			1	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	1212
	CompDrug	IOP	Adult Female			1	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	1802
Day Treatment							<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
COMMUNITY RESIDENTIAL (Level 2)										
Non-Medical	Amethyst	Long Term	Adult Female		C –POM / EMDR	Multiple	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	1849
	Columbus Area Inc	Bell Center	Adult/ Male Crim Just.			1	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	3199
	House Of Hope	Ramseyer House	Adult Male			1	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	1184
	Huckleberry House	Crisis Residential	Youth			1	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	3164
	Maryhaven	Dan Canon Hall/ Women’s Center/ Adol. Residential	Adult/ Adult female/ Youth		MDFT/ACRA/ACC	3	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	1183
	North Central	Fowler House	Dual Dx MH/AOD			1	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	1197
Medical							<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
SUBACUTE (Level 3)										
Ambulatory Detoxification	Marhyaven	Amb. Detox	Adult			1	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	1183
23 Hour Observation Bed							<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Sub-Acute Detoxification	Marhyaven	Detox	Adult			1	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	1183
ACUTE HOSPITAL DETOXIFICATION (Level 4)										
Acute Detoxification							<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

TABLE 2: PORTFOLIO OF MENTAL HEALTH SERVICES PROVIDERS

Promising, Best, or Evidence-Based Practice	a. Provider(s) Name(s)	b. MACSIS UPI(s)	c. Number of Sites	d. Program Name	e. Funding Source (Check all that apply as funding source for practice)	f. Population Served (please be specific)	g. Estimated Number in SFY 2012	h. Estimated Number in SFY 2013
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					Medicaid + Match	GRF (Not as Medicaid Match)	Levy (Not as Medicaid Match)	Other (Not as Medicaid Match)						
Integrated Dual Diagnosis Treatment (IDDT)	CSN, Columbus Area, North Central, Southeast	1169, 3188, 1197, 6723	4		Yes No	Yes No	Yes No	Yes No	Adult SMD w/AOD Co-occurring disorders	310	310			
Assertive Community Treatment (ACT)	CSN, Columbus Area, North Central, Southeast	1169, 3188, 1197, 6723	4		Yes No	Yes No	Yes No	Yes No	Adult SMD w/AOD Co-occurring disorders	310	310			
TF-CBT	St. Vincent's	1164	1		Yes No	Yes No	Yes No	Yes No						
Multi-Systemic Therapy (MST)	Buckeye Ranch, Nationwide Children's, Rosemont	3153 8258 2523	3		Yes No	Yes No	Yes No	Yes No						
Functional Family Therapy (FFT)	Rosemont	2523	1		Yes No	Yes No	Yes No	Yes No						
Supported Employment	COVA	10001	4		Yes No	Yes No	Yes No	Yes No	Adult SMD	310	310			
Supportive Housing	CHN	10996	Multiple		Yes No	Yes No	Yes No	Yes No						
Wellness Management & Recovery (WMR)	Southeast	6723	1		Yes No	Yes No	Yes No	Yes No						
Red Flags	Dublin Counseling	1167	1		Yes No	Yes No	Yes No	Yes No						
EMDR	Nationwide Children's	8258	7		Yes No	Yes No	Yes No	Yes No	Adults w. trauma	100	100			
	Northwest Counseling	1195	1									Adults w. trauma	235	235
	Dublin Counseling	1167	1											
Crisis Intervention Training (CIT)	ADAMH System providers, local system partners, CPD, NAMI	10004			Yes No	Yes No	Yes No	Yes No	All- Franklin County clients in crisis in contact with local police	70 trained officers/yr	70 trained officers/yr			
Therapeutic Foster Care	Rosemont	2523	1		Yes No	Yes No	Yes No	Yes No						

Therapeutic Pre-School	St. Vincent's	1164	1		Yes No	Yes No	Yes No	Yes No			
Transition Age Services	North Central	1197	1		Yes No	Yes No	Yes No	Yes No			
Integrated Physical/Mental Health Svces	Northwest Counseling, Concord	1195, 1161	2		Yes No	Yes No	Yes No	Yes No	Older Adults	295	295
	Southeast, North Central, North Community	6723, 1197, 1186							Older Adults	60	60
									SMD	900	900
Ohio's Expedited SSI Process	CSN, Columbus Area, North Central, Southeast, Concord, North Community, COVA,	1169, 3188, 1197, 6723, 1161, 1186, 10001	7		Yes No	Yes No	Yes No	Yes No	SMD	unknown	unknown
Medicaid Buy-In for Workers with Disabilities	CSN, Columbus Area, North Central, Southeast, Concord, North Community, COVA,	1169, 3188, 1197, 6723, 1161, 1186, 10001	7		Yes No	Yes No	Yes No	Yes No	SMD	unknown	unknown
Consumer Operated Service	The PEER Center	13006	2		Yes No	Yes No	Yes No	Yes No	SMD & GENERAL ADULT	600	600
Peer Support Services	The PEER Center	13006	2		Yes No	Yes No	Yes No	Yes No	SMD & GENERAL ADULT	600	600
MI/DD Specialized Services	Southeast, Netcare	6723, 2589	2		Yes No	Yes No	Yes No	Yes No	MI/DD	126,249	375
Consumer/Family Psycho-Education	NAMI, MHA	10004	2		Yes No	Yes No	Yes No	Yes No	SMD & GENERAL ADULT	270	270

MDFT	Maryhaven	1183	1		Yes			Yes	Adolescent s		
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Please complete the following ODMH Service Level Checklist noting anticipated changes in service availability in SFY 2012:

ODMH SERVICE LEVEL CHECKLIST: This checklist relates to your plan for SFY 2012. The alignment between your planned and actual service delivery will be determined using MACSIS and Board Annual Expenditure Report (FIS-040) data during February 2012.

Instructions - In the table below, provide the following information:

- 1) For SFY 2011 *Offered Service*: What services did you offer in FY 2011?
- 2) For SFY 2012 *Plan to*: What services do you plan to offer?
- 3) For SFY 2012 *Medicaid consumer usage*: How do you expect Medicaid consumer usage to change?
- 4) For SFY 2012 *Non-Medicaid consumer usage*: How do you expect Non-Medicaid consumer usage to change?

