

*Community Mental Health and Recovery CMHRB of Licking and Knox
Counties*

COMMUNITY PLAN FOR SFY 2012-2013

September 1, 2011

MISSION STATEMENT

The mission of the Community Mental Health and Recovery CMHRB of Licking and Knox Counties is to use Recovery and Resiliency Methodology to enhance the quality of life for individuals and families, and to diminish the problems caused by alcoholism, drug addiction and mental illness for the residents of Licking and Knox Counties.

VISION STATEMENT

The vision of the CMHRB will be accomplished through cost effective contracting with behavioral health providers who use Resilience Recovery Methodology; and in cooperation with other local systems and citizens through the provision of quality treatment, prevention and education for individuals and their families coping with behavioral health challenges.

VALUE STATEMENTS

Not applicable.

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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.

Community Mental Health and Recovery Board of Licking and Knox Counties

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

Wendy Wilcox
ADAMHS, ADAS or CMH Board Executive Director

8/30/11
Date

[Signature]
ADAMHS, ADAS or CMH Board Chair

8/30/11
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) CMHRBs, Alcohol and Drug Addiction Services (ADAS) CMHRBs and Community Mental Health Services (CMH) CMHRBs 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 CMHRBs submit plans to ODADAS, three CMH CMHRBs submit plans to ODMH, and 47 ADAMHS CMHRBs submit their community plan to both Departments. The plan, which constitutes the CMHRB'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 – CMHRB Responsibilities

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

- 1) Identify community mental health needs;
- 2) Identify services the CMHRB 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 CMHRB’s responsibilities as the planning agency for alcohol and other drug addiction services. Among the responsibilities of the CMHRB 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 CMHRBs 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 CMHRB 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 CMHRB areas receive State General Revenue Funds (GRF) for the provision of HIV Early Intervention Services. CMHRBs 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 CMHRBs.

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

Economic Conditions: Licking and Knox Counties have both experienced increases in poverty and unemployment during the past five years. In 2009, 13.2% of individuals in Knox County were below the poverty line, up from 10.1% in 2000. Although poverty is slightly lower in Licking County, the upward trend there has been similar; in 2009 11.7% of Licking County individuals were below the poverty line, up from 7.5% in 2000 (U.S. Census Bureau: 2000 Census and 2010 Quick Facts). The proportion of students who are considered “economically disadvantaged” has risen sharply in all school districts in both counties from 2005 to 2010. By the 2010-11 school year, the two largest districts in the two-county area—Newark City Schools and Mount Vernon City Schools—were experiencing rates of 58% and 45.5%, respectively (Ohio Department of Education PowerUser Reports). The unemployment rate in both counties has largely tracked the statewide rate, and peaked at 9.6% in 2009 (Knox). In July 2011, the unemployment rate was 9.4% in Knox County and 8.6% in Licking County (ODJFS, Ohio Labor Market Information, Civilian Labor Force Estimates; July 2011 rate is not seasonally adjusted).

The number of individuals eligible for Medicaid has risen in tandem with these trends. From 2003 to 2010, there was a 60% increase in the number of individuals receiving Medicaid in Licking County in the Covered Families with Children (CFC) category. The increase was 56% for the same time period in Knox County for

the CFC program. The Aged Blind and Disabled category has also seen increases from 2003 to 2010 (33% in Licking, 23% in Knox).

Impact on service delivery: The increase in the number of individuals with Medicaid directly impacts the behavioral health system. As funding has decreased for non-Medicaid-reimbursable services, our contract providers have served fewer non-Medicaid consumers, and this trend will likely continue. Overall, our contracted treatment providers served 8,342 individual consumers in 2009, dropping slightly to 8,021 in 2010. This decrease was made up entirely of a decrease in the number of non-Medicaid consumers (from 4,314 in 2009 to 3,994 in 2010), while the number Medicaid consumers was virtually unchanged (from 4,028 in 2009 to 4,027 in 2010) (FY2010 Individual Providers Report, January 2011). Funding reductions for other non-Medicaid funded services (such as prevention and domestic violence shelter) have been larger, resulting in a significant decline in the number of prevention participants in particular. Many of these cuts took affect in SFY2010, resulting in a 42% decrease in the number of prevention participants served by contract providers from 2009 to 2010.

Cost-saving measures and operational efficiencies:

Rather than establishing an across-board cut for all contract providers in SFY10, SFY11, and SFY12, the Community Mental Health and Recovery Board of Licking and Knox Counties (CMHRB) prioritized and rated all funded services and programs and made funding decisions based on those criteria. This process began in January of 2009 in anticipation of continued funding reductions. Further details of this multi-year process is outlined in the discussion below.

Prioritization Process

- January 2009: Staff introduced new process for provider budget application process (BAP), including changes to the application that request providers define programs and tie programs/services to CMHRB priority populations and prioritize their programs/services. We also asked providers give us a program budget in addition to the UCR documents.
- May 2009: Staff presented decision criteria and rankings for all programs/services to Program/AOD Committee. Programs were divided into four categories: A, B, C, D. Category A included all “core mental health and AOD treatment services,” while the remaining categories included early intervention, CPST and assessment at TMP, outpatient for non-SMD, domestic violence shelters, peer support, and prevention. Staff ranked programs in the B, C, and D categories based on the following criteria:
 - County parity
 - Risk level and population served (priority populations)
 - Evidence of program effectiveness
 - Dose
 - Extent to which program addresses top priorities identified in local needs assessments
 - Provider ranking
- June 2009: Priorities approved but final decision on provider set-aside not made until August due to state delay in approving the biennium budget.
- August 2009: FY10 funding decisions made, including cuts to programs in the C and D categories. Most of the programs that were eliminated were prevention programs that were low-dose (“one-shot”) and/or had weak evidence of effectiveness (e.g., minimal evaluation results, not evidence-based models).

FY11 Budget Process

- January 2010: Staff convened the “Innovations” process. CMHRB board members, provider board members, and board and provider staff came together to identify ideas for adapting to resource reductions and developing system-wide strategies for increasing efficiency. (How can we do better with less?)
- February 2010: Program Committee requested more detailed numerical ranking system for assessing FY11 budgets.
- March-April 2010: Stakeholder Priorities Survey of consumers, stakeholder organizations, and Innovations Committee members (providers)
- March 2010: Process concludes and two initiatives are created to follow through on recommendations: Merger/Consolidation Workgroup and Utilization Management Workgroup
- April 2010: Staff assessed programs/services presented in BAPs using a detailed, numerical rating “grants reviewing” model that reflected a continued shift away from the “allocation model” towards the “purchase of services” model.
- April 2010: Staff presented revised decision criteria and resulting rankings of programs in the “B” category to the Program and Alcohol and other Drug Committee.
- May 2010: Staff presented decision-making process for further prioritizing programs in the “B” category according to the following questions:
 - Is funding required (ODMH mandate or ODADAS required “pass through”)?: Yes or No
 - What is the risk of harm to the consumer or others in the near future if this service is not available? Sorted into three groups—High, Moderate, or Low
 - Within the three risk groups, programs were then listed in rank order according to the criteria introduced in April 2010: Population/Risk, Evidence of Effectiveness, Dose, and Needs Assessment alignment
- June 2010: board approved further reductions including treatment services to non-SMD persons based on priority system.

FY12 Budget Process

- November-December 2010: Staff hosted four Community Forums to gather input from consumers on service priorities (for Community Plan goals).
- November 2010: CMHRB Prioritized System of Care by Tier presented to Program Committee and Alcohol and other Drug Committee. This document prioritizes all programs/services in the “A” and “B” categories by the following criteria:
 - Risk: Potential negative impact if the service was not provided (higher risk= higher priority)
 - Level of Care required to manage risk and meet medical necessity (higher risk/higher medical necessity= higher priority)
 - Other considerations: mandated services or mandated funding, prioritizing access to services for children, programs operating at capacity, duplicated services, results of stakeholder surveys
- January 2011: CMHRB Prioritized System of Care by Tier with dollar amounts presented to Finance Committee
- May 2011: Program and Alcohol and other Drug Committee review funding recommendation and pass recommendation to Finance Committee for funding
- June 2011: SFY12 budgets approved

Innovations Process

In addition to the multi-year prioritization process and to prepare for continued funding reductions CMHRB convened a set of meetings beginning in January of 2010 with our network providers' executive staff and board members:

- to assure there was a shared understanding of the challenges ahead
- to determine if there were possibilities around how we, individually and collectively, could meet the needs of those we serve using fewer resources and,
- to make a commitment to each of our own organizations, to each other, and to those we serve to make the changes that emerge from those possibilities. This included examining revenue enhancements, expense reduction, prioritizations of services

The Innovations Work Group spent several months exploring what strategies could help address the funding changes that would be occurring and developed 11 strategies, most which fell into two major areas:

- Mergers, consolidations, central administrative agency
- Common assessments and utilization models

As a result of this process, several providers are exploring various partnership opportunities to reduce expenses and a utilization management group of clinical directors across the system was formed to focus on access and continuity of care within and between organization to improve client care and reduce risk.

Additionally, we have continued to cut expenses at the board level by reducing staff and outsourcing some functions. We continue to be part of a COG with other boards that manages our MACSIS billing process and our ODADAS peer audits. As a result of new legislation that supports political subdivisions working together to achieve efficiencies, we are in discussions with several local entities to identify opportunities.

Implications of Health Care Reform on Behavioral Health Services

The CMHRB invited a speaker from Access Health Columbus to present information about the Accountable Care Act (ACA) at the 2010 annual CMHRB meeting, and the Executive Director has attended additional training sessions on the topic. The CMHRB will continue to monitor the implementation of health care reform in Ohio. The current "unknowns" with health care reform and budget cuts make it challenging to plan for future services. However, the CMHRB is very aware of three themes related to reform. First, Medicaid expansions in 2014 will lead to a larger number of behavioral health consumers with Medicaid coverage. If this aspect of reform remains intact after the presidential election, we will see a significant increase in persons covered by Medicaid and an increased ability to offer non-Medicaid covered services. The strategy for our budgeting process has been to use our reserves to offset the draconian state funding cuts by minimizing reductions to providers to get us to 2014. If this expansion does not remain as part of the ACA, we project we will need to make another 1 million in cuts to our system of care beginning in SFY14.

Second, greater integration of physical and behavioral health will necessitate stronger partnerships between our providers and physical healthcare providers. We have had preliminary discussion with the hospitals in our service area and the FQHC's that service Richland and Muskingum Counties regarding various integration possibilities.

Third, a greater focus on outcomes, quality, and data systems will push us to continue to improve

effectiveness and efficiency of services. A key factor in how changes will occur in Ohio in the public system will be the redesign recommended by the Office of Health Transformation. Once we have clearer direction for Medicaid and how this Office is conceptualizing other issues related to ACA we will be better able to integrate our local system redesign initiatives. We are very interested in changing the method of payment to providers including incentives for improved outcomes but it will be critical that any redesign we implement complements the states funding strategies.

We are currently working on our public information campaign to prepare for our levy in 2015. If the ACA remains intact we believe we will need to educate the general public about the services supported by levy dollars that are not Medicaid covered services and the importance of these support services such as housing, hotline, prevention and drop-in centers that are an integral part of an overall system of care and critical to improved outcomes.

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

Social and demographic factors: Population growth is an important factor in both Licking and Knox Counties. The total population of each county grew by 11.8% in Knox County and 14.4% in Licking County from 2000 to 2010 (U.S. Census Bureau: 2000 Census and 2010 Quick Facts). As mentioned above, the increase in the number of adults and children living in poverty and receiving Medicaid is also an important demographic factor.

Changes in services: The increase in the size of the population in general, and the size of the Medicaid-eligible population in particular, coupled with decreased funding mean that the behavioral health system will need to continue to focus on serving those with the most serious needs and managing crisis. For the SFY10 and SFY11 budget decisions, the CMHRB prioritized services based upon risk of harm, priority populations, and other criteria (evidence of effectiveness, alignment with community need, cost, etc.). As a result of these decisions, and utilization management strategies implemented by some treatment providers, contract providers are now serving fewer consumers not meeting SMD or SED criteria. From SFY2008 to SFY2010, there was a 22% decline in the number of non-SMD/non-SED consumers served by contract treatment providers (from 3,806 to 2,964 individuals). Conversely, there was a 22% increase in the number of SMD consumers served (2,985 to 3,655) and a 10% increase in the number of SED consumers served (1,276 to 1,402) (FY2010 Individual Providers Report, January 2011). Overall, the shift in the past three years has been toward:

- Serving more Medicaid consumers and fewer non-Medicaid consumers
- Serving more consumers with serious needs (SMD and SED), rather than those with less serious needs
- Maintaining treatment services for people challenged with severe mental illness and decreasing services to general outpatient, and decreasing prevention services

These three trends will likely continue for the next two fiscal years. Additionally, it is expected that the newly instituted SFY 12-13 Medicaid cost containment strategies will further impact trending. To support access to services and maintain quality of care while managing benefit limits, the CMHRB will encourage provider use of utilization management techniques and evidenced based clinical practices. The CMHRB also created a method of prioritization of services providing a framework for the SFY2012 BAP budget decision making process. The "Prioritized System of Care" process (see Attachments A and B) specifically

delineates six tiers of service priorities, ranked by risk, level of care, medical necessity, and other criteria. A discussion of this process occurs in Section III under the heading: Process the CMHRB Used to Determine Prevention, Treatment and Capacity Priorities.

Other recent trends: In addition to the results of local needs assessments that have been completed in the two counties over the past five years (see next section), CMHRB is also exploring potential trends that may impact behavioral health needs in the future, including upward trends in opiates/prescription drug use, suicide rates, homelessness, and potential increases in the number of offenders with behavioral health needs being released back into the community and gambling addiction issues related to the opening of a casino in Columbus in 2012.

The CMHRB recognizes the need for a comprehensive and collaborative approach to community prevention efforts involving other systems of care and stakeholders. Sponsored by the CMHRB, Our Futures of Licking County is a county-wide plan to create a healthier Licking County by improving the educational, social, safety, and economic environments through the use of evidenced-based practices. Utilizing SIG funding the CMHRB will initiate a process in SFY12 in both counties to develop a community wide prevention strategy.

In collaborative partnerships, the CMHRB provides leadership in addressing trends involving forensic consumers and community planning. Following the Sequential Interceptor best practice model in criminal justice-behavioral healthcare collaborative planning involving jail diversion activities, efforts have included the use of universal Ohio-based actuarial assessment system for reentry planning and management (Ohio Risk Assessment System – ORAS), the adoption of Ohio Supreme Court supported special docket courts addressing the forensic needs of offenders impacted with addiction or mental health disorders or co-occurring disorders, the use of a continuum of sanctions and cognitive-behavioral interventions addressing criminogenic behaviors and risk, and a well-established CIT program in both counties. Each county has a misdemeanor behavioral health court and Licking County has a felony drug court. Knox County has a best practice Dually-Diagnosed Intervention Team (DDIT) that plans for mental ill-developmental disabled consumers involved with the criminal justice system. The Licking County Juvenile and Adult Reentry Taskforce was initiated to resolve barriers and improve effectiveness of community reentry planning leading to increased public safety and reduced recidivism. Issues addressed by the taskforce include limited resources and growing concern about new sentencing legislation (Ohio Senate Bill 86) releasing lower level felons with significantly reduced sentences into the community without supervision who historically have related addiction problems and higher rates of re-arrest. The CMHRB, on behalf of the taskforce, applied for the Bureau of Justice Assistance SFY 2011 Second Chance Act Adult Offender Reentry Planning Grant to address reentry and recidivism issues.