Service Category	SFY 2011	SFY 2012			
	(Question 1) Offered Service Yes/No/Don't Know <i>Circle the answer for each category</i>	(Question 2) Plan to: Introduce (Intro) Eliminate (E) Increase (I) Decrease (D) No Change (NC) Don't Know (DK) <i>Circle the answer for each category</i>	(Question 3) Medicaid Consumer Usage: Increase (I) Decrease (D) No Change (NC) Don't Know (DK) <i>Circle the answer for each category</i>	(Question 4) Non-Medicaid Consumer Usage: Increase (I) Decrease (D) No Change (NC) Don't Know (DK) <i>Circle the answer for each category</i>	
Pharmacological Mgt. (Medication/Somatic)	Yes No DK	Intro E I D NC DK	I D NC DK	I D NC DK	
Mental Health Assessment (non-physician)	Yes No DK	Intro E I D NC DK	I D NC DK	I D NC DK	
Psychiatric Diagnostic Interview (Physician)	Yes No DK	Intro E I D NC DK	I D NC DK	I D NC DK	
BH Counseling and Therapy (Ind.)	Yes No DK	Intro E I D NC DK	I D NC DK	I D NC DK	
BH Counseling and Therapy (Grp.)	Yes No DK	Intro E I D NC DK	I D NC DK	I D NC DK	
Crisis Resources & Coordination					
24/7 Hotline	Yes No DK	Intro E I D NC DK	I D NC DK	I D NC DK	
24/7 Warmline	Yes No DK	Intro E I D NC DK	I D NC DK	I D NC DK	
Police Coordination/CIT	Yes No DK	Intro E I D NC DK	I D NC DK	I D NC DK	
Disaster preparedness	Yes No DK	Intro E I D NC DK	I D NC DK	I D NC DK	
School Response	Yes No DK	Intro E I D NC DK	I D NC DK	I D NC DK	

	SFY 2011	SFY 2012			
	(Question 1)	(Question 2)	(Question 3)	(Question 4)	
Service Category	Offered Service Yes/No/Don't Know <i>Circle the answer for each category</i>	Plan to: Introduce (Intro) Eliminate (E) Increase (I) Decrease (D) No Change (NC) Don't Know (DK) <i>Circle the answer for each category</i>	Medicaid Consumer Usage: Increase (I) Decrease (D) No Change (NC) Don't Know (DK) <i>Circle the answer for each category</i>	Non-Medicaid Consumer Usage: Increase (I) Decrease (D) No Change (NC) Don't Know (DK) <i>Circle the answer for each category</i>	
Respite Beds for Adults	Yes No DK	Intro E I D NC DK	I D NC DK	I	D NC DK
Respite Beds for Children & Adolescents (C&A)	Yes No DK	Intro E I D NC DK	I D NC DK	I	D NC DK
Crisis Face-to-Face Capacity for Adult Consumers					
24/7 On-Call Psychiatric Consultation	Yes No DK	Intro E I D NC DK	I D NC DK	I	D NC DK
24/7 On-Call Staffing by Clinical Supervisors	Yes No DK	Intro E I D NC DK	I D NC DK	I	D NC DK
24/7 On-Call Staffing by Case Managers	Yes No DK	Intro E I D NC DK	I D NC DK	I	D NC DK
Mobile Response Team	Yes No DK	Intro E I D NC DK	I D NC DK	I	D NC DK
Crisis Central Location Capacity for Adult Consumers					
Crisis Care Facility	Yes No DK	Intro E I D NC DK	I D NC DK	I	D NC DK
Hospital Emergency Department	Yes No DK	Intro E I D NC DK	I D NC DK	I	D NC DK
Hospital contract for Crisis Observation Beds	Yes No DK	Intro E I D NC DK	I D NC DK	I	D NC DK
Transportation Service to Hospital or Crisis Care Facility	Yes No DK	Intro E I D NC DK	I D NC DK	I	D NC DK
Crisis Face-to-Face Capacity for C&A Consumers					
24/7 On-Call Psychiatric Consultation	Yes No DK	Intro E I D NC DK	I D NC DK	I	D NC DK

	SFY 2011	SFY 2012			
	(Question 1)	(Question 2)	(Question 3)	(Question 4)	
Service Category	Offered Service Yes/No/Don't Know <i>Circle the answer for each category</i>	Plan to: Introduce (Intro) Eliminate (E) Increase (I) Decrease (D) No Change (NC) Don't Know (DK) <i>Circle the answer for each category</i>	Medicaid Consumer Usage: Increase (I) Decrease (D) No Change (NC) Don't Know (DK) <i>Circle the answer for each category</i>	Non-Medicaid Consumer Usage: Increase (I) Decrease (D) No Change (NC) Don't Know (DK) <i>Circle the answer for each category</i>	
24/7 On-Call Staffing by Clinical Supervisors	Yes No DK	Intro E I D NC DK	I D NC DK	I D NC DK	DK
24/7 On-Call Staffing by Case Managers	Yes No DK	Intro E I D NC DK	I D NC DK	I D NC DK	DK
Mobile Response Team	Yes No DK	Intro E I D NC DK	I D NC DK	I D NC DK	DK
Crisis Central Location Capacity for C&A Consumers					
Crisis Care Facility	Yes No DK	Intro E I D NC DK	I D NC DK	I D NC DK	DK
Hospital Emergency Department	Yes No DK	Intro E I D NC DK	I D NC DK	I D NC DK	DK
Hospital Contract for Crisis Observation Beds	Yes No DK	Intro E I D NC DK	I D NC DK	I D NC DK	DK
Transportation Service to Hospital or Crisis Care Facility	Yes No DK	Intro E I D NC DK	I D NC DK	I D NC DK	DK
Partial Hospitalization, less than 24 hr.	Yes No DK	Intro E I D NC DK	I D NC DK	I D NC DK	DK
Community Psychiatric Supportive Treatment (Ind.)	Yes No DK	Intro E I D NC DK	I D NC DK	I D NC DK	DK
Community Psychiatric Supportive Treatment (Grp.)	Yes No DK	Intro E I D NC DK	I D NC DK	I D NC DK	DK
Assertive Community Treatment (Clinical Activities)	Yes No DK	Intro E I D NC DK	I D NC DK	I D NC DK	DK
Assertive Community Treatment (Non-Clinical Activities)	Yes No DK	Intro E I D NC DK	I D NC DK	I D NC DK	DK
Intensive Home Based Treatment (Clinical Activities)	Yes No DK	Intro E I D NC DK	I D NC DK	I D NC DK	DK

Service Category	SFY 2011	SFY 2012			
	(Question 1) Offered Service Yes/No/Don't Know <i>Circle the answer for each category</i>	(Question 2) Plan to: Introduce (Intro) Eliminate (E) Increase (I) Decrease (D) No Change (NC) Don't Know (DK) <i>Circle the answer for each category</i>	(Question 3) Medicaid Consumer Usage: Increase (I) Decrease (D) No Change (NC) Don't Know (DK) <i>Circle the answer for each category</i>	(Question 4) Non-Medicaid Consumer Usage: Increase (I) Decrease (D) No Change (NC) Don't Know (DK) <i>Circle the answer for each category</i>	
Intensive Home Based Treatment (Non- Clinical Activities)	Yes No DK	Intro E I D NC DK	I D NC DK	I D NC DK	
Behavioral Health Hotline Service	Yes No DK	Intro E I D NC DK	I D NC DK	I D NC DK	
Other MH Svc, not otherwise specified (healthcare services)	Yes No DK	Intro E I D NC DK	I D NC DK	I D NC DK	
Other MH Svc., (non-healthcare services)	Yes No DK	Intro E I D NC DK	I D NC DK	I D NC DK	
Self-Help/Peer Services (Peer Support)	Yes No DK	Intro E I D NC DK	I D NC DK	I D NC DK	
Adjunctive Therapy	Yes No DK	Intro E I D NC DK	I D NC DK	I D NC DK	
Adult Education	Yes No DK	Intro E I D NC DK	I D NC DK	I D NC DK	
Consultation	Yes No DK	Intro E I D NC DK	I D NC DK	I D NC DK	
Consumer Operated Service	Yes No DK	Intro E I D NC DK	I D NC DK	I D NC DK	
Employment (Employment/Vocational)	Yes No DK	Intro E I D NC DK	I D NC DK	I D NC DK	
Information and Referral	Yes No DK	Intro E I D NC DK	I D NC DK	I D NC DK	
Mental Health Education	Yes No DK	Intro E I D NC DK	I D NC DK	I D NC DK	
Occupational Therapy Service	Yes No DK	Intro E I D NC DK	I D NC DK	I D NC DK	
Prevention	Yes No DK	Intro E I D NC DK	I D NC DK	I D NC DK	
School Psychology	Yes No DK	Intro E I D NC DK	I D NC DK	I D NC DK	
Social & Recreational Service	Yes No DK	Intro E I D NC DK	I D NC DK	I D NC DK	
Community Residence	Yes No DK	Intro E I D NC DK	I D NC DK	I D NC DK	
Crisis Care/Bed Adult [see service definition below]	Yes No DK	Intro E I D NC DK	I D NC DK	I D NC DK	

	SFY 2011	SFY 2012			
Service Category	(Question 1) Offered Service Yes/No/Don't Know <i>Circle the answer for each category</i>	(Question 2) Plan to: Introduce (Intro) Eliminate (E) Increase (I) Decrease (D) No Change (NC) Don't Know (DK) <i>Circle the answer for each category</i>	(Question 3) Medicaid Consumer Usage: Increase (I) Decrease (D) No Change (NC) Don't Know (DK) <i>Circle the answer for each category</i>	(Question 4) Non-Medicaid Consumer Usage: Increase (I) Decrease (D) No Change (NC) Don't Know (DK) <i>Circle the answer for each category</i>	
Crisis Care/Bed Youth [see service definition below]	Yes No DK	Intro E I D NC DK	I D NC DK	I D NC DK	
Foster Care Adult	Yes No DK	Intro E I D NC DK	I D NC DK	I D NC DK	
Foster Care Youth [see service definition below]	Yes No DK	Intro E I D NC DK	I D NC DK	I D NC DK	
Residential Care Adult (ODMH Licensed) [see service definition below]	Yes No DK	Intro E I D NC DK	I D NC DK	I D NC DK	
Residential Care Adult (ODH Licensed) [see service definition below]	Yes No DK	Intro E I D NC DK	I D NC DK	I D NC DK	
Residential Care Youth [see service definition below]	Yes No DK	Intro E I D NC DK	I D NC DK	I D NC DK	
Respite Care/Bed Adult [see service definition below]	Yes No DK	Intro E I D NC DK	I D NC DK	I D NC DK	
Respite Care/Bed Youth [see service definition below]	Yes No DK	Intro E I D NC DK	I D NC DK	I D NC DK	
Permanent Supportive Housing (Subsidized Supportive Housing) Adult [see service definition below]	Yes No DK	Intro E I D NC DK	I D NC DK	I D NC DK	
Independent Community Housing Adult (Rent or Home Ownership) [see service definition below]	Yes No DK	Intro E I D NC DK	I D NC DK	I D NC DK	
Temporary Housing Adult [see service definition below]	Yes No DK	Intro E I D NC DK	I D NC DK	I D NC DK	
Forensic Service	Yes No DK	Intro E I D NC DK	I D NC DK	I D NC DK	
Inpatient Psychiatric Service Adult (Private hospital only)	Yes No DK	Intro E I D NC DK	I D NC DK	I D NC DK	
Inpatient Psychiatric Service Youth (Private hospital only)	Yes No DK	Intro E I D NC DK	I D NC DK	I D NC DK	

ODMH 2012 Community Plan Adult Housing Categories

Please answer the following question for each category for your SPMI/SMI population:

For SFY 2012, please indicate the number of planned Units & Beds for Adults who are SPMI/SMI.

ODMH is also interested in knowing for each category how many beds/units are set-aside for the forensic sub-population and for those sex offenders who are a sub-population of SPMI/SMI.