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

Achievements from the SFY2010-2011 Community Plan: The SFY2010-11 plan included measurable outcomes for each goal area. The completed tasks and outcomes at or above target are listed below:

System stabilization: Both objectives related to funding strategy and contracts were met:

- Developed a criteria rating process for the SFY11 BAP that more closely aligned funding with priority populations and a purchase-of-services model
- Completed Financial Dashboard Reporting Policy and Procedures, and provided resources for organizations not meeting minimum criteria

State hospital bed day usage: SFY10 and SFY 11 targets were met.

Crisis Intervention Training (CIT): Strong participation in training sessions from both counties.

- 38 Licking County participants trained in SFY10 and 12 were trained in SFY 11
- 12 Knox County participants trained in SFY10 and 15 were trained in SFY 11

ATOD prevention data collection: CMHRB now has an excellent source of consistent data on youth ATOD outcomes via the Pride Survey.

- Three waves of county-wide youth surveys have been completed. The Pride Survey was administered in all 14 Licking County school districts in May 2011. (Pride Survey in May 2009, May 2010, and May 2011).
- The Pride Survey was administered in four out of five districts in Knox County during the 2010-2011 school year.

ATOD prevention, youth wellbeing/protective factors, and evidence-based prevention programs: Our Futures in Licking County collaborative project is being fully implemented and has made **several achievements in SFY10 and SFY11:**

- Secured a competitive, five-year Drug Free Communities grant (started October 2010)
- Trained 54 Triple P providers and served 993 parents with Triple P parenting program
- Trained 163 teachers from 10 different school districts in the PAX Good Behavior Game
- Completed 120 alcohol and tobacco vendor compliance checks as part of the Reward and Reminder program
- Launched PAX-IT Note program in 6 districts

Wellness Management and Recovery (WMR): WMR groups at The Main Place achieved their participation objectives.

Assertive Community Treatment Team (ACT): ACT participation, outcome, and fidelity objectives were met.

Formalization of multi-system team models for high-risk youth: Adolescent Integrated Dual Diagnosis Treatment (IDDT) and Team Facilitator programs fully implemented in Licking County in SFY10 and SFY11.

Housing: All objectives related to funding for housing resources were met.

In addition to these targets from the FY10-11 Community Plan being met, the CMHRB has also made the following **accomplishments:**

- **Innovation Process:** See Section I discussion of Cost-saving measures and operational efficiencies for information.
- **MHSIP/YSS/YSS-F Surveys:** All contracted treatment providers have completed two data collection waves using the Mental Health Statistical Improvement Project (MHSIP), Youth Services Survey (YSS), and Youth Services Survey for Families (YSS-F)—providing valuable information about consumer satisfaction and outcomes that is benchmarked to national and state results. Surveys were collected in January 2010 and July 2010 and will be repeated twice each year.

Significant unrealized goals and barriers to achieving them: The following delayed tasks and outcomes were below target:

- **Access to Services for Children and Adolescents:** Both mental health and alcohol and other drug service (AOD) providers missed access to service targets for children and adolescents during most quarters in SFY10. AOD providers came closer to meeting the targets' 90% threshold measure with a cumulative average of 89% of youth in need of service for routine situations were offered a clinical appointment within 14 calendar days of the initial call and a

cumulative average of 77.5% of newly identified youth were scheduled for their second appointment within 14 calendar days. Mental health providers performed significantly lower with a cumulative average of 26% of youth in need of service for routine situations were offered a clinical appointment within 14 calendar days of the initial call and a cumulative average of 57% of newly identified youth were scheduled for their second appointment within 14 calendar days. It should be noted that the system's largest provider of mental health services for children adolescents individually averaged 46.5% of newly identified youth were scheduled for their second appointment within 14 calendar days. In some cases this is due to problems with overall system capacity (i.e., consumer demand is greater than can be absorbed by existing resources), while in other cases providers are working on improving productivity and utilization management. The CMHRB has been closely following performance targets related to access over the past two years and has urged providers to improve their utilization management and productivity to improve access. This will be one of the top three continuous quality improvement goals for SFY12.

- **Recovery and resiliency-oriented system of care:** Minimal progress made toward evaluating system fidelity to recovery principals. Within the current fiscal climate, the system is focused on survival and maintaining core services. Once funding is more stable, we will renew our focus on evaluating the extent recovery principals are an integral part of our provider system.
- **Hospital follow-up:** Providers continued to struggle to meet many of these targets throughout SFY10, indicating possible gaps in the transition from hospital to community for many high-risk consumers. This will be one of the top three continuous quality improvement goals for SFY12.

In addition, the CMHRB is also very concerned about:

- **Overall system capacity** will be of concern in SFY12 as providers struggle to meet the needs of a growing—and increasingly impoverished—population with fewer resources.

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 CMHRB used to assess behavioral health needs

In determining the goals and objectives of the SFY12-SFY13 Community Plan, the CMHRB drew upon a wide array of community needs assessments that have been conducted by CMHRB and/or other community stakeholders over the past four years. A matrix describing all needs assessments from 2006 to 2011 is included as Attachment C. The full *Preliminary 2011 Needs Assessment and Gaps Analysis* is included as Attachment D. More recent assessments (completed in SFY10 and SFY11) are described below in detail.

SFY10-SFY11 Needs Assessment Process and Key Findings in Relationship to Specific Populations

The key findings of the needs assessments were used in developing goals and objectives with related strategies for the SFY12-SFY 13 Community Plan. Included in the chart below are key findings in relation to specific populations. The needs of several populations: Children and families receiving services through a Family and Children First Council; persons with substance abuse and mental illness (SAMI); individuals involved in the criminal justice system (both adults and children); adult residents of the district hospitalized at the Regional Psychiatric Hospitals; and veterans, including the National Guard, from the Iraq and Afghanistan conflict, are integrated within the identified needs of other populations.

Needs assessment (data source), year conducted (time frame), and Organization that conducted the assessment	Method and Stakeholders Involved/Number of participants	Key Findings	Populations
<i>Preliminary 2011 Needs Assessment and Gaps Analysis, CMHRB (April 2011)</i>	Supplemental assessment of secondary data on behavioral health needs and related health, social, demographic, and economic issues in Licking and Knox Counties. <ul style="list-style-type: none"> ▪ Data from online compilations of county-level health, economic, and demographic indicators from across multiple community systems. ▪ Community indicators used to identify trends that will likely affect the behavioral health system over the next five years, and potential service gaps, and challenges to system capacity. 	Preliminary report reviewed at April 2011 CMHRB Board Meeting <ul style="list-style-type: none"> ▪ Growing population and higher proportion living in poverty. The increase in the number of poor individuals will likely present a challenge to the behavioral health and other community systems. ▪ Sharp increase in opiate use and unintentional drug-related death rate. The behavioral health system needs a <i>comprehensive strategy to address the rise in opiate addiction</i>, while maintaining or improving capacity to serve ongoing needs related to more commonly abused substances (e.g., alcohol, marijuana). 	All populations but most specifically: <ul style="list-style-type: none"> ▪ SMD adults, and SED children ▪ SAMI ▪ Adult and adolescents abusing/addicted to alcohol and/or other drugs ▪ Individuals receiving general outpatient services ▪ Children and families receiving services through Children & Family First Councils

Needs assessment (data source), year conducted (time frame), and Organization that conducted the assessment	Method and Stakeholders Involved/Number of participants	Key Findings	Populations
		<ul style="list-style-type: none"> ▪ High rates of obesity, and the relationships between poor behavioral health and chronic medical conditions, call for an integrated response and a focus on wellness and prevention. ▪ Low kindergarten readiness in some communities signals a need to improve <i>early intervention and services for families with young children.</i> ▪ Potential <i>state policy changes</i> regarding the <i>release of non-violent offenders from prisons and/or SMD nursing home residents</i> being transitioned out of facilities may increase the number of adults needing behavioral health services. 	<ul style="list-style-type: none"> ▪ Individuals involved in the criminal justice system ▪ Veterans
<p>2010 Consumer Forums (for feedback on SFY12-13 Community Plan goals), CMHRB, November-December 2010</p>	<p>46 behavioral health consumers participated 4 forums held at neutral community locations, two in each county</p> <ul style="list-style-type: none"> ▪ Discussion of community plan goals; participants voted on top priorities ▪ Strong representation for adult mental health (particularly consumers from The Main Place who were largely older, male, and challenged with co-occurring issues), moderate for drug and alcohol treatment, and minimal for domestic violence shelter and prevention programs. 	<p>46 behavioral health consumers participated 4 forums held at neutral community locations, two in each county, suggested the following goals be added to the plan:</p> <ul style="list-style-type: none"> ▪ Basic survival/poverty issues relating to housing and employment and stigma among employers ▪ Family/child-related prevention <ul style="list-style-type: none"> ○ Increase positive family management (AOD Prevention) ○ Prevention of child sexual abuse (MH Prevention) ○ School based mental health (MH Prevention) ▪ More case management and peer support 	<p>Most specifically:</p> <ul style="list-style-type: none"> ▪ SMD adults and SED children ▪ SAMI ▪ Adult and adolescents abusing/addicted to alcohol and/or other drugs ▪ Individuals receiving general outpatient services ▪ Children and families receiving services through Children & Family First Councils
<p>2010 Stakeholder Priorities Survey Results, CMHRB, May 2010</p>	<p>Overall, 332 Licking and Knox County community members completed the survey, representing three groups of stakeholders:</p> <ul style="list-style-type: none"> ▪ 212 consumers (convenience sample, paper-and-pencil survey administered at all contract providers) ▪ 97 stakeholder organization representatives (purposive and snowball sampling, online survey) ▪ 23 Innovations Committee members, including CMHRB members (purposive sample, online survey) ▪ Purpose of the survey was to obtain quantitative feedback about which behavioral health services are the most important 	<p>Surveys with 212 consumers, 97 stakeholder organization representatives, and 23 Innovations Committee members identified the following priorities:</p> <p>Top-priority adult mental health services:</p> <ul style="list-style-type: none"> ▪ 24-hour emergency services/crisis management ▪ Counseling ▪ Treatment for co-occurring disorders (clients with both mental health and addiction issues) ▪ Local outpatient psychiatry <p>Top priority child/youth mental health services:</p> <ul style="list-style-type: none"> ▪ Early intervention for at-risk children ▪ Family therapy ▪ 24-hour emergency services/crisis management ▪ Counseling ▪ Local child psychiatry ▪ Parenting education <p>Top priority adult and youth alcohol and drug services:</p> <ul style="list-style-type: none"> ▪ Detoxification ("detox") 	<p>All populations but most specifically:</p> <ul style="list-style-type: none"> ▪ SMD adults and SED children ▪ SAMI ▪ Adult and adolescents abusing/addicted to alcohol and/or other drugs ▪ Individuals receiving general outpatient services ▪ Children and families receiving services through Children & Family First Councils ▪ Individuals involved in the criminal justice system ▪ Veterans ▪ Persons seeking crisis services without Medicaid and/or other insurance

Needs assessment (data source), year conducted (time frame), and Organization that conducted the assessment	Method and Stakeholders Involved/Number of participants	Key Findings	Populations
		<ul style="list-style-type: none"> ▪ Outpatient treatment (assessment, group, individual) ▪ 24-hour emergency services/crisis management ▪ Intensive Outpatient (IOP) ▪ Alcohol and drug prevention 	
<p><i>Consumer Focus Group Report, CMHRB, January 2010</i></p>	<p>5 focus groups held at treatment provider sites, 3 in Licking County and 2 in Knox County; facilitated by CMHRB staff</p> <ul style="list-style-type: none"> ▪ Total of 34 consumers participated ▪ 2 groups with adult mental health consumers, 2 groups with adult AOD consumers, and 1 group with parents of child mental health consumers ▪ Purpose of the groups was to obtain consumer feedback regarding proposed consumer satisfaction and outcomes surveys (MHSIP and YSS-F) and priorities for mental health and alcohol and other drug treatment services, and ideas for improving efficiency and quality in the system 	<p>Five focus groups with a total of 34 consumers (adults and parents) concluded that:</p> <ul style="list-style-type: none"> ▪ The MHSIP and YSS-F surveys are feasible and appropriate for consumers in Licking and Knox counties. (focus group included pilot-testing of the surveys) ▪ Adult consumers prioritized the following mental health services: case management, housing assistance, peer support, ACT Team, and psychiatry. ▪ Parents prioritized the following mental health resources for children: case management, emergency services, child psychiatry in county, and pooled funds. ▪ Adult consumers prioritized the following AOD resources: group counseling and IOP, referrals and links to other resources for basic needs, and individual counseling. <p>Consumers identified the following concerns and suggestions for improving services:</p> <ul style="list-style-type: none"> ▪ Concerns about access to services at MGC. ▪ Reduce duplication between mental health and AOD providers, and provide better link between inpatient detox and community services. ▪ Increase consumer participation in treatment decisions at MGC. ▪ Improve initial access and support for staying engaged in treatment. ▪ Add or expand specific services, including nutrition education and wellness, medication education, and help paying for medications ▪ Maintain housing assistance (see as critical to recovery) 	<p>Most specifically</p> <ul style="list-style-type: none"> ▪ SMD adults and SED children ▪ SAMI ▪ Adult and adolescents abusing/addicted to alcohol and/or other drugs ▪ Individuals receiving general outpatient services ▪ Children and families receiving services through Children & Family First Councils ▪ Veterans
<p><i>January and July 2010 Consumer Satisfaction and Outcomes Survey Results, CMHRB, 2010</i></p>	<p>All mental health and AOD treatment providers participated in administering the following satisfaction and outcome surveys to consumers in January 2010 and July 2010: MHSIP (ages 18+), YSS (ages 13-17), and YSS-F (parents of children ages 0-12)</p> <ul style="list-style-type: none"> ▪ Data collection method: in person on site at provider agencies, self-administered paper-and-pencil ▪ Instrument: standardized MHSIP/YSS/F instruments 	<p>Analysis of MHSIP, YSS, and YSS-F surveys with current consumers at two points identified the following:</p> <p>System Strengths</p> <ul style="list-style-type: none"> ▪ The majority of mental health and AOD consumers report they are satisfied with the care they have received, and rate agencies positively regarding several indicators of perceived quality. ▪ The vast majority of adult AOD consumers report that they have achieved meaningful outcomes as a result of the services they have 	<p>Most specifically:</p> <ul style="list-style-type: none"> ▪ SMD adults and SED children ▪ SAMI ▪ Adult and adolescents abusing/addicted to alcohol and/or other drugs ▪ Individuals receiving general outpatient services ▪ Children and families receiving services through Children &