Housing Categories	Definition	Examples	<i>Number of SPMI/SMI (Please include Forensic & Sex Offender Sub- Populations)</i>	Number of Units	Number of Beds
Crisis Care	Provision of short-term care to stabilize person experiencing psychiatric emergency. Offered as an alternative to inpatient psychiatric unit. Staff 24 hours' day/7 days a week. Treatment services are billed separately.	<ul style="list-style-type: none"> • Crisis Bed • Crisis Residential • Crisis Stabilization Unit 	Total #:4,018 Crisis Bed: 2,267 SMI , 3,957 total Crisis Residential: 175 SMI , 205 total CSU:441 SMI , 649 total	Total : 17,250 Crisis Bed: 7,755 SMI, 11,860 total Crisis Res: 2,134 SMI, 2,483 total CSU: 2,066 SMI, 2,907	Total: 43 Crisis Bed: 26 Crisis Residential: 8 CSU: 9
			<i>Forensic #: no set asides</i>		
			<i>Sex Offender #: no set asides</i>		
ODMH Licensed Residential Care	Includes room and board, and personal care 24/7 if specified in license. Rules in program or service agreement attached to housing are applicable. Treatment services are billed separately. Usually	<ul style="list-style-type: none"> • Licensed as Type I, II or III (Residential Facility Care) • Residential Support • Supervised Group Living • Next-Step Housing from psychiatric 	Total #: 162 SMI People	<u>1014</u> <u>Months</u>	95 Total Beds

	agency operated and staffed; provides 24-hour supervision in active treatment oriented or structured environment. <u>Type 1</u> : Room & Board; Personal Care; Mental Health Services <u>Type 2</u> : Room & Board; Personal Care <u>Type 3</u> : Room and Board	hospital and/or prison	Forensic #:		
			Sex Offender #:		
ODH Licensed Residential Care	Includes room and board, and personal care 24/7 if specified in license. Rules in program or service agreement attached to housing are applicable. Treatment services are billed separately. Usually operator owned and staffed; provides 24-hour supervision in structured environment.	<ul style="list-style-type: none"> • Adult Care Facilities • Adult Family Homes • Group Homes 	Total #: 13 SMI People	95 Months	10 Total Beds
			Forensic #:		
			Sex Offender #:		
Respite Care	Short-term living environment, it may or may not be 24-hour care. Reasons for this type of care are more environmental in nature. May provide supervision, services and accommodations. Treatment services are billed separately	<ul style="list-style-type: none"> • Placement during absence of another caretaker where client usually resides • Respite Care 	Total #:		
			Forensic #:		
			Sex Offender #:		

Temporary Housing	Non-hospital, time limited residential program with an expected length of occupancy and goals to transition to permanent housing. Includes room and board, with referral and access to treatment services that are billed separately.	<ul style="list-style-type: none"> • Commonly referred to and intended as time-limited, short term living • Transitional Housing Programs • Homeless county residence currently receiving services • Persons waiting for housing • Boarding Homes • YMCA/YWCA (not part of a supportive housing program) 	Total #: 29 SMI People	70 Months	10 Total Beds
			<i>Forensic #:</i>		
			<i>Sex Offender #:</i>		
Board/Agency Owned Community Residence	Person living in an apartment where they entered into an agreement that is NOT covered by Ohio tenant landlord law. Rules in program or service agreement attached to housing. Refers to financial sponsorship and/or provision of some degree of on-site supervision for residents living in an apartment dwelling. Treatment services are billed separately.	<ul style="list-style-type: none"> • Service Enriched Housing • Apartments with non-clinical staff attached • Supervised Apartments • No leases: NOT covered by Ohio tenant landlord law 	Total #:		
			<i>Forensic #:</i>		
			<i>Sex Offender #:</i>		
Permanent Supportive Housing (Subsidized Supportive)	Person living in an apartment where they entered into a lease with accordance to Ohio tenant landlord law or a mortgage and, in instances where	<ul style="list-style-type: none"> • HAP • Housing as Housing • Supervised Apartments • Supportive Housing • Person with Section 8 	Total #: 341 SMI People	2487 Months	327 Total Beds

Housing) with Primary Supportive Services On-Site	ODMH allocated funds have been used, an exit strategy for the subsidy has been developed. Treatment services are billed separately. (The landlord may be a housing agency that provides housing to mental health consumers.)	<ul style="list-style-type: none"> or Shelter Plus Care Voucher • Tenant has lease Supportive Services staff primary offices are on-site and their primary function are to deliver supportive services on-site; these staff many accompany residents in the community to access resources.	Forensic #:		
			Sex Offender #:		
Permanent Supportive Housing (Subsidized Supportive Housing) with Supportive Services Available	Person living in an apartment where they entered into a lease with accordance to Ohio tenant landlord law or a mortgage and, in instances where ODMH allocated funds have been used, an exit strategy for the subsidy has been developed. Treatment services are billed separately. (The landlord may be a housing agency that provides housing to mental health consumers.)	<ul style="list-style-type: none"> • HAP • Housing as Housing • Supervised Apartments • Supportive Housing • Person with Section 8 or Shelter Plus Care Voucher • Tenant has lease • Supportive Services staff <u>primary offices</u> are <u>not on-site</u>; supportive serve staff may come on- 	Total #: 298 SMI People	2920 Months	308 Total Beds
			Forensic #: 45 SMI People	415 Months	42 Total Beds
			Sex Offender #:		

		<p>site to deliver supportive services or deliver them off-site. (In this model a primary mental health CPST worker may be delivering the supportive services related to housing in addition to treatment services.</p>			
<p>Independent Community Housing (Rent or Home Ownership)</p>	<p>Refers to house, apartment, or room which anyone can own/rent, which is not sponsored, licensed, supervised, or otherwise connected to the mental health system. Consumer is the designated head of household or in a natural family environment of his/her choice.</p>	<ul style="list-style-type: none"> • Own home • Person with Section 8 Voucher (not Shelter Plus Care) • Adult with roommate with shared household expenses • Apartment without any public assistance • Housing in this model is not connected to the mental health system in any way. Anyone can apply for and obtain this housing. 	<p>Total #: 736 SMI People</p>	<p>7131 Months</p>	<p>802 Total Beds</p>
			<p><i>Forensic #:</i></p>		
			<p><i>Sex Offender #:</i></p>		