Needs assessment (data source), year conducted (time frame), and Organization that conducted the assessment	Method and Stakeholders Involved/Number of participants	Key Findings	Populations
	<p>with additional items for assessing National Outcome Measures related to employment/school, housing, and law enforcement involvement</p> <ul style="list-style-type: none"> ▪ Sampling: CMHRB identified target sample sizes based on the typical number of clients who visit the agency each week, excluding first-time client visits (95% confidence level, confidence interval of 5). ▪ January 2010: 892 surveys were completed (690 MHSIP, 152 YSS, and 50 YSS-F) ▪ July 2010: 966 surveys were completed (764 MHSIP, 124 YSS, and 56 YSS-F) 	<p>received.</p> <ul style="list-style-type: none"> ▪ Contact with providers appears to reduce homelessness for mental health and AOD consumers. ▪ AOD treatment appears to be associated with a reduction in encounters with the police. <p>System Challenges</p> <ul style="list-style-type: none"> ▪ BHPCO-MH, the system's largest provider, did not meet most performance targets related to satisfaction or outcomes, and did not make adequate progress on outcome domains for adults or children. ▪ Regardless of time in treatment and service type, most outcome-related targets for most mental health providers were not met. 	<ul style="list-style-type: none"> ▪ Family First Councils Veterans
<p><i>SFY10 Year-End CMHRB Performance Target Report, CMHRB, 2010</i></p>	<p>Review of quarterly performance target reports submitted by contract providers to CMHRB</p>	<p>In addition to identifying several system strengths, this analysis identified the following system challenges:</p> <ul style="list-style-type: none"> ▪ Community demand for mental health services for adults and children appears to be exceeding capacity, particularly at BHPCO-MH. ▪ Community demand for AOD services is also challenged by provider capacity in some areas. ▪ Seasonal demand patterns may have magnified access "bottlenecks" during SFY10. ▪ Persistent concerns about: access to services, hospital follow-up, domestic violence shelter use, housing vacancy rates (TMP housing), and relatively low use of evidence-based programs among prevention providers. 	<p>All populations most specifically:</p> <ul style="list-style-type: none"> ▪ SMD adults, and SED children ▪ SAMI ▪ Adult and adolescents abusing/addicted to alcohol and/or other drugs ▪ Individuals receiving general outpatient services ▪ Children and families receiving services through Children & Family First Councils ▪ Individuals involved in the criminal justice system ▪ Veterans ▪ Persons receiving crisis services without Medicaid and/or other insurance ▪ Adult residents of the district hospitalized at the regional Psychiatric Hospitals
<p><i>Prevention Planning and Policy: Changing the Odds in Licking County, PAXIS Institute for CMHRB, 2010</i></p>	<p>Consultant compilation of peer-reviewed research on prevention science, recent trends in behavioral disorders for children/teens, and recommendations for improving the effectiveness of prevention programming in Licking County</p>	<p>Review of prevention research literature provided the following policy implications for the prevention system:</p> <ul style="list-style-type: none"> ▪ Multi-problem focus: Prevention strategies that significantly affect several outcomes are to be preferred over strategies that only affect one type of outcome. ▪ Behavior change: Prevention programs or efforts that emphasize knowledge or attitude change in the 	<p>Most specifically:</p> <ul style="list-style-type: none"> ▪ SED children ▪ Adolescents abusing/addicted to alcohol and/or other drugs ▪ Children and families receiving services through Children & Family First Councils

Needs assessment (data source), year conducted (time frame), and Organization that conducted the assessment	Method and Stakeholders Involved/Number of participants	Key Findings	Populations
		<p>absence of measurable behavior change should be discontinued. Simple awareness campaigns that do not involve clear behavior change topography and tools should not be funded.</p> <ul style="list-style-type: none"> ▪ Simplicity and cost-effectiveness: Prevention efforts that can be easily applied to intervention and treatment with simple adjustments to dose, supports, or intensity are to be preferred. Prevention efforts that are less expensive in terms of training, supports, and infrastructure and more efficient are to be preferred. ▪ Third party payers: Strategies that can be funded through third-party mechanisms should be pursued 	<ul style="list-style-type: none"> ▪ Youth involved in the criminal justice system ▪ Youth receive general outpatient services
<p><i>Pride Survey of Licking County Youth, 2008-09 School Year (baseline), Our Futures, September 2009</i></p>	<p><i>Pride Questionnaire for Grades 6 to 12</i> was administered to students in grades 6, 8, 10, and 12 in May 2009 and May 2010</p> <ul style="list-style-type: none"> ▪ 7 of the 10 public school districts in Licking County participated both years, representing 81% of public school students in the county ▪ 5,078 students completed the survey in May 2010; 84% response rate ▪ Survey addresses youth ATOD use and risk/protective factors 	<p>Survey of 5,097 students in grades 6, 8, 10, and 12 in 7 Licking county school districts found that:</p> <ul style="list-style-type: none"> ▪ Alcohol, tobacco, and other drug use (ATOD) was slightly higher in Licking County than in the US overall for 8th, 10th, and 12th graders ▪ ATOD use rates were lower for Licking County 6th graders ▪ Alcohol was the most commonly used drug among youth, followed by marijuana and prescription drugs ▪ Licking County teens reported easier access to alcohol, marijuana, and tobacco compared to the national sample ▪ Most students believe ATOD use is harmful ▪ Most ATOD use occurs at home, not in school ▪ Parental monitoring and supervision drops considerably at the high school level ▪ Most—but not all—parents disapprove of youth ATOD use, and local high school students were less likely than their national counterparts to say their parents disapprove of alcohol use 	<p>Most specifically:</p> <ul style="list-style-type: none"> ▪ SED children ▪ Adolescents abusing/addicted to alcohol and/or other drugs ▪ Children and families receiving services through Children & Family First Councils ▪ Youth involved in the criminal justice system ▪ Youth receive general outpatient services
<p><i>Community Themes and Strengths Assessment, Licking County Health Department, 2010</i></p>	<p>Online survey of 69 community stakeholders to identify strengths, needs, and priorities</p>	<p>Online survey of 69 community stakeholders found high levels of concern about the following issues overall (in rank order)*:</p> <ul style="list-style-type: none"> ▪ Unemployment and lack of jobs ▪ Obesity ▪ Affordable health insurance ▪ Drug abuse ▪ Affordable dental care <p>*60% of more rated item as "major issue"</p> <p>Among issues related to behavioral health, social problems, and child wellbeing, the highest-priority topics were (in rank order)**:</p> <ul style="list-style-type: none"> ▪ Drug abuse 	<p>All populations</p>

Needs assessment (data source), year conducted (time frame), and Organization that conducted the assessment	Method and Stakeholders Involved/Number of participants	Key Findings	Populations
		<ul style="list-style-type: none"> ▪ Alcohol abuse ▪ Poverty ▪ Mental illness ▪ Teen pregnancy (40% of more rated item as "major issue") 	
<p><i>County Suicide Trends, 2004 to 2010</i>, data compiled by Pathways of Central Ohio, 2010</p>	<p>Compilation of county-level suicide data</p>	<p>Total number of suicides in 2009:</p> <ul style="list-style-type: none"> ▪ 28 in Licking County, up 58% from 2008 ▪ 11 in Knox County, up 55% from 2008 <p>Average age for suicides was 48 years in Licking and 46 years in Knox.</p> <p>Total number of suicides in 2010:</p> <ul style="list-style-type: none"> ▪ 23 in Licking County, down 18% from 2009 ▪ 7 in Knox County, down 36% from 2009 	<p>All populations</p>

Access to Service

Major issues in access to services

Significant funding reductions have affected service access to several populations. Mental health services to non-SMD individuals seeking general outpatient treatment and/or involved in the criminal justice system are very limited. Additionally, prevention services have been decreased.

Regardless of decreases in funding, the CMHRB has maintained core safety net services for the community. This included provision of core intervention and treatment services to SMD adults and SED children; SAMI adults and adolescents, NGRI and IST-U-CJ forensic consumers; adults, children, and adolescent who abuse or are addicted to alcohol or other drugs; access to aftercare services for children and adult residents following state or private hospitalization; availability of crisis services to all persons regardless of payer source or ability to pay; and the CMHRB contribution to pooled funding for Children and Family First Councils of both counties and the partial funding of the Licking County family team facilitator. While services are limited to non-SMD adults and non-SED children, this population may be served through the use of evidenced based shorter term therapies and/or may access support groups offered by CMHRB providers. In planning for the needs and provision of services to adults and individuals involved in the criminal justice system, the CMHRB is a very committed partner with other systems and stakeholders. These partnerships include Licking County Juvenile and Adult Reentry Taskforce, behavioral health courts in both counties, specialized teams including DDIT and ACT/FACT, and the Licking County Community Corrections Planning CMHRB. Several CMHRB providers collaborate with local veterans' groups by providing prevention activities and participation in support groups. Planning for the needs of veterans also occurs in a number of community collaborations including suicide prevention collations, CIT steering committees, and the various drug taskforce initiatives.

Both mental health and alcohol and other drug service (AOD) providers missed access to service targets for children and adolescents during most quarters. in SFY 10. In some cases this is likely due to problems with overall system capacity (i.e., consumer demand is greater than can be absorbed by existing resources) while in other cases providers are working on improving productivity and utilization management. While some improvement occurred in SFY 11, the trend still continued. Of particular concern is access to services for children and adolescents. Access to services will be one of the top three continuous quality improvement goals for SFY12 and is prioritized throughout the goals, objectives, and strategies of the SFY12-SFY13 Community Plan.

To address access to service issues, several providers have initiated utilization management efforts coupled with the use of evidenced based intervention and treatment practices when clinically applicable. Additionally, as a result of CMHRB sponsored Innovation Planning process the Innovations Utilization Management Work Group was formed to:

- Explore utilization models being used at various agencies in Licking and Knox County and assess model effectiveness
- Standardize utilization management techniques across the system of care

- Coordinate provider utilization management practices to address SFY 12-SFY13 Medicaid cost containment strategies, improve access to care, decrease duplication of services, and increase the quality of services overall.

Crisis care services (OAC 5122-29-10 (B))

The CMHRB, in spite of significant funding cuts over the past two years, has prioritized and maintained core and safety net services for the community. Crisis intervention services are a funding priority and a behavioral health capacity goal of the SFY 12-SFY 13 Community Plan. All persons in need of crisis services, regardless of their ability to pay and/or the county of residence will receive crisis interventions services as outlined in OAC 5122-29-10 (B). Identified gaps in service include the need for a short term stabilization unit and increased access to psychiatry 24/7.

Identifying and prioritizing training needs for crisis intervention services personnel

Assessment/Survey/Method	Priority Need	SFY 10-SFY 11 Plan	SFY 12-SFY 13 Plan
1. Knox County Behavioral Health Needs Prioritization Survey (2006) 2. CIT steering committee review of CIT officer intervention field sheets and best practice fidelity and outcomes (2011)	Timely access to 24-hour crisis services	Maintain Knox CIT program and conduct CIT training academy for each year to train 10 – 20 additional officers	Maintain Knox CIT program. By June 2013, train at least 15 additional CIT officers
1. Licking County Community Blueprint (2006) 2. CIT steering committee review of CIT officer intervention field sheets and best practice fidelity and outcomes (2011)	Access to behavioral healthcare	Maintain Licking CIT program and conduct CIT training academy for each year to train 10 – 20 additional officers.	Maintain Licking CIT program. By June 2013, train at least 25 additional CIT officers
1. CMHRB Health Officer Policy #351 2. SAMHSA evidenced best practice: Practice Guidelines: <i>Core: Elements in Responding to Mental Health Crises</i> 3. CMHRB case consultation and review of all OAC 5122 activities (pink slipping and probate) and other hospital assessment documentation	Provide annual training for CMHRB contract provider crisis intervention/emergency service personnel.	If funding is available, the CMHRB will provide further risk assessment & management training for both years. Training opportunities will be extended to other systems of care and service in both counties	Annual OAC 5122 refresher training to be offered both years. The CMHRB, if funding available, will provide further risk assessment & management training for both years. Training opportunities will be extended to other systems of care and service in both counties.

Workforce Development and Cultural Competence

Work force development

While providers are the primary driver for recruitment, development and retention, CMHRB has collaborated with providers to offer the following:

- Training on mental health and addiction issues specific to delivering integrated services from the SAMI CCOE

- Motivational interviewing
- Dual diagnosis – mental health and developmental disabilities
- Cognitive behavioral therapy
- Triple P parenting strategies
- PAX Good Behavior Game
- Youth risk assessment and safety plan development
- Providing services to returning veterans and their families
- Psychiatric risk assessment and hospital diversion strategies

We also have worked with criminal justice organizations to identify system needs to better serve that population and will be offering opportunities to increase staffs skill set in addressing trauma issues. As part of our offender task force, we are identifying issues not just in the behavioral health system but our response system as a whole to prepare for the increase in non-violent offenders returning to the community. This includes strategies necessary to successfully respond to the state policy change and staff training will be included in this process..

Due to shrinking resources, many of our network providers are using on-line training as a preferred means of meeting training needs, offering greater flexibility with a minimal impact on productivity. We have shared information about a number of web-based training opportunities with providers on a variety of clinical and administrative issues.

We will be using the results of our upcoming prevention planning processes as a basis for prevention staff workforce development especially as it relates to the implementation of the *(Institute of Medicine report Prevention of Mental Disorders and Substance Abuse Among Children, Youth, and Young Adults: Research Advances and Promising Interventions)* recommendations that we are using as a guide to focus our local prevention strategy implementation.

Recruitment of qualified, independently licensed staff continues to be an issue in our system for both mental health and addiction providers. This is especially true for staff skilled in family work. Psychiatrists and advanced practice nurses with prescribing authority are also extremely difficult to attract outside of a metropolitan area. We have offered funds for the use of a recruiting firm in the past but in large part that strategy was unsuccessful. Both the board and providers offer placement opportunities for associate, bachelors, masters and psychiatric internships on an ongoing basis.

As we continue to work to increase the integration of mental health and addiction services there is an ongoing need to offer training that will increase that skill set. We have also identified a need to address the potential increase in demand for services to address problem gambling and we need to expand the number of practitioners that have the knowledge and skill set to assist this population. We have started discussions to identify training needs to achieve improved integration with primary health care. Additionally we are working with our addiction providers to determine training needs that will increase the effectiveness of services for those experiencing addiction to opiates.

One of the most concerning trends we are seeing in staff turnover is they are not just leaving a particular organization, they are leaving the field. The issue of a qualified work force with sufficient numbers to meet clinical and administrative demand is an ongoing issue that will need to be addressed far beyond the local level.

Cultural Competency

The board has worked to refine the manner in which we identify issues related to cultural competence and track trends in Licking and Knox counties. The largest shift in population in our service area that we can quantify is the increase in poverty. Providers are not reporting an increase in requests for interpreters or ASL providers. We have analyzed MHSIP data by race, ethnicity and gender and have not identified variances from non-white respondents (note the number of non-whites served is small) or significant gender differences. We do see a difference in responses of those under 18 and are working with providers to define what may be contributing to this difference. We have co-sponsored training in the Culture of Poverty and fund a parenting program that address issues of poverty as a component of that program. We monitor the level of service delivery to Medicaid and non-Medicaid persons identified as having a severe mental illness and find no appreciable difference in level of service delivery. Our clinical manager monitors the service utilization and progress of those discharged from the state psychiatric hospital system and works with providers if there appear to be gaps in service delivery. The majority of persons released from state prisons has substance abuse issues but are not on supervision when released and are more difficult to track.

In addition to areas addressed in the workforce development section, board staff informs providers of training opportunities on cultural competence and we are on multiple list serves that provide information that increases our awareness and knowledge of service delivery issues that inform our planning process.

Another area of focus for our board is addressing is the culture of systems and system change. As interplay between various systems in the community increases such as with criminal justice and primary health care, we have identified a need to assist multiple systems in increasing their understanding of the needs, requirements and pressures of each system. The goal being to increase the ease in which various systems are collaborating to work more effectively and efficiently to meet our mutual goals. As an example, we are using the offender re-entry task force as a vehicle to increase the effectiveness in working together to increase community safety and reduce recidivism. We are just beginning to look at the relationship between primary healthcare and behavioral healthcare locally to identify vehicles to increase planning and collaboration

Capital Improvements

The CMHRB is an active partner in the development of local housing/homelessness strategies and participation in each county's continuity of care housing planning process. The participation in a housing collaborative and supporting The Main Place in obtaining funding for housing projects are two of the CMHRB SFY12-SFY13 behavioral health capacity goals. Currently, there is one capital improvement projects under consideration for development. The Main Place, funded by the CMHRB and a consumer-operated peer support services provider, will both own the properties and provide supportive services. Capital improvement projects include the development of a Licking County permanent supportive housing project for SMD adults with co-occurring disorders, at risk of hospitalization, without income and a recent history of homelessness. (SFY13 - SFY14). Project description is provided below:

Licking County (SFY13-SFY14): The Place Next Door will provide permanent supportive housing to adults experiencing serious and persistent mental illness with co-occurring disorders, at risk for

hospitalization, without income, and a recent history of homelessness. Potential tenants will be referred from the ACT/FACT and SAMI teams, both serving the CMHRB's highest risk adult SMD consumers. Program admission will be prioritized for consumers transitioning from long term hospitalization, who have been living in Adult Care Facilities, and are ready to move to less restrictive environments of their choice. Certified Peer Specialists will be on site 16 hours per day with a resident manager overnight. Supportive Services staff and the resident manager will be persons who have completed Ohio's Peer Specialist Certification and are trained appropriate to their scope of practice to provide supportive housing services. The project will be located adjacent to the consumer-operated Peer Recovery Center where tenants will have access to education, advocacy and supports in an environment that promotes recovery and wellness. Through collaborations with other CMHRB treatment providers, tenants will have access to behavioral health care. The project will provide 10 units of housing.

The CMHRB will continue to work with housing partners to seek funding to increase the housing stock. Focus will be for those involved in the criminal justice system and have addiction or mental health issues.

While there is a need to expand on-site supported housing for men in both counties we do not anticipate we will have operating funds in the next two years to staff the facilities. Both our addiction and mental health provider outpatient facilities are in need or renovations to operate in a more cost effective manner.

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 CMHRB used to determine prevention, treatment and capacity priorities

The CMHRB system of care has faced many challenges resulting from significant decreases in funding. In spite of this, the CMHRB has been committed in maintaining core and safety net services, especially to children and adolescents and their families.

The prioritization of the CMHRB system of care was conducted to address future funding reductions and identify investment and resource allocations. The prioritization included all treatment, intervention, and prevention programs/services that were approved for funding in SFY 11. A similar process occurred in SFY10 as a result of state and federal funding cuts allowing the continued funding of core and safe net services/programs and additional prevention and intervention services.

Prioritization included ranking of programs and services by risk, level of care and medical necessity, and other criteria taking into consideration priority populations. The CMHRB Board was first introduced to the prioritization of the CMHRB system of care in November 2010 and utilized the process in the SFY12 allocation decision making process by aligned funding amounts to programs/services

Services/programs were ranked and placed into six tiers according to:

1. **Risk:** Potential negative impact if the service was not provided.
 - Risk to public safety
 - Risk to self and/or others
 - Risk of diminished functioning or capacity
 - Risk of medical emergency (access to detox services)
 - Risk of institutionalization
 - Financial risk or high utilization of system resources

2. **Level of Care** required to manage risk and meet **medical necessity** (ORC 5101:3-1-01).

Medically necessary services are defined as services that are necessary for the diagnosis or treatment of disease, illness, or injury and without which the individual can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of body organ or part, or significant pain and discomfort. (ODMH May 2010). A medically necessary service must meet generally accepted standards of medical practice, be appropriate to the illness or injury for which it is performed as to the type of service and expected outcome, and to the intensity of the service and level of setting.

- The higher the risk and/or the greater the medical necessity, the higher the level of care required.
- Programs providing higher levels of care were prioritized higher by tier. Programs with higher levels of care generally provided greater intensity and frequency of service.
- Prioritization aligned with ODMH and ODADAS service certification requirements. Service certification requirements address medical necessity and levels of care.
- For AOD programs, prioritization aligned with ODADAS Levels of Care. These levels of care incorporate medical necessity.

Tier placement and prioritization also included:

1. Programs that contain mandated services and/or funding
2. Access to services for children and adolescents and their families
3. Duplication of services:
 - Is there more than one program provided for the same identified population with the same clinical objectives?
 - Are these programs operating at full capacity?
 - What would be the impact to the identified population if one or more of these duplicated services would be decreased or eliminated?
4. Results of April 2010 Stakeholder Surveys (Consumers, Community Stakeholders, and Innovations Committee members)

Based upon the ranking criteria, services and programs were ranked and placed onto one of six tiers:

Tier 1: CRISIS SERVICES – RISK OF IMMINENT HARM

Criteria: Risk of serious and imminent harm (includes need for emergency or urgent services due to danger to self/others, and/or incapable of self-care due to behavioral healthcare issues and/or potential life threatening symptoms resulting from withdrawal from substances). Services include assessment of risk, crisis/safety planning, and referral to appropriate level of care to resolve any imminent harm.

Characteristics

- All providers on Tier One have their own crisis workers and or crisis/hotline – 24/7 access.
- Serves all populations and provided to general community.
- Participants present with life & death crises.
- Participants may not currently receive treatment services or may have never received treatment services.

- Level of risk determined and safety plan developed with assistance/referral to appropriate level of care to resolve imminent harm including hospitalization, other institutionalization, or DV shelter stay. Plans may involve law enforcement or court involvement.
- Brief therapy (EBP – evidenced based practice) coupled with medication management may be provided in an urgent care model with the goal of returning the individual to a safe level of functioning and resolving the immediate crisis.
- Referral made to longer term treatment/care if necessary.

Tier 2: TREATMENT SERVICES – HIGH RISK

Criteria: Court ordered NGRI/IST-U-CJ forensic care, monitoring, and treatment; services to persons of CMHRB priority populations with histories of community violence, treatment non-compliance, and/or criminal justice involvement; services to persons with co-occurring disorders and/or multiple hospitalizations and/or multiple detoxification stays; and services to youth (birth – 17) involved with multi community system involvement and/or in danger of out of home placement. Includes the use of consumer specific plan and must be medically necessary.

Characteristics

- Priority Populations
- Medically necessary
- All youth MH and AOD treatment services including highest risk youth and their families
- Highest risk MH and AOD adult treatment services
- Often includes the use of EBP – evidenced based practices with moderate use of fidelity or other recognized clinical based practices

Tier 3: TREATMENT SERVICES – MODERATE RISK

Criteria: Risk of serious negative outcomes, but not imminent harm (includes need for treatment or intervention to persons of CMHRB priority populations that provides structured recovery focused activities leading to stabilization of behavioral healthcare symptoms and/or other safety issues and/or increased functioning). Includes the use of a consumer specific plan and must be medically necessary.

Characteristics

- Priority Populations
- Medically necessary
- Remaining adult MH and AOD treatment services
- Some services, especially AOD, include the use of EBP – evidenced based practices with limited fidelity or other recognized clinical based practices

Tier 4: INTERVENTION SERVICES – POTENTIAL MODERATE RISK

Criteria: Risk of potential negative outcomes in long-term (includes need for intervention that provides structured recovery focused activities and support leading to stabilization of behavioral healthcare symptoms and/or other safety issues, and/or increased functioning OR need for intervention that provides activities that support the recovery process). Typically includes the use of a consumer specific plan and generally are not medically necessary. May or may not include CMHRB Priority populations. Consumers may receive other medically necessary services on other tiers

Characteristics

- May or may not include Priority Populations.
- Does not include MH or AOD treatment services.
- Services are not medically necessary but represent wellness and recovery/resiliency.
- Services may include life skill development or provide resources and referral to community services leading to greater self-sufficiency and increased functioning.
- People receiving intervention services may represent high and medium risk groups and receive medically necessary services on other tiers.
- Intervention services are often part of a person's recovery plan and contribute to his/her stability.
- Intervention services often contribute to a person remaining in the community and not requiring a higher level of care or institutionalization.
- Some use of EBP – evidenced based practices with limited fidelity or other recognized clinical or services based practices

Tier 5: PREVENTION – POTENTIAL MODERATE RISK

Criteria: Potential risk for negative outcomes for many participants in the intermediate to longer-term if services are not provided before more serious problems develop. Early intervention refers to programs delivered to young children and/or their parents and programs delivered to at – risk adolescents before serious problems emerge. Negative outcomes these programs aim to prevent include child abuse and neglect, behavioral and social-emotional problems, school failure, alcohol and other drug abuse, teen pregnancy, delinquency, and violence. Interventions are not considered medically necessary and typically do not include the use of a consumer specific plan. May or may not include CMHRB Priority Population

Characteristics

- Early intervention services provided to young children and their families and at risk adolescents that present potentially serious problems.
- Participants may not currently receive treatment services or may have never received treatment services.
- Services represent resiliency based interventions.
- Participants may have involvement with other community services or systems of care.
- Some use of EBP – evidenced based practices with limited to more rigorously utilized fidelity or other recognized service practices

Tier 6: PREVENTION UNIVERSAL PREVENTION WITH YOUTH & THEIR FAMILIES - POTENTIAL LOWER RISK

Criteria: Potential risk for negative outcomes in the long-term for some participants. Negative outcomes these programs aim to prevent include alcohol and other drug use, violence, and sexual assault. Typically serve the general population of children or adolescents and their families, without regard to risk factors. Aims to prevent problems before they arise (primary prevention). Does not include a consumer specific plan and is not medically necessary. May or may not include CMHRB Priority Populations.

Characteristics

- Services provided to the general population targeted at alcohol and other drug use, violence, and sexual assault.

- Participants may not currently receive treatment services or may have never received treatment services.
- Participants may have involvement with other community services or systems of care.
- Services may include resiliency based interventions.
- Some use of EBP – evidenced based practices with limited to more rigorously utilized fidelity or other recognized service practices

The prioritization process was used as the decision making framework and integrated with other processes to determining prevention, treatment, and capacity priorities for the SFY 12- SFY 13 Community Plan. Results were analyzed and incorporated into the plan to align with both local and state priorities. Other processes included:

- **Needs assessment findings (2006-2011):** The *Preliminary 2011 Needs Assessment and Gaps Analysis*, the *Community Themes and Strengths Assessment* conducted by the Licking County Health Department (2010), *County Suicide Trends 2004-2009* data compiled by Pathways of Central Ohio (2010), *Our Future's Pride Survey of Licking County Youth* (May 2009 and May 2010), *Licking County Community Blueprint* conducted by United Way (2006), and *Moving Toward a Stronger Knox County Community Assessment* (2004-2005).
- **Consumer and General Public Input:** CMHRB Consumer Forums (four forums conducted in December 2010) and CMHRB Focus Groups (five groups conducted in January 2010)
- **Satisfaction Surveys:** *2010 CMHRB Stakeholder Priorities Survey Results, January and July* and *2010 CMHRB Consumer Satisfaction and Outcomes Survey Results (MHSIP, YSS, YSS-F)*
- **CMHRB Performance Targets:** SFY10 Year-End CMHRB Performance Targets and SFY 11 First and Second Quarter CMHRB Performance Targets
- **CMHRB Budget Application Process (BAP):** SFY12 BAP

CMHRB staff analyzed the results of needs assessment findings and satisfaction surveys and data and trending of CMHRB performance targets and other outcome reports and drafted a proposed plan that included prevention, treatment, and capacity priorities for the SFY12-SFY 13 plan. Planning aligned with the CMHRB system of care prioritization, CMHRB priority treatment population policy, local and state priorities, and the CMHRB BAP process. The draft plan was presented to a number of groups for their review and input:

- In November and December 2010 there were four Community Forums held in both Licking and Knox Counties in which a total of 46 consumers participated. CMHRB presented the SFY 2012-13 Community Plan draft goals; Consumers generally agreed those draft goals were among the highest priorities, however, there were three themes that varied from the initial goals, objectives and strategies as follows:
 1. Basic survival/poverty issues relating to housing and employment and stigma among employers
 2. Family/child-related prevention
 - Increase positive family management (AOD Prevention)
 - Prevention of child sexual abuse (MH Prevention)
 - School based mental health (MH Prevention)
 3. More case management and peer support

- In response to this feedback, the CMHRB added or re-emphasized three specific areas in the plan's goals and objectives:
 1. New goal added to Behavioral Health Capacity: "Work with other systems to improve opportunities for stable housing and employment for behavioral health consumers."
 2. New goal added to Alcohol and Other Drug Prevention: "Increase positive family management."
 3. An additional strategy added to the Mental Health Treatment goal "increase positive outcomes, social connectedness and functioning: "Utilization Management Workgroup will address supports for consumers leaving services and provision of follow up supports, including peer-led supports."

The SFY 12-SFY 13 Community Plan was presented to the CMHRB Board Program and Alcohol and other Drug Committee on November 9, 2010 and January 7, 2011 and to the full CMHRB Board at their November 18, 2010 meeting. CMHRB provider executive directors and CEOs reviewed the plan for input and comment during a January 5, 2011 meeting.

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

Behavioral Health Capacity Goals, Objectives, and Strategies

Table One

Goal #1: Maintain access to crisis services for persons with SPMI, SMD, and SED regardless of ability to pay. (ODMH goal)	
Objective	Strategy
Objective 1a. For cumulative FY12 and FY13, no more than 5% of Pathways Hotline calls will be dropped calls (PT A1a).	Prioritize funding for crisis services during the FY12 and FY13 budget processes.
Objective 1b. For cumulative FY12 and FY13, all providers will meet board performance target A2(1): 90% of individuals in crisis/emergency situations will be responded to within 1 hour of their initial contact.	Prioritize funding for crisis and emergency services during the FY12 and FY13 budget processes.

Goal #2: Promote and sustain the use of "evidence-based" policies, practices, strategies, supportive housing, peer support, and other programs. (ODMH/ODADAS goal)	
Objective	Strategy
Objective 2a. By June 2012, CMHRB will conduct a cost-benefit analysis of evidence-based programs currently funded by the board (mental health and AOD treatment, and prevention) to guide decision-making about future investments.	<ul style="list-style-type: none"> ▪ CMHRB staff will identify all currently funded evidence-based programs, gather available data from MACSIS and other sources, and prepare a report. ▪ The board will review the results and use them to guide future funding decisions.
Objective 2b. For cumulative FY12 and FY13, all ACT Team fidelity targets will be met (PT H1a. staff-to-consumer ratio no greater than 1:10, and PT H1b. 65% of all face-to-face service contacts in community).	Prioritize funding for ACT/FACT Team during the FY12 and FY13 budget processes (contingent upon demonstration of positive outcomes and cost-effectiveness) to support clinically appropriate service delivery to high risk SPMI/SMD consumers and to lower psychiatric hospitalizations.
Objective 2c. For cumulative FY 12 and FY 13, 75% of FACT (NGRI & ISTU-CJ) consumers released to community control will meet the terms of their	Prioritize funding for ACT/FACT Team during the FY12 and FY13 budget processes (contingent upon demonstration of positive outcomes and cost-

conditional release and remain in the least restrictive treatment environment (PT H1c).	effectiveness) to support public safety and clinically appropriate service delivery to high profile, high risk forensic (NGRI & ISTU-CJ) consumers and to lower conditional release recidivism.
Objective 2d. In FY12 and FY13, the SAMI Team programs will demonstrate improvements in fidelity by meeting at least 80% of fidelity performance targets (PT H2a-5, improvements in fidelity scores for Training, Supervision, Process Monitoring, Outcome Monitoring, and Quality Improvement; meet at least 8 out of 10, 5 targets x 2 counties).	<ul style="list-style-type: none"> ▪ Prioritize funding for SAMI during the FY12 and FY13 budget processes (contingent upon demonstration of positive outcomes and cost-effectiveness) to support clinically appropriate service delivery to high risk SPMI/SMD/SAMI consumers and to lower jail and hospital recidivism. ▪ Continue to support the CCOE's annual Fidelity Review process.
Objective 2e. For cumulative FY12 and FY13, at least 25% of prevention program participants (contract providers) will take part in evidence-based programs (PT K3).	Continue to include evidence-based status and fidelity as criteria for prioritizing programs in the FY12 and FY13 budget application processes.
Objective 2f. By June 2012, evidence best practice programs/models will be identified that address opiate dependency and other addiction issues.	Implementation of community strategies utilizing evidenced best practices addressing opiate dependency and other addiction issues including access to Medication Assisted Treatment (MAT).
Objective 2g. By June 2013, evidence best practice programs/models will be identified that address alcohol and other drug recovery support systems.	Implementation by providers of evidenced best practice alcohol and other drug recovery support programs/models in recovery management beyond the acute phase of addiction.
Goal #3: Make the best use of existing resources to maintain access to core services for priority populations. (CMHRB goal)	
Objective	Strategy
Objective 3a. For cumulative FY12 and FY13, all treatment providers will demonstrate an efficient relationship between productivity and access to services, as measured by meeting productivity performance targets for core outpatient services (PT D5). (Note: Providers will report high productivity/high access [green] or high productivity/low access [yellow] on the "Productivity and Access" quadrant chart for individual counseling, group counseling, case management, and pharmacological management.)	<p>Core services include pharmacological management, counseling, and case management/CPST.</p> <ul style="list-style-type: none"> ▪ Prioritize funding for services for priority populations during the FY12 and FY13 budget processes. ▪ Continue Utilization Management Workgroup (CMHRB staff-led group with representation from all tx providers) to develop system utilization management plan. ▪ Implemented revised Semi-Annual CQI Plan process by July 2011. <ul style="list-style-type: none"> ○ Consolidate and streamline: Semi-Annual QA/QI Reports, BAP Goals and Objectives, and Quarterly Performance Target comments for unmet targets. ○ Include in contracts with providers. ○ Semi-annual CQI reporting and meetings with CMHRB staff.
Goal #4: Work with other systems to improve opportunities for stable housing and employment for behavioral health consumers. (CMHRB goal)	
Objective	Strategy
Objective 4a. During FY12 and FY13, CMHRB will conduct four semi-annual waves of MHSIP data collection.	Collect data about housing and employment outcomes for consumers in order to track progress and needs (National Outcome Measures included on the CMHRB MHSIP