SFY 2012 & 2013 ODMH Budget Templates

The final budget template, narrative template and instructions will be posted on the ODMH website (<http://mentalhealth.ohio.gov>) on December 1, 2010. (ORC Section 340.03)

Board Name: Franklin County ADAMH
 SFY: 2012

HCPCS Procedure	Category	State 401 (C) Forensic Monitoring	State 401 (S) Forensic Centers	State 419 Community Medication	State 505 Local MH SOC	State 505 Special	State Other Funds	Federal Block Grant (forensic portion) CFDA 93.958	Federal Block Grant (Base) CFDA 93.958	Federal Title XX CFDA 93.667	Federal PATH CFDA 93.150	Federal Other	Local Levy	Local Other	Total Board Spending	Medicaid	Notes
	BALANCES:																
	Beginning Mental Health Fund Balance																
	PRIOR PERIOD ADJUSTMENTS (Explain in the Note column)																
	Restated MH Beginning Fund Balance														\$ -		
	REVENUES:																
	Total Mental Health Revenues	60,657	450,837	765,314	0	0	950,000	2,683	782,750	746,594	403,953	500,000	36,332,240	1,012,832	\$ 42,007,860.09		
	BOARD ADMINISTRATION:																
	Salaries, Fringes, and Operating												6,317,713				
	Board Capital Expenditures												1,000,000				
	BOARD SERVICES TO OTHER BOARDS OR AGENCIES:																
	Agency Salaries, Fringes, and Operating																
	Agency Capital Expenditures																
	EXPENSES:																
90862	Pharmacologic Mgt. (Medication/Somatic)						130,045			222,678			3,971,771	81,928		11,973,870	
H0031	Mental Health Assessment (non-physician)(Diag. Assess.)						18,693			42,093			570,921	14,663		3,645,289	
90801	Psychiatric Diagnostic Interview (Physician)(Diag. Assess.)						3,578			7,451			109,279			634,725	
H0004	BH Counseling and Therapy (Ind.)(Ind. Counseling)						10,280			18,491			313,961	12,888		2,874,538	
H0004	BH Counseling and Therapy (Gp.)(Gp. Counseling)						46,450			32,082			1,418,657	137,903		12,864,683	
S9484	Crisis Intervention MH Services (Crisis Intervention)						56,639			545			1,729,855			1,525,561	
S0201	Partial Hospitalization, less than 24 hr. (Partial Hospitalization)						8,393			0			256,344			5,414,430	
H0036	Community Psychiatric Supportive Treatment (Ind.)(Ind. CPST)						134,936			415,014			4,121,155	296,748		25,125,395	
H0036	Community Psychiatric Supportive Treatment (Gp.)(Gp. CPST)						22,254			4,085			679,668	28,982		5,077,467	
	Board Support for Medications			765,314													
H0040	Assertive Community Treatment (Clinical Activities)																
M1910	Assertive Community Treatment (Non-Clinical Activities)																
H2016	Intensive Home-Based Treatment (Clinical Activities)																
M1810	Intensive Home-Based Treatment (Non-Clinical Activities)																
H0030	Behavioral Health Hotline Service (Hotline)						4,907						149,876				
H0046	Other MH Svcs., not otherwise specified (hlthcare) ²												137,549				
M3140	Other MH Svcs (non-hlthcare) ²						187,011		782,750		403,953	500,000	5,574,058	439,720			
H0038	Self-Help/Peer Svcs. (Peer Support)																
M1440	Adjunctive Therapy																
M1540	Adult Education																
M4120	Consultation						21,907						669,068				
M3120	Consumer Operated Service																
M1620	Employment / Vocational						53,852						1,644,731				
M4130	Information and Referral																
M4140	Mental Health Education						5,600						171,026				
M1430	Occupational Therapy Svc																
M4110	Prevention						4,594						140,319				
M1530	School Psychology																
M1550	Social & Recreational Svc																
M2240	Community Residence						48,010						1,466,299				
M2280	Crisis Care (Crisis Bed)						40,395						1,233,715				
M2250	Foster Care																
M2200	Residential Care (Residential Treatment/Residential Support)						127,249						3,886,397				
M2270	Respite Care (Respite Bed)						637						19,465				
M2260	Subsidized Housing						23,509						718,014				
M2290	Temporary Housing						1,061						32,401				
**	Forensic Evaluation	60,657	450,837					2,683									
**	PASARR																
**	Inpatient Psychiatric Service (Private hospital only)																
	Total Mental Health Expenditures	\$ 60,657	\$ 450,837	\$ 765,314	\$ -	\$ -	\$ 950,000	\$ 2,683	\$ 782,750	\$ 742,439	\$ 403,953	\$ 500,000	\$36,332,240	\$1,012,832	\$ 42,003,705	\$ 69,135,959	
	Net Mental Health Current Year																
	Ending Mental Health Fund Balance	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
	Non-Mental Health Revenue																
	Non-Mental Health Expenditures																
	Net Non-Mental Health						0										

Specify Type of Accounting (cash, accrual, modified accrual): Modified Accrual

NOTES (refer to Instructions):

1. Beginning Balance (Prior Ending Balance) SFY 2011
2. Enter Totals here and details on sheet titled "Other MH Svcs Detail".