	survey).
Objective 4b. The Main Place will secure additional funding for housing development by FY12.	<ul style="list-style-type: none"> ▪ Assist The Main Place in securing funding outside the mental health system to support housing development (sale of CMHRB-owned property). ▪ Submit capital plan to leverage other funding for the development of a Licking County permanent supportive housing project for SMD adults with co-occurring disorders, at risk of hospitalization, without income and a recent history of homelessness. (SFY13-SFY14)
Objective 4c. For cumulative FY12 and FY13 providers will meet at least 80% of housing vacancy performance targets (vacancy of 10% or less).	Continue to monitor vacancy rates in housing units managed by CMHRB-contracted providers and ensure efficient use of existing housing resources
Objective 4d. By FY13, CMHRB staff will participate in at least two housing, employment, and/or re-entry-related collaborations.	<ul style="list-style-type: none"> ▪ Advocate for the needs of behavioral health consumers within the housing and employment assistance systems by actively participating in housing and employment-related collaborations. This includes the Licking County Re-Entry Task Force (ex-offenders) and the VRP3 initiative in both counties. ▪ Advocate for the needs of behavioral health consumers among employers and employment assistance service providers. Participate in VRP3 project.

Alcohol and Other Drug Prevention Goals, Objectives, and Strategies

Table Two

Objective	Strategy
Goal #5: "Programs that increase the number of customers who avoid ATOD use and perceive non-use as the norm." (ODADAS goal) & "Childhood/Underage Drinking" (ODADAS Priority) & "Individuals over the lifespan" (ODADAS population)	
Objective 5a. Decrease by at least 5% from the May 2009 baseline the rate of 12 th graders past 30-day use of alcohol, tobacco, and marijuana, by June 2012. (Source: Pride Survey in 7 school districts in Licking County. Drug Free Communities Grant objective.)	Licking County <ul style="list-style-type: none"> ▪ Implement strategies of Our Futures of Licking County. ▪ Maintain Drug Free Communities grant.
Objective 5b. Increase by at least 5% from the May 2009 baseline the rate of parental disapproval for alcohol, tobacco, and marijuana use among 10 th and 12 th graders, by June 2012. (Source: Pride Survey in 7 school districts in Licking County. Drug Free Communities Grant objective.)	Licking and Knox Counties <ul style="list-style-type: none"> ▪ Conduct prevention planning in each county to develop strategic community prevention plan. ▪ Invest in evidence-based AOD prevention services from contract providers, as funding levels permit.
Objective 5c. Knox County: By June 2011, at least three of the five school districts in Knox County will administer the Pride Survey with middle and high school students, providing baseline data	<ul style="list-style-type: none"> ▪ Partner with United Way of Knox County to coordinate survey process in Knox County. ▪ Share cost of surveys with schools districts and other stakeholders.
Objective 5d. All ATOD prevention programs implemented by contract providers will demonstrate effectiveness by providing outcome evaluation results on	<ul style="list-style-type: none"> ▪ Maintain semi-annual reporting requirement for ATOD prevention outcomes. ▪ Maintain evaluation section in funding application.

FY12 and FY13 year-end CMHRB prevention reports and in the FY12 and FY13 funding applications.	<ul style="list-style-type: none"> ▪ Provide technical assistance to prevention providers, as needed, to improve program evaluation capacity. ▪ CMHRB will use evidence of effectiveness to guide future investment decisions for prevention.
Goal #6. Increase positive family management (ODADAS goal) & Evidence-based Practice (ODADAS priority)	
Objective	Strategy
Objective 6a. All early intervention and parenting programs implemented by contract providers will demonstrate effectiveness by providing outcome evaluation results on FY12 and FY13 year-end CMHRB prevention reports and in the FY12 and FY13 funding applications.	<ul style="list-style-type: none"> ▪ Maintain semi-annual reporting requirement for prevention outcomes. ▪ Maintain evaluation section in funding application. ▪ Provide technical assistance to prevention providers, as needed, to improve program evaluation capacity. ▪ CMHRB will use evidence of effectiveness to guide future investment decisions for prevention.
Objective 6b. Reduce child maltreatment by FY13, as measured by number of children in Children’s Services custody, and number of CS referrals (baseline is 2008) (Ohio Children’s Trust Fund goal and Our Futures in Licking County goal).	<ul style="list-style-type: none"> ▪ Implement strategies of Our Futures in Licking County, including Triple P and Families United. ▪ Invest in evidence-based early intervention and parenting programs from contract providers, as funding levels permit. ▪ Continue to utilize the Licking County Team Facilitator (contingent on funding) to enhance service coordination efforts access multi-systems in Licking County for high risk SED youth and their families.

Mental Health Prevention Goals, Objectives, and Strategies

Table Three

Goal #7: “Strengthen families by targeting problems, teaching effective parenting and communication skills, and helping families deal with disruptions.” (ODMH goal) & “Children/youth with SED” (ODMH population) & “Early Intervention Programs” (ODMH priority)	
Objective	Strategy
Objective 7a. All early intervention and parenting programs implemented by contract providers will demonstrate effectiveness by providing outcome evaluation results on FY12 and FY13 year-end CMHRB prevention reports and in the FY12 and FY13 funding applications.	<ul style="list-style-type: none"> ▪ Maintain semi-annual reporting requirement for prevention outcomes. ▪ Maintain evaluation section in funding application. ▪ Provide technical assistance to prevention providers, as needed, to improve program evaluation capacity. ▪ CMHRB will use evidence of effectiveness to guide future investment decisions for prevention.
Objective 7b. Reduce child maltreatment by FY13, as measured by number of children in Children’s Services custody, and number of CS referrals (baseline is 2008) (Ohio Children’s Trust Fund goal and Our Futures in Licking County goal).	<ul style="list-style-type: none"> ▪ Implement strategies of Our Futures in Licking County, including Triple P and Families United. ▪ Invest in evidence-based early intervention and parenting programs from contract providers, as funding levels permit. ▪ Continue to utilize the Licking County Team Facilitator (contingent on funding) to enhance service coordination efforts access multi-systems in

	Licking County for high risk SED youth and their families.
Goal #8: “Strengthen individuals by building resilience and skills and improving cognitive processes and behaviors.” (ODMH goal) & “Adults with SMI, SPMI, and SMD/Children with SED” (ODMH populations) & “Crisis Intervention Training and other Jail Diversion Activities” (ODMH priority)	
Objective 8a. By June 2013, at least 25 additional CIT officers will be trained in Licking County.	Licking County CIT Steering Committee will plan and implement annual training academies in FY12 and FY13 meeting the suggested CIT training standards of the CCOE for Criminal Justice.
Objective 8b. By June 2013, at least 15 additional CIT officers will be trained in Knox County.	Knox County CIT Steering Committee will plan and implement annual training academies in FY12 and FY13 meeting the suggested CIT training standards of the CCOE for Criminal Justice.
Objective 8c. For FY 12 and FY 13 CIT Programs will be maintained in both Licking and Knox Counties through the activities of the Licking County CIT Steering Committee and the Knox County CIT Steering Committee.	Both steering committees will: a) ensure that county CIT program protocols meet, when feasible, the suggested CIT CCOE for Criminal Justice program standards, and b) will assess the training needs of CIT officers and provide opportunities for advanced CIT training in FY 12 and FY 13.
Objective 8d. For cumulative FY12 and FY13, 5% or less of current SAMI Team consumers will spend at least one night in jail or prison.	Prioritize funding for SAMI during the FY12 and FY13 budget processes (contingent upon demonstration of positive outcomes and cost-effectiveness) to reduce jail recidivism for high risk SPMI/SMD/SAMI consumers.
Objective 8e. For FY 12 and FY 13 continue to participate in the development and implementation of a comprehensive plan for mental health and criminal justice collaboration incorporating, when feasible, the Sequential Intercept Model (SAMHSA-National GAINS Center).	Continued participation with stakeholders in the development and support of jail diversion activities including CIT, special docket courts, and re-entry activities. Stakeholders include: Licking County Community Corrections Board, Licking County Municipal Behavioral Health Court Steering Committee, Knox County Municipal Behavioral Health Court Steering Committee, the Licking County CIT Steering Committee, the Knox County CIT Steering Committee, the Licking County Juvenile & Adult Re-entry Taskforce, and the Knox County DDIT Team Steering Committee (developmental disabilities & SPMI/SMI/AOD & criminal justice).

Alcohol and Other Drug Treatment and Recovery Services Goals, Objectives, and Strategies

Table Four

Goal #9: “Increase the number of customers who are abstinent at completion of the program.” (ODADAS goal) & “Women and Criminal Justice Involved Clients” (ODADAS population)	
Objective	Strategy
Objective 9a. For cumulative FY12 and FY13, all AOD providers will meet performance target G2 (abstinence at completion).	<ul style="list-style-type: none"> ▪ Continued incorporation by CMHRB contract AOD providers in service delivery of engagement and treatment strategies utilizing Motivational Interviewing, Stages of Change, and Stage Wise Treatment. Includes the use of these best practices and other population specific best practices in serving women, pregnant women, and criminal justice involved consumers. ▪ Continued CMHRB participation with community stakeholders in

	<p>the development and implementation of community strategies addressing opiate dependency including access to Medication Assisted Treatment (MAT).</p> <ul style="list-style-type: none"> ▪ Participate in Licking County prescription taskforce. ▪ Convene Knox County substance abuse taskforce ▪ Co-lead Licking County re-entry taskforce ▪ Utilization Management Workgroup will address supports for consumers leaving services and provision of follow-up supports, including peer-led supports.
<p>Objective 9b. On semi-annual basis in FY12 and FY13, CMHRB will monitor alcohol and other drug use for all consumer groups (mental health and AOD, adult and youth).</p>	<p>In April 2011, CMHRB will add items about AOD use to the Consumer Satisfaction and Outcomes instruments (MHSIP and YSS).</p>

Mental Health Treatment and Recovery Support Goals, Objectives, and Strategies

Table Five

<p>Goal #10: “Increase the number of consumers reporting positively about social connectedness and functioning and client perception of care.” (ODMH goal)</p>	
Objective	Strategy
<p>Objective 10a. Throughout FY12 and FY13, mental health providers will demonstrate adequate improvements in MHSIP, YSS, and YSS-F results for the <i>Outcomes Domain</i>, as measured by meeting board performance target G7a(b), G9a(b), and G11a(b).</p>	<ul style="list-style-type: none"> ▪ Develop new strategies for integrating peer support and a recovery focus throughout the behavioral health system. ▪ Implement revised Semi-Annual CQI Plan process by July 2011. <ul style="list-style-type: none"> ○ Consolidate and streamline: Semi-Annual QA/QI Reports, BAP Goals and Objectives, and Quarterly Performance Target comments for unmet targets. ○ Include in contracts with providers. ○ Semi-annual CQI reporting and meetings with CMHRB staff. ▪ Explore meaningful contract incentives to promote positive outcomes. ▪ Explore “no wrong door” service integration model (to be addressed by Utilization Management Workgroup). ▪ Support efficient use of evidence-based models for mental health treatment, including training and technical assistance on fidelity and outcomes.
<p>Objective 10b. Throughout FY12 and FY13, mental health providers will demonstrate adequate improvements in MHSIP and YSS-F results for the <i>Social Connectedness Domain</i>, as measured by meeting board performance target G7b(b), G9b(b), and G11b(b).</p>	
<p>Objective 10c. Throughout FY12 and FY13, mental health providers will demonstrate improvements in MHSIP and YSS-F results for the <i>Functioning Domain</i>, as measured by meeting board performance target G7c(b), G9c(b), and G11c(b).</p>	
<p>Goal #11: Improve provider follow-up with consumers being released from state and private hospitals. (CMHRB goal)</p>	
<p>Objective 11a. For cumulative FY12 and FY13, providers will meet at least 75% of the hospital follow-up performance targets (E1-E4 and F1-F3). [baseline Q4 FY10, 50% of targets were met; 12 of 24 provider-specific data points]</p>	<p>Include hospital follow-up targets in the Semi-Annual CQI Plan (see above), for appropriate providers.</p>

Access to Services

The following SFY12-SFY13 Community Plan goals and objectives with strategies address access to behavioral health services issues identified as key findings in needs assessments conducted in both provider organizations and in the community. Of particular concern is overall access to treatment services for children and adolescents; long periods of time between initial provide contact and the first appointment/second appointment; access to 24-hour emergency services/crisis intervention services, local outpatient psychiatry, early intervention for at-risk children and their families, alcohol and drug prevention, housing assistance; the sharp increase in opiate use and unintentional drug-related death rate; the community demand for behavioral health services appears to be exceeding capacity; and the potential impact of state policy changes and state budget cuts to other related systems (education, criminal justice, jobs and family services, etc.) on system capacity. Goals and objectives with strategies addressing these key findings of concern are found below.