Board Name: Franklin County ADAMH
 SFY: 2013

HCPCS Procedure	Category	State 401 (C) Forensic Monitoring	State 401 (S) Forensic Centers	State 419 Community Medication	State 505 Local MH SOC	State 505 Special	State Other Funds	Federal Block Grant (forensic portion) CFDA 93.958	Federal Block Grant (Base) CFDA 93.958	Federal Title XX CFDA 93.667	Federal PATH CFDA 93.150	Federal Other	Local Levy	Local Other	Total Board Spending	Medicaid	Notes
BALANCES:																	
	Beginning Mental Health Fund Balance																
PRIOR PERIOD ADJUSTMENTS (Explain in the Note column)																	
	Restated MH Beginning Fund Balance														\$ -		
REVENUES:																	
	Total Mental Health Revenues	60,657	450,837	765,314	0	0	0	2,683	782,750	746,594	403,953	500,000	36,332,240	1,012,832	\$ 41,057,860.09		
BOARD ADMINISTRATION:																	
	Salaries, Fringes, and Operating												6,317,713				
	Board Capital Expenditures												1,000,000				
BOARD SERVICES TO OTHER BOARDS OR AGENCIES:																	
	Agency Salaries, Fringes, and Operating																
	Agency Capital Expenditures																
EXPENSES:																	
90862	Pharmacologic Mgt. (Medication/Somatic)									222,678			3,971,771	81,928		1,991,721	
H0031	Mental Health Assessment (non-physician)(Diag. Assess.)									42,093			570,921	14,663		606,353	
90801	Psychiatric Diagnostic Interview (Physician)(Diag. Assess.)									7,451			109,279			105,580	
H0004	BH Counseling and Therapy (Ind.)(Ind. Counseling)									18,491			313,961	12,888		478,148	
H0004	BH Counseling and Therapy (Gp.)(Gp. Counseling)									32,082			1,418,657	137,903		2,139,897	
S9484	Crisis Intervention MH Services (Crisis Intervention)									545			1,729,855			253,760	
S0201	Partial Hospitalization, less than 24 hr. (Partial Hospitalization)									0			256,344			900,630	
H0036	Community Psychiatric Supportive Treatment (Ind.)(Ind. CPST)									415,014			4,121,155	296,748		4,179,331	
H0036	Community Psychiatric Supportive Treatment (Gp.)(Gp. CPST)									4,085			679,668	28,982		844,580	
	Board Support for Medications			765,314													
H0040	Assertive Community Treatment (Clinical Activities)																
M1910	Assertive Community Treatment (Non-Clinical Activities)																
H2016	Intensive Home-Based Treatment (Clinical Activities)																
M1810	Intensive Home-Based Treatment (Non-Clinical Activities)																
H0030	Behavioral Health Hotline Service (Hotline)												149,876				
H0046	Other MH Svcs., not otherwise specified (hlthcare) ²												137,549				
M3140	Other MH Svcs (non-hlthcare) ²								782,750		403,953	500,000	5,574,058	439,720			
H0038	Self-Help/Peer Svcs. (Peer Support)																
M1440	Adjunctive Therapy																
M1540	Adult Education																
M4120	Consultation												669,068				
M3120	Consumer Operated Service																
M1620	Employment / Vocational												1,644,731				
M4130	Information and Referral																
M4140	Mental Health Education												171,026				
M1430	Occupational Therapy Svc																
M4110	Prevention												140,319				
M1530	School Psychology																
M1550	Social & Recreational Svc																
M2240	Community Residence												1,466,299				
M2280	Crisis Care (Crisis Bed)												1,233,715				
M2250	Foster Care																
M2200	Residential Care (Residential Treatment/Residential Support)												3,886,397				
M2270	Respite Care (Respite Bed)												19,465				
M2260	Subsidized Housing												718,014				
M2290	Temporary Housing												32,401				
**	Forensic Evaluation	60,657	450,837					2,683									
**	PASARR																
**	Inpatient Psychiatric Service (Private hospital only)																
	Total Mental Health Expenditures	\$ 60,657	\$ 450,837	\$ 765,314	\$ -	\$ -	\$ -	\$ 2,683	\$ 782,750	\$ 742,439	\$ 403,953	\$ 500,000	\$36,332,240	\$1,012,832	\$ 41,053,705	\$ 11,500,000	
	Net Mental Health Current Year																
	Ending Mental Health Fund Balance	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -		
	Non-Mental Health Revenue																
	Non-Mental Health Expenditures																
	Net Non-Mental Health						0										

Specify Type of Accounting (cash, accrual, modified accrual): Modified Accrual

NOTES (refer to Instructions):

1. Beginning Balance (Prior Ending Balance) SFY 2012
2. Enter Totals here and details on sheet titled "Other MH Svcs Detail".

**Additional ODMH Requirements
(Formerly Community Plan – Part B)**

CSN Services

I anticipate renewing contracts for CSN services.

Yes

No

Board Membership Catalog for ADAMHS/CMHS Boards

Board Name ADAMH Board of Franklin County		Date Prepared 7/26/11
Board Member Derek Anderson		<u>Appointment</u> Franklin County Board of Commissioners <u>Sex</u> Male <u>Ethnic Group</u> African American
Mailing Address (street, city, state, zip) The Treasurer of State 30 East Broad St. Columbus, OH 43215		<u>Officer</u> Secretary <u>Hispanic or Latino (of any race)</u> Representation: select all that apply:
Telephone (include area code) 614-752-8475	County of Residence Franklin	<u>Mental Health</u> <input type="checkbox"/> Consumer <input type="checkbox"/> Family Member <input type="checkbox"/> MH Professional <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Other Physician
Occupation Chief		<u>Alcohol Other Drug Addiction</u> <input type="checkbox"/> Consumer <input type="checkbox"/> Family Member <input type="checkbox"/> Professional <input type="checkbox"/> Advocate
Term Full	Year Term Expires 2013	
Board Name ADAMH Board of Franklin County		Date Prepared 7/26/11
Board Member Jerome Bahlmann		<u>Appointment</u> Franklin County Board of Commissioners <u>Sex</u> Male <u>Ethnic Group</u> Caucasian
Mailing Address (street, city, state, zip) Porter Wright Morris & Arthur 41 S. High St. Columbus, Oh 43215		<u>Officer</u> Member <u>Hispanic or Latino (of any race)</u> Representation: select all that apply:
Telephone (include area code) 614-227-2002	County of Residence Franklin	<u>Mental Health</u> <input type="checkbox"/> Consumer <input type="checkbox"/> Family Member <input type="checkbox"/> MH Professional <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Other Physician
Occupation Attorney		<u>Alcohol Other Drug Addiction</u> <input type="checkbox"/> Consumer <input type="checkbox"/> Family Member <input type="checkbox"/> Professional <input type="checkbox"/> Advocate
Term Full	Year Term Expires 2012	
Board Name ADAMH Board of Franklin County		Date Prepared 4/9/10
Board Member Tamara Davis		<u>Appointment</u> ODMH <u>Sex</u> Female <u>Ethnic Group</u> Caucasian
Mailing Address (street, city, state, zip) The Ohio State University College of Social Work 1947 College Rd., 325 Stillman Hall Columbus, OH 43215		<u>Officer</u> Vice Chair <u>Hispanic or Latino (of any race)</u> Representation: select all that apply:
Telephone (include area code) 614-247-5025	County of Residence Franklin	<u>Mental Health</u> <input type="checkbox"/> Consumer <input type="checkbox"/> Family Member <input type="checkbox"/> MH Professional <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Other Physician
Occupation Assistant Professor		<u>Alcohol Other Drug Addiction</u> <input type="checkbox"/> Consumer <input type="checkbox"/> Family Member <input type="checkbox"/> Professional <input type="checkbox"/> Advocate
Term Full	Year Term Expires 2011	
Board Name ADAMH Board of Franklin County		Date Prepared 7/26/11
Board Member Dona England-Afek		<u>Appointment</u> Franklin County Board of Commissioners <u>Sex</u> Female <u>Ethnic Group</u> Caucasian
Mailing Address (street, city, state, zip) Columbus Center for Human Services, Inc. 600 Industrial Mile Rd. Columbus, OH 43228		<u>Officer</u> Chair <u>Hispanic or Latino (of any race)</u>

Telephone (include area code) 614-278-9362	County of Residence Franklin	<u>Representation: select all that apply:</u>	
Occupation Director/President		<u>Mental Health</u> <input type="checkbox"/> Consumer <input type="checkbox"/> Family Member <input type="checkbox"/> MH Professional <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Other Physician	<u>Alcohol Other Drug Addiction</u> <input type="checkbox"/> Consumer <input type="checkbox"/> Family Member <input type="checkbox"/> Professional <input type="checkbox"/> Advocate
Term Full	Year Term Expires 2011 (Pending Reppt)		
Board Name ADAMH Board of Franklin County		Date Prepared 7/26/11	
Board Member J.S. Jindal		<u>Appointment</u> Franklin County Board of Commissioners	<u>Sex</u> Male <u>Ethnic Group</u> Indian
Mailing Address (street, city, state, zip) 2128 Statham Ct. Dublin, OH 43016		<u>Officer</u> Member	<u>Hispanic or Latino (of any race)</u>
Telephone (include area code) 614-975-6669	County of Residence Franklin	<u>Representation: select all that apply:</u>	
Occupation Retired		<u>Mental Health</u> <input type="checkbox"/> Consumer <input type="checkbox"/> Family Member <input type="checkbox"/> MH Professional <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Other Physician	<u>Alcohol Other Drug Addiction</u> <input type="checkbox"/> Consumer <input type="checkbox"/> Family Member <input type="checkbox"/> Professional <input type="checkbox"/> Advocate
Term Full	Year Term Expires 2014		
Board Name ADAMH Board of Franklin County		Date Prepared 7/26/11	
Board Member Kim Kehl		<u>Appointment</u> ODADAS	<u>Sex</u> Male <u>Ethnic Group</u> Caucasian
Mailing Address (street, city, state, zip) ODYS Div. of Parole & Community SRVCS 51 N. High St. Columbus, OH 43215		<u>Officer</u> Member	<u>Hispanic or Latino (of any race)</u>
Telephone (include area code) 614-644-6540	County of Residence Franklin County	<u>Representation: select all that apply:</u>	
Occupation Executive Assistant		<u>Mental Health</u> <input type="checkbox"/> Consumer <input type="checkbox"/> Family Member <input type="checkbox"/> MH Professional <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Other Physician	<u>Alcohol Other Drug Addiction</u> <input type="checkbox"/> Consumer <input type="checkbox"/> Family Member <input type="checkbox"/> Professional <input type="checkbox"/> Advocate
Term Full	Year Term Expires 2012		
Board Name ADAMH Board of Franklin County		Date Prepared 7/26/11	
Board Member Mitzi Kirkbride		<u>Appointment</u> ODMH	<u>Sex</u> Female <u>Ethnic Group</u> Caucasian
Mailing Address (street, city, state, zip) 4339 Malin Drive East Columbus, OH 43224		<u>Officer</u> Member	<u>Hispanic or Latino (of any race)</u>
Telephone (include area code) 614-478-5915	County of Residence Franklin	<u>Representation: select all that apply:</u>	
Occupation		<u>Mental Health</u> <input type="checkbox"/> Consumer <input type="checkbox"/> Family Member <input type="checkbox"/> MH Professional <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Other Physician	<u>Alcohol Other Drug Addiction</u> <input type="checkbox"/> Consumer <input type="checkbox"/> Family Member <input type="checkbox"/> Professional <input type="checkbox"/> Advocate
Term Full	Year Term Expires 2015		
Board Name ADAMH Board of Franklin County		Date Prepared 7/26/11	
Board Member Dennis Lieb		<u>Appointment</u> ODMH	<u>Sex</u> Male <u>Ethnic Group</u> Caucasian