Behavioral Health Capacity Goals, Objectives, and Strategies – Access to Service

Goal #1: Maintain access to crisis services for persons with SPMI, SMD, and SED regardless of ability to pay. (ODMH goal)	
Objective	Strategy
Objective 1a. For cumulative FY12 and FY13, no more than 5% of Pathways Hotline calls will be dropped calls (PT A1a)*	Prioritize funding for crisis services during the FY12 and FY13 budget processes.
Objective 1b. For cumulative FY12 and FY13, all providers will meet CMHRB performance target A2(1): 90% of individuals in crisis/emergency situations will be responded to within 1 hour of their initial contact.	Prioritize funding for crisis and emergency services during the FY12 and FY13 budget processes.
Goal #2: Promote and sustain the use of “evidence-based” policies, practices, strategies, supportive housing, peer support, and other programs. (ODMH/ODADAS goal)	
Objective	Strategy
Objective 2b. For cumulative FY12 and FY13, all ACT Team fidelity targets will be met (PT H1a. staff-to-consumer ratio no greater than 1:10, and PT H1b. 65% of all face-to-face service contacts in community).	Prioritize funding for ACT/FACT Team during the FY12 and FY13 budget processes (contingent upon demonstration of positive outcomes and cost-effectiveness) to support clinically appropriate service delivery to high risk SPMI/SMD consumers and to lower state and private hospitalizations.
Objective 2c. For cumulative FY 12 and FY 13, 75% of FACT (NGRI & ISTU-CJ) consumers released to community control will meet the terms of their conditional release and remain in the least restrictive treatment environment (PT H1c).	Prioritize funding for ACT/FACT Team during the FY12 and FY13 budget processes (contingent upon demonstration of positive outcomes and cost-effectiveness) to support public safety and clinically appropriate service delivery to high profile, high risk forensic (NGRI & ISTU-CJ) consumers and to lower conditional release recidivism.
Objective 2d. In FY12 and FY13, the SAMI Team programs will demonstrate improvements in fidelity by meeting at least 80% of fidelity performance targets (PT H2a-5, improvements in fidelity scores for Training, Supervision, Process Monitoring, Outcome Monitoring, and Quality Improvement; meet at least 8 out of 10, 5	<ul style="list-style-type: none"> ▪ Prioritize funding for SAMI during the FY12 and FY13 budget processes (contingent upon demonstration of positive outcomes and cost-effectiveness) to support clinically appropriate service delivery to high risk SPMI/SMD/SAMI consumers and to lower jail and hospital

targets x 2 counties).	<ul style="list-style-type: none"> ▪ recidivism. ▪ Continue to support the CCOE's annual Fidelity Review process.
Goal #3: Make the best use of existing resources to maintain access to core services for priority populations. (CMHRB goal)	
Objective	Strategy
Objective 3a. For cumulative FY12 and FY13, all treatment providers will demonstrate an efficient relationship between productivity and access to services, as measured by meeting productivity performance targets for core outpatient services (PT D5). (Note: Providers will report high productivity/high access [green] or high productivity/low access [yellow] on the "Productivity and Access" quadrant chart for individual counseling, group counseling, case management, and pharmacological management.)	<p>Core services include pharmacological management, counseling, and case management.</p> <ul style="list-style-type: none"> ▪ Prioritize funding for services for priority populations during the FY12 and FY13 budget processes. ▪ Continue Utilization Management Workgroup (CMHRB staff-led group with representation from all tx providers) to develop system utilization management plan. ▪ Implement revised Semi-Annual CQI Plan process by July 2011. <ul style="list-style-type: none"> ○ Consolidate and streamline: Semi-Annual QA/QI Reports, BAP Goals and Objectives, and Quarterly Performance Target comments for unmet targets. ○ Select 3 to 5 CQI objectives for each fiscal year. Provide specific timelines and targets for activities and outcomes. ○ Include in contracts with providers. ○ Semi-annual CQI reporting and meetings with CMHRB staff.
Goal #4: Work with other systems to improve opportunities for stable housing and employment for behavioral health consumers. (CMHRB goal)	
Objective	Strategy
Objective 4a. During FY12 and FY13, CMHRB will conduct four semi-annual waves of MHSIP data collection.	Collect data about housing and employment outcomes for consumers in order to track progress and needs (National Outcome Measures included on the CMHRB MHSIP survey).
Objective 4b. The Main Place will secure additional funding for housing development by FY12.	<ul style="list-style-type: none"> ▪ Assist The Main Place in securing funding outside the mental health system to support housing development (sale of CMHRB-owned property) ▪ Capital Improvement Projects for the development of a Licking County permanent supportive housing project for SMD adults with co-occurring disorders, at risk of hospitalization, without income and a recent history of homelessness. (SFY13-SFY14). Planning for a similar capital improvement project in Knox County. (SFY15-SFY16).
Objective 4c. For cumulative FY12 and FY13 providers will meet at least 80% of housing vacancy performance targets (vacancy of 10% or less).	Continue to monitor vacancy rates in housing units managed by CMHRB-contracted providers and ensure efficient use of existing housing resources
Objective 4d. By FY13, CMHRB staff will participate in at least two housing, employment, and/or re-entry-related collaborations.	<ul style="list-style-type: none"> ▪ Advocate for the needs of behavioral health consumers within the housing and employment assistance systems by actively participating in housing and employment-related collaborations.

	<p>This includes the Licking County Re-Entry Task Force (ex-offenders) and the VRP3 initiative.</p> <ul style="list-style-type: none"> ▪ Advocate for the needs of behavioral health consumers among employers and employment assistance service providers. This includes the VRP3 initiative.
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Alcohol and Other Drug Prevention Goals, Objectives, and Strategies – Access to Service

Objective	Strategy
Goal #5: “Programs that increase the number of customers who avoid ATOD use and perceive non-use as the norm.” (ODADAS goal) & “Childhood/Underage Drinking” (ODADAS Priority) & “Individuals over the lifespan” (ODADAS population)	
Objective 5a. Decrease by at least 5% from the May 2009 baseline the rate of 12 th graders past 30-day use of alcohol, tobacco, and marijuana, by June 2012. (Source: Pride Survey in 7 school districts in Licking County. Drug Free Communities Grant objective.)	<p>Licking County</p> <ul style="list-style-type: none"> ▪ Implement strategies in Our Futures of Licking County. ▪ Maintain Drug Free Communities grant.
Objective 5b. Increase by at least 5% from the May 2009 baseline the rate of parental disapproval for alcohol, tobacco, and marijuana use among 10 th and 12 th graders, by June 2012. (Source: Pride Survey in 7 school districts in Licking County. Drug Free Communities Grant objective.)	<p>Licking and Knox Counties</p> <ul style="list-style-type: none"> ▪ Invest in evidence-based AOD prevention services from contract providers, as funding levels permit.
Goal #6. Increase positive family management (ODADAS goal) & Evidence-based Practice (ODADAS priority)	
Objective	Strategy
Objective 6b. Reduce child maltreatment by FY13, as measured by number of children in Children’s Services custody, and number of CS referrals (baseline is 2008) (Ohio Children’s Trust Fund goal and Our Futures in Licking County goal).	<ul style="list-style-type: none"> ▪ Implement strategies in Our Futures in Licking County, including Triple P and Families United. ▪ Invest in evidence-based early intervention and parenting programs from contract providers, as funding levels permit. ▪ Continue to utilize the Licking County Team Facilitator (contingent on funding) to enhance service coordination efforts access multi-systems in Licking County for high risk SED youth and their families.

Mental Health Prevention Goals, Objectives, and Strategies – Access to Service

Goal #7: “Strengthen families by targeting problems, teaching effective parenting and communication skills, and helping families deal with disruptions.” (ODMH goal) & “Children/youth with SED” (ODMH population) & “Early Intervention Programs” (ODMH priority)	
Objective	Strategy
Objective 7b. Reduce child maltreatment by FY13, as measured by number of children in Children’s Services custody, and number of CS referrals (baseline is 2008) (Ohio Children’s Trust Fund goal and Our Futures in Licking County goal).	<ul style="list-style-type: none"> ▪ Implement strategies in Our Futures in Licking County, including Triple P and Families United. ▪ Invest in evidence-based early intervention and parenting programs from contract providers, as funding levels permit. ▪ Continue to utilize the Licking County Team Facilitator (contingent on funding) to enhance

	service coordination efforts access multi-systems in Licking County for high risk SED youth and their families.
Goal #8: “Strengthen individuals by building resilience and skills and improving cognitive processes and behaviors.” (ODMH goal) & “Adults with SMI, SPMI, and SMD/Children with SED” (ODMH populations) & “Crisis Intervention Training and other Jail Diversion Activities” (ODMH priority)	
Objective 8a. By June 2013, at least 25 additional CIT officers will be trained in Licking County.	Licking County CIT Steering Committee will plan and implement annual training academies in FY12 and FY13 meeting the suggested CIT training standards of the CCOE for Criminal Justice.
Objective 8b. By June 2013, at least 15 additional CIT officers will be trained in Knox County.	Knox County CIT Steering Committee will plan and implement annual training academies in FY12 and FY13 meeting the suggested CIT training standards of the CCOE for Criminal Justice.
Objective 8c. For FY 12 and FY 13 CIT Programs will be maintained in both Licking and Knox Counties through the activities of the Licking County CIT Steering Committee and the Knox County CIT Steering Committee.	Both steering committees will: a) ensure that county CIT program protocols meet, when feasible, the suggested CIT CCOE for Criminal Justice program standards, and b) will assess the training needs of CIT officers and provide opportunities for advanced CIT training in FY 12 and FY 13.
Objective 8d. For cumulative FY12 and FY13, 5% or less of current SAMI Team consumers will spend at least one night in jail or prison.	Prioritize funding for SAMI during the FY12 and FY13 budget processes (contingent upon demonstration of positive outcomes and cost-effectiveness) to reduce jail recidivism for high risk SPMI/SMD/SAMI consumers.
Objective 8e. For FY 12 and FY 13 continue to participate in the development and implementation of a comprehensive plan for mental health and criminal justice collaboration incorporating, when feasible, the Sequential Intercept Model (SAMHSA-National GAINS Center).	Continued participation with stakeholders in the development and support of jail diversion activities including CIT, special docket courts, and re-entry activities. Stakeholders include: Licking County Community Corrections CMHRB, Licking County Municipal Behavioral Health Court Steering Committee, Knox County Municipal Behavioral Health Court Steering Committee, the Licking County CIT Steering Committee, the Knox County CIT Steering Committee, the Licking County Juvenile & Adult Re-entry Taskforce, and the Knox County DDIT Team Steering Committee (developmental disabilities & SPMI/SMI/AOD & criminal justice).

Alcohol and Other Drug Treatment and Recovery Services Goals, Objectives, and Strategies – Access to Service

Goal #9: “Increase the number of customers who are abstinent at completion of the program.” (ODADAS goal) & “Women and Criminal Justice Involved Clients” (ODADAS population)	
Objective	Strategy
Objective 9a. For cumulative FY12 and FY13, all AOD providers will meet performance target G2 (abstinence at completion).	<ul style="list-style-type: none"> ▪ Continued incorporation by CMHRB contract AOD providers in service delivery of engagement and treatment strategies utilizing Motivational Interviewing, Stages of Change, and Stage Wise Treatment. Includes the use of these best practices and other population specific best practices in serving women, pregnant women, and criminal justice involved consumers.

	<ul style="list-style-type: none"> ▪ Continued CMHRB participation with community stakeholders in the development and implementation of community strategies addressing opiate dependency including access to Medication Assisted Treatment (MAT). Participation to include planning for a community task force. ▪ Utilization Management Workgroup will address supports for consumers leaving services and provision of follow-up supports, including peer-led supports.
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Mental Health Treatment and Recovery Support Goals, Objectives, and Strategies – Access to Service

Goal #10: “Increase the number of consumers reporting positively about social connectedness and functioning and client perception of care.” (ODMH goal)	
Objective	Strategy
Objective 10a. Throughout FY12 and FY13, mental health providers will demonstrate adequate improvements in MHSIP, YSS, and YSS-F results for the <i>Outcomes Domain</i> , as measured by meeting CMHRB performance target G7a(b), G9a(b), and G11a(b).	<ul style="list-style-type: none"> ▪ Develop new strategies for integrating peer support and a recovery focus throughout the behavioral health system. ▪ Implement revised Semi-Annual CQI Plan process by July 2011. <ul style="list-style-type: none"> ○ Consolidate and streamline: Semi-Annual QA/QI Reports, BAP Goals and Objectives, and Quarterly Performance Target comments for unmet targets. ○ Select 3 to 5 CQI objectives for each fiscal year. Provide specific timelines and targets for activities and outcomes. ○ Include in contracts with providers. ○ Semi-annual CQI reporting and meetings with CMHRB staff. ▪ Explore meaningful contract incentives to promote positive outcomes. ▪ Explore “no wrong door” service integration model (to be addressed by Utilization Management Workgroup). ▪ Support efficient use of evidence-based models for mental health treatment, including training and technical assistance on fidelity and outcomes.
Objective 10b. Throughout FY12 and FY13, mental health providers will demonstrate adequate improvements in MHSIP and YSS-F results for the <i>Social Connectedness Domain</i> , as measured by meeting CMHRB performance target G7b(b), G9b(b), and G11b(b).	
Objective 10c. Throughout FY12 and FY13, mental health providers will demonstrate adequate improvements in MHSIP and YSS-F results for the <i>Functioning Domain</i> , as measured by meeting CMHRB performance target G7c(b), G9c(b), and G11c(b).	
Goal #11: Improve provider follow-up with consumers being released from state and private hospitals. (CMHRB goal)	
Objective 11a. For cumulative FY12 and FY13, providers will meet at least 75% of the hospital follow-up performance targets (E1-E4 and F1-F3). [baseline Q4 FY10, 50% of targets were met; 12 of 24 provider-specific data points]	Include hospital follow-up targets in the Semi-Annual CQI Plan (see above), for appropriate providers.

Workforce Development and Cultural Competence

See Workforce Development and Cultural Competence discussion in Section II: Needs Assessment

ORC 340.033(H) Goals

CMHRB meets with the Commissioners and Job and Family Services staff annually to review access to our treatment services for parents/guardians referred by JFS for substance abuse services. The board has reviewed our priorities for funding addiction treatment services with both the commissioners and Job and Family Services in each county. The prioritization is based primarily on level of clinical risk as described earlier in Section III: Process the CMHRB Used to Determine Prevention, Treatment and Capacity Priorities. Our goal is to assure as much as funding allows, that those who are most at risk including parents, guardians and children themselves have access to the most appropriate service to meet their treatment needs.

Goal: to maintain timely access to out-patient treatment services to persons whose child is at imminent risk of abuse or neglect due to substance abuse.

Objective: Persons meeting this criterion will be scheduled for an initial clinical assessment appointment within 14 calendar days of the initial call.

Historically we have received \$66,227.00 in 484 funds for services to this population and funding has remained flat until this biennium when all funding is being used for match at the state level. CMHRB will be using local levy funds to serve the non-Medicaid portion of this population and there are no planned decreases to services at this time. Neither the Knox nor Licking JFS set aside funds specifically for this purpose for adults. Both contribute dollars to a pooled fund process that can be used to provide residential substance abuse treatment services for children if appropriate. Knox JFS contributes \$29,668 and Licking JFS contributes \$30,000 to pooled funds. We are currently working with JFS in Licking County to develop a strategy to increase case management services to this population to improve treatment outcomes. The Licking County JFS will be providing financial resources to this project.

HIV Early Intervention Goals

The CMHRB does not receive State General Funds (GRF) for the provision of HIV Early Intervention Services.

Addressing Needs of Civilly and Forensically Hospitalized Adults

In 2007 the CMHRB conducted a hospital admissions review project to analyze the characteristics of high risk civilly hospitalized adults with frequent and/or multiple hospitalizations and long lengths of stay. Results indicated while this population experienced more frequent and longer hospitalizations, they were less likely to engage in treatment or remain in service. To better meet the needs of this population, the CMHRB funded the evidence based practice ACT/Forensic ACT (FACT) team in Licking County. While team staff provides services to all ACT/FACT consumers, ACT serves non-forensic adults and FACT the forensic population. Serving some of the highest risk mental health consumers, the ACT/FACT team has consistently exceeded its performance targets and fidelity measures. This includes a significant decrease in hospitalizations and improved and continued participation in treatment by consumers. ACT/FACT was

ranked highly by consumers participating in the January 2010 Consumer Focus Groups.

In addition, the CMHRB has instituted two performance targets that measure discharge planning and access to care:

- 95% of clients being discharged from inpatient (non-state hospital)/detox/residential care (with stays of 3 or more calendar days) will have face-to-face or phone follow up contact within 7 calendar days of discharge
- 90% of adult clients hospitalized (AOD or psych) for 3 or more calendar days, active previous to hospitalization, and/or likely to receive on-going follow up services, will have contact while in the hospital to assist with discharge planning

Progress toward these performance targets is measured and reviewed quarterly with providers instituting strategies for improvement.

Forensically hospitalized consumers are followed by Behavioral Healthcare Partners of Central Ohio (BHPCO), a CMHRB provider and the CMHRB Forensic Monitor. In Licking County forensic consumers are served by the ACT/FACT team and in Knox County by adult CPST services. Both BHPCO and the forensic monitor attend hospital treatment team meetings to plan for discharge and conditional release into the community. BHPCO staff frequently involve The Main Place, the CMHRB funded peer support/consumer operated center in both counties, as part of a coordinated team effort to address the needs of forensic consumers as part of the conditional release plan. Both providers take consumers into the community prior to release so that the plan can be practiced and the consumer become reintegrated.