Mailing Address (street, city, state, zip) 944 Old Farm Rd. Columbus, OH 43213		<u>Officer</u> <u>Hispanic or Latino (of any race)</u> Treasurer	
Telephone (include area code) 614-861-2278	County of Residence Franklin	<u>Representation: select all that apply:</u>	
Occupation		<u>Mental Health</u> <input type="checkbox"/> Consumer <input type="checkbox"/> Family Member <input type="checkbox"/> MH Professional <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Other Physician	<u>Alcohol Other Drug Addiction</u> <input type="checkbox"/> Consumer <input type="checkbox"/> Family Member <input type="checkbox"/> Professional <input type="checkbox"/> Advocate
Term Full	Year Term Expires 2015		
Board Name ADAMH Board of Trustees			Date Prepared 7/26/11
Board Member Rory McGuiness		<u>Appointment</u> Franklin County Board of Trustees	<u>Sex</u> Male <u>Ethnic Group</u> Caucasian
Mailing Address (street, city, state, zip) Coleman for Columbus PO Box 1596 Columbus, OH 43216		<u>Officer</u> <u>Hispanic or Latino (of any race)</u> Member	
Telephone (include area code) 614-477-0337	County of Residence Franklin	<u>Representation: select all that apply:</u>	
Occupation Director of Finance		<u>Mental Health</u> <input type="checkbox"/> Consumer <input type="checkbox"/> Family Member <input type="checkbox"/> MH Professional <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Other Physician	<u>Alcohol Other Drug Addiction</u> <input type="checkbox"/> Consumer <input type="checkbox"/> Family Member <input type="checkbox"/> Professional <input type="checkbox"/> Advocate
Term Full	Year Term Expires 2011 (Pending Reappt)		
Board Name ADAMH Board of Franklin County			Date Prepared 7/26/11
Board Member Ronald Rotaru		<u>Appointment</u> ODADAS	<u>Sex</u> Male <u>Ethnic Group</u> Caucasian
Mailing Address (street, city, state, zip) Accountancy Board of Ohio 77 South High St., 18th Flr Columbus, OH 43215		<u>Officer</u> <u>Hispanic or Latino (of any race)</u> Member	
Telephone (include area code) 614-995-0192	County of Residence Franklin	<u>Representation: select all that apply:</u>	
Occupation Executive Director		<u>Mental Health</u> <input type="checkbox"/> Consumer <input type="checkbox"/> Family Member <input type="checkbox"/> MH Professional <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Other Physician	<u>Alcohol Other Drug Addiction</u> <input type="checkbox"/> Consumer <input type="checkbox"/> Family Member <input type="checkbox"/> Professional <input type="checkbox"/> Advocate
Term Full	Year Term Expires 2012		
Board Name ADAMH Board of Franklin County			Date Prepared 7/26/11
Board Member Jonathan Sadler		<u>Appointment</u> Franklin County Board of Commissioners	<u>Sex</u> Male <u>Ethnic Group</u> Caucasian
Mailing Address (street, city, state, zip) Bank of America 8800 Lyra Dr., Suite 200 Columbus, OH 43240		<u>Officer</u> <u>Hispanic or Latino (of any race)</u> Member	
Telephone (include area code) 614-985-4249	County of Residence Franklin	<u>Representation: select all that apply:</u>	
Occupation Branch Manager		<u>Mental Health</u> <input type="checkbox"/> Consumer <input type="checkbox"/> Family Member <input type="checkbox"/> MH Professional <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Other Physician	<u>Alcohol Other Drug Addiction</u> <input type="checkbox"/> Consumer <input type="checkbox"/> Family Member <input type="checkbox"/> Professional <input type="checkbox"/> Advocate
Term Full	Year Term Expires 2012		

Board Name ADAMH Board of Franklin County		Date Prepared 7/26/11
Board Member Laura Thielbar		<u>Appointment</u> ODADAS
Mailing Address (street, city, state, zip) 1212 McCleary Court Columbus, OH 43235		<u>Sex</u> Female
Telephone (include area code) 614-431-8910		<u>Ethnic Group</u> Caucasian
County of Residence Franklin		<u>Officer</u> Member
Occupation		<u>Hispanic or Latino (of any race)</u>
Term Full	Year Term Expires 2012	<u>Representation: select all that apply:</u>
		<u>Mental Health</u>
		<input type="checkbox"/> Consumer
		<input type="checkbox"/> Family Member
		<input type="checkbox"/> MH Professional
		<input type="checkbox"/> Psychiatrist
		<input type="checkbox"/> Other Physician
		<u>Alcohol Other Drug Addiction</u>
		<input type="checkbox"/> Consumer
		<input type="checkbox"/> Family Member
		<input type="checkbox"/> Professional
		<input type="checkbox"/> Advocate

Board Name ADAMH Board of Franklin County		Date Prepared 7/26/11
Board Member Eric Troy		<u>Appointment</u> Franklin County Board of Commissioners
Mailing Address (street, city, state, zip) 981 Oakshade Dr. Gahanna, OH 43230		<u>Sex</u> Male
Telephone (include area code) 614-657-4544		<u>Ethnic Group</u> African American
County of Residence Franklin		<u>Officer</u> Member
Occupation Associate of Education		<u>Hispanic or Latino (of any race)</u>
Term Full	Year Term Expires 2012	<u>Representation: select all that apply:</u>
		<u>Mental Health</u>
		<input type="checkbox"/> Consumer
		<input type="checkbox"/> Family Member
		<input type="checkbox"/> MH Professional
		<input type="checkbox"/> Psychiatrist
		<input type="checkbox"/> Other Physician
		<u>Alcohol Other Drug Addiction</u>
		<input type="checkbox"/> Consumer
		<input type="checkbox"/> Family Member
		<input type="checkbox"/> Professional
		<input type="checkbox"/> Advocate

Board Forensic Monitor and Community Linkage Contacts

a. Please provide the name, address, phone number, and email of the Board's Forensic Monitor:

Name	Street Address	City	Zip	Phone Number	Email
Pam Garretson	447 E. Broad St.	Columbus	43215	614-222-3752	pgarretson@adamh.co.franklin.oh.us

b. Please provide the name, address, phone number, and email of the Board's Community Linkage Contact:

Name	Street Address	City	Zip	Phone Number	Email
Stephanie Patrick	447 E. Broad St.	Columbus	43215	614-222-3758	spatrick@adamh.co.franklin.oh.us

INSERT ADDITIONAL BOARD APPENDICES AS NEEDED



RESOLUTION
Approving the Submission of the
Combined Community Plan
For State Fiscal Year 2012-2013
To the Ohio Departments of Mental Health (ODMH) and Alcohol and Drug
Addiction Services (ODADAS)

WHEREAS, the ADAMH Board of Franklin County has the duty to submit a biennial Community Plan for Mental Health and Alcohol and Drug Addiction Services pursuant to section 340.03 (c) of the Ohio Revised Code; and

WHEREAS, ODMH and ODADAS provided specific guidelines for the Combined Community Plan, and the plan is due to the Departments on September 1, 2011.

NOW, THEREFORE, BE IT RESOLVED, that the ADAMH Board of Franklin County approves the submission of the Combined Community Plan for SFY 2012-2013 to ODMH and ODADAS on September 1, 2011.

Witness thereof, I have hereunto subscribe my name on this twenty-third day of August, Two Thousand and Eleven.

David A. Royer, CEO
ADAMH Board of Franklin County

Dona England-Afek, Chair
ADAMH Board of Franklin County

Approved August 23, 2011