The CMHRB forensic monitor becomes involved with a forensically hospitalized consumer fairly early in the process generally beginning during competency evaluation or restoration process. This is to establish a relationship with the consumer and provide consultation to the treatment team, BHPCO, and the court. The CMHRB Chief Clinical Officer reviews the conditional releases of each forensic consumer and provides additional consultation. The forensic monitor has implemented a reporting system to monitor risk and adherence to the conditional release requirements and reports any violations to the court.

The CMHRB and BHPCO adhere to the conditions of the Continuity of Care agreement with Twin Valley Behavioral Healthcare in assuring that needs of hospitalized consumers are met in discharge planning and the provision of aftercare services.

CMHRB will continue efforts to educate and offer consultation to misdemeanor/municipal court judges and probation departments regarding non-violent offenders. Both counties' misdemeanor courts have a behavioral health courts for non-violent offenders that work closely with CMHRB providers.

Implications of Behavioral Health Priorities to Other System

We have determined our resources need to target those most at risk of negative consequences if substance abuse and or addiction treatment services were not available and to treatment services to children. The consequence of this strategy is those who are not severely ill have access to minimal services other than crisis intervention. We met with key stakeholders to explain the prioritization process. Our largest provider has implemented a solution focused therapy model to provide services to the general out-patient population. A significant area of impact is a reduction of mental health treatment services to

persons referred from the criminal justice system that do not meet the criteria for severe mental illness. While there is access to services, it is minimal. Additionally, we have reduced resources to prevention services impacting services to schools in both counties. With shrinking resources, providers are continually seeking ways to increase efficiency that has led to the closing or reduction of hours to satellite offices in Licking County.

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

Please see Section III: Process the CMHRB Used to Determine Prevention, Treatment and Capacity Priorities, for an explanation of the prioritization process used by CMHRB to date. In the event of further funding reductions we will continue making decisions based on the principals used to date. We will continue to seek consumer and stakeholder feedback and will revise our needs assessment data to inform the process.

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

Private hospitals:

- Both the Licking and Knox County CIT programs have developed procedure protocols that actively involve law enforcement, community hospitals and CMHRB contract providers in increasing face-to-face capacity of emergency service provision to both adults and children and adolescents. Both community hospitals provide the central location for CIT identified cases in need of further crisis intervention or pre-hospital screening that cannot be addressed in the field.
- Shepherd Hill Hospital, the behavioral healthcare inpatient psychiatric unit for Licking Memorial Hospital, participates in collaborative efforts involving crisis intervention and pre-hospital screening activities with the staff of Licking Memorial Hospital and the BHPCO Crisis Intervention/Emergency Services Department.
- The CMHRB allocates detoxification funding to their AOD providers to purchase detoxification and short term treatment private facilities. Shepherd Hill Hospital partners with CMHRB AOD agencies to provide detoxification and other addiction services. This includes the use of MAT treatment.
- Both community hospitals participate in multi-system collaborative groups that address issues of planning and implementation of programming. These groups include:
 - The Emergency Services Committee (Licking County)
 - The Crisis Services Committee (Knox County)

- The Licking County CIT Steering Committee
- The Knox County CIT Steering Committee
- The CMHRB has designated funding for families having no means of payment for inpatient psychiatric care for their children. The CMHRB contracts with private hospitals which provide inpatient psychiatric care for children and manages this funding in conjunction with the hospital pre-screening activities provided by the BHPCO Crisis Intervention/Emergency Services Department.
- The CMHRB allocates designated funding to BHPCO for adults with no means of payment for inpatient psychiatric care. Without this funding, state hospital bed day use would increase. This ensured greater flexibility in using private hospitalization with shorter lengths of stay when it was clinically appropriate. BHPCO directly contracts with private hospitals to purchase beds as needed.
- Both community hospitals; Licking Memorial Hospital (Licking County) and Knox Community Hospital (Knox County) work very closely with the BHPCO Crisis Intervention/Emergency Services Department by providing safe observation space in their emergency room departments and the support of their emergency room staff for individuals in need of crisis intervention and/or pre-hospitalization screening and medical clearance.

Licking County CIT Steering Committee & CIT Program - Newark Police Department, Licking County Sheriff's Office, Licking Memorial Hospital, Licking County Common Pleas Court Adult Probation, Licking County Municipal Court Adult Probation, Licking County Juvenile Court Probation, BHPCO, LAPP, Pathways, and the CMHRB: Development and collaboration of a county-wide CIT Program involving 18 law enforcement agencies, including Denison University, and over 100 trained officers. The CMHRB also offers, at no cost to Licking County departments, an annual CIT training academy and advanced CIT training. Since its implementation in 2004, the Licking County CIT Program has served over 1000 people. The program works closely with the CCOE for Criminal Justice.

Knox County CIT Steering Committee & CIT Program – Knox County Sheriff's Office, Mt. Vernon Police Department, Mount Vernon Municipal Court Probation Department, Knox Community Hospital, Knox County CMHRB of DD, Mental Health America-Knox County, The FREEDOM CENTER, BHPCO, Pathways, New Directions, and the CMHRB: Development and collaboration of a county-wide CIT program, involving law enforcement and other first responders, including Kenyon College and 29 trained officers. The CMHRB also offers, at no cost to Knox County departments, an annual CIT training academy and advanced CIT training. Since its implementation in 2009, the Knox County CIT Program has served over 150 people. The program works closely with the CCOE for Criminal Justice.

Licking County Reentry Juvenile and Adult Taskforce

The Licking County Reentry Juvenile and Adult Taskforce was initiated to resolve barriers and improve effectiveness of community reentry planning leading to increased public safety and reduced recidivism. Taskforce membership includes county commissioners, the CMHRB, misdemeanor and felony judges and probation personnel, the prosecutor and defense bar, the sheriff's office and other law enforcement, the state prison system and adult parole authority, local jail, job and family services, mental health and alcohol and other drug treatment providers, housing and homelessness groups, faith based and other advocacy groups, family members, and ex-offenders. The CMHRB, on behalf of the taskforce, submitted a Bureau of Justice Assistance Second Chance Adult Reentry Grant to continue planning and service provision efforts.

Knox County Dually-Diagnosed Intervention Team (DDIT Team) – Knox County CMHRB of DD, Mount Vernon Municipal Court Adult Probation, Knox County Job and Family Services, BHPCO, the FREEDOM CENTER, and the CMHRB. The DDIT Team is modeled after the promising practice supported by the

CCOE for Mental Health/DD. The team was formed 2009 and has identified cases that include involvement of both the DD and behavioral healthcare systems of care and the criminal justice system. To date, 10 people have been served through the interventions developed by this team. The team also works closely with the CCOE for Mental Health/MRDD.

Licking County LIFT Behavioral Healthcare Court: - The LIFT Steering Committee: Licking County Municipal Court – Judge David Stansbury, Licking County Municipal Court Adult Probation, BHPCO, LAPP, and the CMHRB. The LIFT (Licking County Intervention for Treatment) Behavioral Health Court program was implemented in SFY 09 with the support of the Supreme Court of Ohio. The program has served over 40 adults.

Licking County OMVI Court – The OMVI Steering Committee consists of representatives from the municipal/misdemeanor court and adult probation, the CMHRB and its providers. The OMVI Court was recently implemented in SFY11.

Knox County Mount Vernon Municipal Court Behavioral Healthcare Court – The Mt. Vernon Municipal Behavioral Healthcare Court Steering Committee – Judge Paul Spurgeon, Mt. Vernon Municipal Court Adult Probation, Mt. Vernon Police Department, Knox County CMHRB of DD, BHPCO, FREEDOM CENTER, and the CMHRB. The Mt. Vernon Municipal Behavioral Healthcare Court was implemented in SFY 11 with the support of the Supreme Court of Ohio.

Children & Family First Council (Licking) & Family & Children First Council (Knox): The CMHRB participates with other multi-system representatives from Job & Family Services, Juvenile Court, MRDD, health departments, school systems, and behavioral healthcare providers on Family and Children First Councils in both counties. Each council has appointed a committee with multi-system representation, Licking - the Clinical Committee and Knox - the Community Team, to serve the most challenging, high risk, multi-system children and their families in the community. Through the use of pooled and FCSS funding and service coordination, the committees support family teams in creating and implementing plans to maintain children safely in their homes and avoiding out of home placements. Plans are based on resiliency activities supporting a strengths based approach of intervention. In SFY 09, the position of Licking County Team Facilitator was implemented as a result of planning by the Licking County Children & Family First Council. The team facilitator is responsible to enhance service coordination efforts across multi-systems in Licking County. In SFY 11, over 52 children and their families were served through the efforts of this position. The Center for Innovative Practices CCOE has providing consultation and training for this project including resiliency strategies and multi-system family team approaches.

Drug Taskforce and other Addiction Initiatives and Strategies: To address the sharp increase in opiate use and unintentional drug-related death rate as well as other addiction issues, the CMHRB is participating with other systems and community stakeholders in several drug taskforce initiatives and strategies in both counties. Included are a Licking County prescription drug taskforce, Knox County Substance Abuse Action Team (KSAAT), and a Medication Assisted Treatment (MAT) workgroup. The CMHRB is convening the KSAAT team. Activities include drug take back days, prevention planning, social marketing, training events, and the development of a MAT program utilizing CMHRB providers and Shepherd Hill Hospital.

Knox County Suicide Prevention Collation and the Licking County Suicide Prevention Collation:

The CMHRB participates with suicide prevention collations in both counties. Activities include prevention planning and community education, gatekeeper training, social marketing, and training events.

Our Futures in Licking County: This prevention collaborative had developed a governance structure that is representative of and collaborates with twelve sectors of the Licking County community. These sectors include youth, parents, business, media, schools, youth-serving organizations, law enforcement agencies, religious and cultural organizations, civic and volunteer groups, healthcare professionals, state and local agencies with expertise in the field of substance abuse, and other organizations involved in reducing substance abuse.

Licking County Job and Family Services Planning Group: This group is comprised of commissioner appointees representing the CMHRB, Pathways-211, housing, development, education, and faith-based organizations. Members serve as an advisory group to Licking County Job and Family Services providing input and recommendations for services.

Involvement of customers and general public in the planning process

The CMHRB involved consumers and the general public in the planning process in a number of ways. This included the use of consumer forums and focus groups (2010), consumer satisfaction and outcomes surveys (MHSIP/YSS/YSS-F) (January & July 2010), a stakeholder priorities survey (2010), and the Pride Survey administered in Licking County schools (May 2009 & 2010). Forty-six behavioral health consumers participated in four forums held in neutral community locations, two in each county. The proposed community plan goals and priorities were discussed with consumers providing additional suggestions. Many of these suggestions were included in the final plan. Input from consumer groups and survey results coupled with needs assessments and other evaluation/outcome management tools were used to determine prevention, treatment and recovery services priorities and goals for the SFY 12-13 plan. See Section III: Process the CMHRB Used to Determine Prevention, Treatment and Capacity Priorities, for more detailed explanation.

Regional Psychiatric Hospital Continuity of Care Agreements

The Continuity of Care Agreement between Twin Valley Behavioral Healthcare, Behavioral Healthcare Providers of Central Ohio, Inc. (BHPCO), and the CMHRB has been implemented 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 by the following:

1. All BHPCO staff involved in the Continuity of Care process is knowledgeable about its content and expectations. Additionally, the CMHRB provides annual training opportunities for health officers including review of OAC 5122 and best practice crisis intervention models. Supervision for the Continuity of Care implementation is provided by the BHPCO Medical Director, the BHPCO Emergency Services Supervisors for Licking and Knox Counties, the BHPCO Adult CPST Supervisor for Licking and Knox Counties, and the Licking County ACT/FACT Team Supervisor. CMHRB monitoring and consultation is provided by the CMHRB Clinical Manager on a 24/7 as needed basis. There are approximately 6 people at MGC who have an operational knowledge of the document, including administrators and clinical supervisors. There are also approximately 31

direct line staff (emergency service workers and case managers) who have a working knowledge of MGC obligations related to MGC responsibilities of hospital admission, inpatient-outpatient team participation, discharge planning, and aftercare services.

2. Aggressive Utilization Management

- Daily the CMHRB Clinical Manager refers to the ODMH PCS Data system for consumer information. This information is faxed to BHPCO for distribution to all pertinent staff.
- BHPCO health officers daily fax all probate and pink slip documents to the CMHRB Clinical Manager for review.
- The BHPCO Medical Director, other BHPCO supervisors, and the CMHRB Clinical Manager regularly consult on admissions, continuing stays, and discharge planning. All consult with TVBH administration concerning consumer inpatient status.
- BHPCO staff participates in scheduled team meetings with TVBH in person, via phone conference, or by teleconferencing. In between scheduled team meetings, the BHPCO Medical Director and other BHPCO clinical staff meet with hospitalized consumers and hospital staff to continue to develop the discharge plan and assess for continued stay.

3. Administrative Meetings

- Administrative staff from TVBH, the BHPCO Medical Director and other clinical staff, and the CMHRB confers frequently on the implementation of the Continuity of Care Agreement, methods of improving the collaborative partnership, and specific cases.

Consultation with county commissioners regarding services for individuals involved in the child welfare system

See Section III: ORC 340.033(H) Goal discussion.

Funds available for parents/caregivers in the child welfare system

See Section III: ORC 340.033(H) Goal discussion.

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

Description of Current Evaluation Focus

In meeting the requirements of ORC 340.03 (A)(4), the CMHRB has initiated several key processes. These address the evaluation criteria found in Appendix C of the Community Plan application.

The CMHRB has refined a program evaluation process to assess the quality, effectiveness and efficiency of services purchased by the Board. The CMHRB developed a set of performance targets and outcome and fidelity measures, qualitative and quantitative, based on best service provision practices and industry standards; utilization management; state and federal regulations and outcome measures; and local, state, and federal priorities. The evaluation process, coupled with the prioritization of services/programs served as the framework for the allocation of funding under the SFY12 BAP process.

While there have been decreases in some services due to funding cuts, by utilizing the program evaluation process and results of needs assessments, several new programs were funded in SFY12. This included specialized services for sexually aggressive youth and youth survivors of sexual abuse, and SAMI Quadrant III AOD treatment. Additionally funding was reestablished to Compeer and suicide prevention activities in Licking County.

Measuring Success of the Community Plan for SFY12-SFY 13 and Milestones and Achievement Indicators

The SFY12-SFY13 Community Plan includes corresponding objectives and strategies (milestones and achievement indicators) of each goal to measure success. While progress toward achieving the plan's goals is reviewed on an annual basis, many objectives are reviewed more frequently as they also represent CMHRB performance indicators or consumer survey results (MHSIP, YSS, YSS-F). Detail of objectives and strategies (milestones and achievement indicators) of each SFY12-SFY13 Community Plan goals is found in Section III: Behavioral Health Capacity, Prevention, and Treatment and Recovery Support Goals and Objectives.

CMHRB providers are required to report quarterly or semi-annually on performance targets specific to the services provided by the organization funded by the Board. After analyzing results, CMHRB staff provides

summary information on progress toward goal attainment to the Program and other Drug Committee for review. Action improvement strategies are also present at that time. These results are then reviewed by the full board. Analysis and trending is also shared with individual providers. Resulting improvement strategies are developed by each provider and across a broader context for the CMHRB system of care. Performance targets were used both a method for determining the SFY12-SFY13 Community Plan goals and as those goals' objectives.

Engagement of Contract Agencies and the Community

CMHRB providers are engaged in the current evaluation process in several ways. In developing SFY12 performance targets, board staff met with providers, as a group and individually, to review the effectiveness of the process and suggest improvements. This included changes to current targets or additions of new ones to assure that system's priorities were identified and measured. Discussion also focused on the utilization of results in both a system and provider quality improvement process. To support providers in the program evaluation process, the CMHRB has provided evaluation and outcome management training and ongoing technical assistance.

As was mentioned in Section II under Major Issues in Access to Services, the Innovations Utilization Management Work Group was established to address system-wide access issues identified as part of the program evaluation process and results of needs assessments.

The CMHRB has engaged the community in the evaluation process through the use of consumer and community focus groups and forums, satisfaction and outcome surveys, participation in community collaborations, and the Innovations Process. Results of community engagement are found in Section III: Process the CMHRB Used to Determine Prevention, Treatment and Capacity Priorities and Behavioral Health Capacity, Prevention, and Treatment and Recovery Support Goals and Objectives and are incorporated throughout the SFY12-SFY13 Community Plan.

Portfolio of Providers and Services Matrix

Table 1: SFY12-13 Community Plan Portfolio of Alcohol and Drug Service Providers

Table 2: SFY12-13 Community Plan Portfolio of Mental Health Service Providers Using EBPs

ODMH Service Level Checklist

ODMH 2012 Community Plan Adult Housing Categories

Table 1: SFY 12-13 Licking/Knox Community Plan Portfolio of Alcohol and Drug Service Providers

Prevention Strategy & Level of Care	Provider Name	Program Name	Population Served	Prevention Level	EBP	Number of Sites	Outside of Board of Area	Funding Source- ODADAS (Indicate yes or no)	Funding Source- Medicaid Only (Indicate yes or no)	MACSIS UPI
Information Dissemination Alternatives	Pathways-LC	Wellness Partnership	Health professionals, other adults	Universal		Multiple	No	Yes	No	1325
	FREEDOM CENTER-KC	Power to the Sixth	Sixth graders	Selected		Multiple	No	Yes	No	1311
	FREEDOM CENTER-KC	Summer Parks Program	Youth	Selected	Second Step	2	No	Yes	No	1311
	Pathways-LC	Incredible Years Dina Dinosaur Small group Therapy	Pre-school children identified as having difficulty with socialization.	Selected, Indicated	Incredible Years	2	No	Yes	No	1325
	Pathways-LC	Incredible Years Early Childhood Parent Program	Parents of pre-school students in Dina Dinosaur Program	Selective, Indicated	Incredible Years	1	No	Yes	No	1325
Education	Pathways-LC	Parents as Teachers	Expectant parents and parents of children newborn through kindergarten entry and their children.	Universal, Selective	Born to Learn	Multiple	No	Yes	No	1325
	Pathways-LC	Active Parenting NOW	Parents of 1-12 year olds	Universal, selective	Active Parenting NOW	Multiple	No	Yes	No	1325
	Pathways-LC	Clean & Sober Parenting	Women & men residing at Behavioral Health Care Partners Spenser House or Courage House Non-medical Community Residence Program	Selective, Indicated		2	No	Yes	No	1311
	Pathways-LC	Project Alert	Youth grades 6 & 7	Universal	Project Alert	Multiple	No	Yes	No	1325
	Pathways-LC	Life skills Training	Elementary through high school youth	Universal	Life Skills Training	Multiple	No	Yes	No	1325
FREEDOM CENTER-KC	ADER (Young Adult: Drug Education & Review)	Young adults, 15-21, evaluated as early ATOD experimenters	Selected, indicated	TAAD (Prime for Life)	1	No	Yes	No	1325	

Table 1: SFY 12-13 Licking/Knox Community Plan Portfolio of Alcohol and Drug Service Providers

	FREEDOM CENTER-KC	Juvenile Court CYP (Community Youth Project)	Youth, 12-17, involved in Knox County Juvenile Drug Court Program	Selected, indicated	TAAD	1	No	Yes	No	1311
	FREEDOM CENTER-KC	Project BOLD	Grades 2, 3, and 5	Universal	Protecting You, Protecting Me	Multiple	No	Yes	No	1311
	FREEDOM CENTER-KC	Second Step	Grades 2, 3, and 5	Universal	Second Step	1	No	Yes	No	1311
	FREEDOM CENTER-KC	Classes for SED	Youth	Selected	Second Step, Project Northland	Multiple	No	Yes	No	1311
Community-Based Process	Pathways-LC	Wellness Partnership	Health professionals, other adults	Universal	Protecting You, Protecting Me	Multiple	No	Yes	No	1325
Problem Identification and Referral	FREEDOM CENTER-KC	Alternative School Screening	Youth ages 11-17 that by life situation are at greater risk to AOD abuse	Selected		1	No	No	No	1311
Treatment										
Level 0.5 Pre-treatment	LAPP-LC	Outreach	SD Adults	NA	Motivational Interviewing Stages of Change	Multiple	No	No	No	1332
	FREEDOM CENTER-KC	AToD Crisis Response (Crisis Intervention, Hotline, Outreach)	General/SA/SD Adults General/SA/SD Youth	NA	Motivational Interviewing, Stages of Change	Multiple	No	No	No	1311
Level I Outpatient	LAPP-LC	Adult Outpatient (Non-gender specific)	SD/SA Adults	NA	Stages of Change, Stage Wise Treatment, Motivational Interviewing, Gorski Model of Relapse Prevention, SAMHSA TIP 35: Group Treatment for Substance Abuse	2	No	Yes	No	1322
	LAPP-LC	Women's	SD/SA Women	NA	Stages of Abuse	2	No	Yes	No	1322

Table 1: SFY 12-13 Licking/Knox Community Plan Portfolio of Alcohol and Drug Service Providers

	Fund	purchase acute detoxification services								
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Table 2: SFY 12-13 Licking/Knox Community Plan Portfolio of Mental Health Service Providers Using EBPs

EBP	Provider	MACSIS UPI	Number of Sites	Program Name	Medicaid Match yes or no	GRF (Not as Medicaid Match) yes or no	Levy (Not as Medicaid Match) yes or no	Other (Not as Medicaid Match) yes or no	Population Served	Estimated # Planned for FY 12	Estimated # Planned for FY 13
<i>Integrated Dual Diagnosis Treatment (IDDT)</i>	Behavioral Healthcare Partners (BHPCO)	10183	2	Knox (KC) IDDT/SAMI Adult Team	Yes	Yes	Yes	No	SPMI/SMD/SAMI	KC - 45	KC - 45
	BHPCO	10183	1	Licking (LC) IDDT/SAMI Adult Team LC - Kids Multi-System IDDT/Home Based Treatment Based on CCOE of Innovative Practice Integrated Co-occurring Treatment (ICT) model	Yes	Yes	Yes	No	SED/AOD	20	LC - 50
<i>Assertive Community Treatment (ACT)</i>	BHPCO	10183	1	LC-ACT Adult Team	Yes	Yes	Yes	No	SPMI/SMD	50	50
	BHPCO	10183	1	LC-FACT Adult Team	Yes	Yes	Yes	No	Forensic SMI/SPMI/SMD	15	15
	BHPCO	10183	2	Employment Services (KC & LC)	Yes	Yes	No	Yes	Forensic SMI/SPMI/SMD	90	90
<i>Supported Housing</i>	BHPCO	10183	4	River Valley ACF for Women Church Street Apartments for Men	No	Yes	Yes	Yes	Forensic SMI/SPMI/SMD	50	50
	The Main Place	12175	21 Units of housing	Transitional Housing Program Housing Assistance (KC & LC)	No	No	No	Yes	Forensic SMI/SPMI/SMD	30	30
	The Main Place	12175	2	WMR Program (KC & LC)	Yes	No	No	No	Forensic SMI/SPMI/SMD	150	150
<i>Wellness Management & Recovery (WMR)</i>	BHPCO Pathways, Inc.	10182 1325	2	Knox County CIT Program Licking County CIT Program	No	No	Yes	Yes	Forensic SMI/SPMI/SMD SED SAMI AOD Other special needs populations	KC - 100 LC - 200	KC - 100 LC - 200
	The Main Place	12175	2	The Recovery Center Main Place - Knox County The Main Place - Licking County	No	No	Yes	No	Forensic SMI/SPMI/SMD SAMI	650	650

Table 2: SFY 12-13 Licking/Knox Community Plan Portfolio of Mental Health Service Providers Using EBPs

Peer Support Services	The Main Place	12175	2	The Recovery Center Main Place – Knox County	No	No	Yes	No	Forensic SMI/SPMI/SMD SAMI	650	650
MI/MR Specialized Services	BHPCO	10182	2	The Main Place – Licking Knox County DDIT Team Licking County DDIT Team	Yes As related to services provided by BHPCO	Yes As related to services provided by BHPCO	Yes As related to services provided by BHPCO & The Main Place	Yes As related to services provided by the county boards of developmental disabilities and targeted training support provided by the CCOE for MI/DD	SMI/SPMI/SMD Developmentally Disabled w/o criminal justice involvement	KC – 10 LC - 10	KC – 10 LC - 10
Consumer/Family Psycho-Education	The Main Place	12175	2	Bridges (KC & LC) WRAP (KC & LC)	No	No	Yes Provided as part of The Main Place Consumer Operated Service/Peer Support	No	Forensic SMI/SPMI/SMD SAMI	90	90

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>
Pharmacological Mgt. (Medication/Somatic)	Yes No DK	Intro E I D NC DK	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	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	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	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	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	I D NC DK	
24/7 Warmline	Yes No DK	Intro E I D NC DK	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	I D NC DK	
Disaster preparedness*	Yes No DK	Intro E I D NC DK	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	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) 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>	
Service Category					
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 C&A 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	
Partial Hospitalization, less than 24 hr.	Yes No DK	Intro E I D NC DK	I D NC DK	I D NC DK	
Community Psychiatric Supportive Treatment (Ind.)	Yes No DK	Intro E I D NC DK	I D NC DK	I D NC DK	
Community Psychiatric Supportive Treatment (Grp.)	Yes No DK	Intro E I D NC DK	I D NC DK	I D NC DK	
Assertive Community Treatment (Clinical Activities)***	Yes No DK	Intro E I D NC DK	I D NC DK	I D NC DK	
Assertive Community Treatment (Non-Clinical Activities)	Yes No DK	Intro E I D NC DK	I D NC DK	I D NC DK	
Intensive Home Based Treatment (Clinical Activities)	Yes No DK	Intro E I D NC DK	I D NC DK	I D NC DK	

	SFY 2011	SFY 2012		SFY 2011
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>
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

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>	
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	

*SERVICE PROVIDED WITH BOARD DOLLARS BUT NOT BILLED THROUGH MACSIS

**ACT TEAM BILLED AS CPST

***CMHRB POOLED FUNDING CONTRIBUTION TO LICKING & KNOX CHILDREN & FAMILY FIRST COUNCILS

ODMH 2012 Community Plan Adult Housing Categories

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

For SFY12, 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	Number of SPMI/SMI <i>(Please include Forensic & Sex Offender Sub-Populations)</i>	Number of Units	Number of Beds
Crisis Care: Not provided in CIMHRB system	Provision of short-term care to stabilize person experiencing psychiatric emergency. Offered as an alternative to inpatient psychiatric unit. Staff 23 hours' day/7 a week. Treatment services are billed separately.	<ul style="list-style-type: none"> ▪ Crisis Bed ▪ Crisis Residential ▪ Crisis Stabilization Unit 	Total Number: Forensic Sub-Population Total: Sex Offender Sub-Population Total:	0 NA NA	0 NA NA
ODMH Licensed Residential Care Not provided in CIMHRB system	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 agency operated and staffed; provides 24-hour supervision in active treatment oriented or structured environment. Type 1: Room & board, personal care, mental health services Type 2: Room & board, personal care Type 3: Room 7 board	<ul style="list-style-type: none"> ▪ Licensed as Type 1, 2, or 3 (Residential Facility Care) ▪ Residential Support ▪ Supervised Group Living ▪ Next-step Housing from psychiatric hospital and/or prison 	Total Number: Forensic Sub-Population Total: Sex Offender Sub-Population Total:	0 NA NA	0 NA NA
ODH Licensed Residential Care Forensic Beds are provided as needed Availability of Sex Offender Beds due to funding restriction and/or location to school, childcare, etc.	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 Number: Forensic Sub-Population Total: Sex Offender Sub-Population Total:	8 0 NA	8 0 NA

<p>Respite Care <i>Not provided in CMHRB system</i></p>	<p>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.</p>	<ul style="list-style-type: none"> ▪ Placement during absence of another caretaker where client usually resides ▪ Respite Care 	<p>Total Number: 0</p> <p>Forensic Sub-Population Total: NA</p> <p>Sex Offender Sub-Population Total: NA</p>	<p>0</p> <p>NA</p> <p>NA</p>
<p>Temporary Housing <i>Forensic Beds are provided as needed</i> <i>Availability of Sex Offender Beds due to funding restriction and/or location to school, childcare, etc.</i></p>	<p>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.</p>	<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) 	<p>Total Number: 8</p> <p>Forensic Sub-Population Total: 0</p> <p>Sex Offender Sub-Population Total: 0</p>	<p>8</p> <p>0</p> <p>0</p>
<p>CMHRB/Agency Owned Community Residence <i>Forensic Beds are provided as needed</i> <i>Availability of Sex Offender Beds due to funding restriction and/or location to school, childcare, etc.</i></p>	<p>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.</p>	<ul style="list-style-type: none"> ▪ Service Enriched Housing ▪ Apartments with non-clinical staff attached ▪ Supervised Apartment ▪ No lease: NOT covered by Ohio tenant landlord law 	<p>Total Number: 7</p> <p>Forensic Sub-Population Total: 0</p> <p>Sex Offender Sub-Population Total: NA</p>	<p>7</p> <p>0</p> <p>NA</p>
<p>Permanent Supportive Housing (Subsidized Supportive Housing) with Primary Supportive</p>	<p>Person living in an apartment where they entered into a lease with accordance to Ohio tenant landlord law or a mortgage and, in instances</p>	<ul style="list-style-type: none"> ▪ HAP ▪ Housing as Housing ▪ Supervised Apartments ▪ Supportive Housing 	<p>Total Number: 0</p>	<p>0</p>

<p>Services On-Site <i>Not provided in CMHRB system</i></p>	<p>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.)</p>	<ul style="list-style-type: none"> ▪ Person with Section 8 or Shelter Plus Care Voucher ▪ Tenant has lease <p>Supportive Services staff primary offices are on-site and their primary function are to deliver supportive services on-site; these staff may accompany residents in the community to access resources</p>	<p>Forensic Sub-Population Total:</p>	<p>NA</p>	<p>NA</p>
<p>Permanent Supportive Housing (Subsidized Housing) with Supportive Services Available Forensic Beds are provided as needed Availability of Sex Offender Beds due to funding restriction and/or location to school, childcare, etc.</p>	<p>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.)</p>	<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 <p>Supportive Services staff primary offices are not on-site; supportive service staff may come on-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>Total Number:</p>	<p>141</p>	<p>141</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 the model is not connected to the mental health system in any way. Anyone can apply for and obtain this housing. 	<p>Total Number:</p>	<p>0</p>	<p>0</p>
		<p>Forensic Sub-Population Total:</p>	<p>NA</p>	<p>NA</p>	<p>NA</p>
		<p>Sex Offender Sub-Population Total:</p>	<p>NA</p>	<p>NA</p>	<p>NA</p>

TABLE 1: PORTFOLIO OF ALCOHOL AND DRUG SERVICES PROVIDERS
ODADAS Waivers

Waiver Request for Inpatient Hospital Rehabilitation Services

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

Complete this form providing a brief explanation of services to be provided and a justification for this requested waiver. **Medicaid-eligible recipients receiving services from hospital-based programs are exempt from this waiver.**

A. HOSPITAL	ODADAS UPID #	ALLOCATION

B. Request for Generic Services

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

B.AGENCY	ODADAS UPID #	SERVICE	ALLOCATION

Not applicable for Licking/Knox CMHRB