TRUMBULL COUNTY
Mental Health and Recovery Board
PREVIOUSLY TRUMBULL LIFELINES

Community Plan for SFY 2012-2013

Submitted to

Ohio Department of Alcohol & Drug Addiction Services

Ohio Department of Mental Health

Due Date ..... December 30, 2010

Submission Date ..... December 22, 2010

The mission of the Trumbull County Mental Health and Recovery Board is to improve the well-being of our community by establishing and maintaining an effective, efficient and quality system of alcohol, drug and mental health services in Trumbull County.

Our Vision

- ***We believe that mental illness and drug dependency are treatable diseases.***
- ***We believe treatment works and people can recover from mental illness and drug dependency.***
- ***We work to build a system of care that has the best services, is recipient-driven and encourages people to participate in their own care.***
- ***We fund services based on performance measures and outcomes.***
- ***We promote cooperation between the Board, the community, and provider agencies.***
- ***We advocate for consumers and support service accountability.***

PREAMBLE / COMMUNITY PLAN FOOTNOTE

While boards understand that a certain amount of unpredictability around funding assumptions for the next biennium are a normal process of the community plan, there are several key pieces of information and unresolved policy considerations from the departments that do not allow the community plan to be the useful document and management tool that it was designed to be. Many of these issues revolve around state psychiatric hospitals. At this time, we have not yet received written information about the state psychiatric hospital per diem rate. Governing board members want to know how much a service costs before they decide how much to buy and approve the plan in the form of a resolution. ODMH has also recently announced an intention to eliminate our risk sharing agreement for hospital bed days (SCUD). As we have shared with ODMH staff, boards simply cannot move forward in bed day planning without a way to address risk. There are serious issues to negotiate around hospitals and a process for doing that is dictated in our 1999 settlement agreement. These are crucial factors that impact a board's decision to opt in or out, which under statute is not linked with the community plan and is a decision boards have until May 1 of next year to make.

Finally, the funding assumption guidance has been very confusing, ranging from flat funding to a 10% cut, while the budget the ODMH director submitted eradicated state funding for the community mental health system of care and proposed drastic changes in hospital operations that would have significant and dire consequences. The community plan asks boards to elect distribution of 408 funds without the per diem, budget, or how to logically plan for bed days. Boards want the community plan process to be useful and meaningful. Regrettably, in the absence of critical information, this community plan offers little in the way of utility. Our board reserves our rights under statute and the settlement agreement, including the ability to amend the community plan, negotiate the SCUD, and opt out of 408.

SIGNATURE PAGE

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

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

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

Trumbull County Mental Health and Recovery Board

(Please print or type)

April J. Caraway, Board Executive Director — Date

Teresa M. Massucci, Board Chair — Date

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

I. Legislative & Environmental Context of the Community Plan

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

SECTION I: LEGISLATIVE AND ENVIRONMENTAL CONTEXT

Legislative Context of the Community Plan

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

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

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

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

1) Identify community mental health needs;
2) Identify services the Board intends to make available including crisis intervention services;
3) Promote, arrange, and implement working agreements with social agencies, both public and private, and with judicial agencies;
4) Review and evaluate the quality, effectiveness, and efficiency of services; and

5) Recruit and promote local financial support for mental health programs from private and public sources.

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

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

ORC Section 340.033(H)

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

OAC Section 5122-29-10(B)

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

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

present; and
(4) Policies and procedures that address coordination with and use of other community and emergency systems.

HIV Early Intervention Services

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

Federal Substance Abuse Prevention and Treatment (SAPT) Block Grant

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

Federal Mental Health Block Grant

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

Environmental Context of the Community Plan

Economic Conditions and the Delivery of Behavioral Health Care Services

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

As the data in Tables 1 through 3 suggest, a "perfect storm" of negative social forces has been buffeting Trumbull County in recent years. Between 1990 and 2008, the total population of the county declined by more than 16,000 (-7.2%) while the number of residents living in poverty increased by more than 6,400 (+24.9%). Trumbull County's poverty rate was below the statewide rate in 1990 and 2000, but was more than 2 percentage points above Ohio's rate in 2008. These trends were even more pronounced for children. In 2008, the county's child poverty rate (23.3 percent) far exceeded the statewide rate for children of 18.5 percent. In that year nearly one–quarter of children in Trumbull County were living in poverty.

Table 1

Persons in Poverty: 1990

	Trumbull County		*Ohio*
	N	*%*	*%*
All ages	25,687	11.4	12.5
Under 18	9,613	16.8	17.6
County population:		227,813	

Persons in Poverty: 2000

	Trumbull County		*Ohio*
	N	*%*	*%*
All ages	22,788	10.3	10.6
Under 18	8,287	15.4	14.0
County population:		225,116	

Persons in Poverty: 2008

	Trumbull County		*Ohio*
	N	*%*	*%*
All ages	32,109	15.5	13.3
Under 18	10,602	23.3	18.5
County population:		211,317	

Data Source: US Dept of Agriculture, Economic Resource Service, www.ers.usda.gov

In the past two years unemployment has exploded in Trumbull County, rising from 7.5 per cent of the labor force (7,900 persons) in 2008 to 13.8 percent of the labor force (14,700

Table 2

TRUMBULL COUNTY	*2005*	*2006*	*2007*	*2008*	*2009*
Labor Force	105,300	105,800	106,000	105,700	107,200
Employed	98,200	99,300	99,400	97,800	92,500
Unemployed	7,100	6,500	6,600	7,900	14,700
Unemployment Rate	6.7	6.2	6.2	7.5	13.8

Data source: Ohio Dept of Development, Office of Policy, Research and Strategic Planning
http://development.ohio.gov/research/files/s0/Trumbull.pdf

persons) in 2009. This ranked Trumbull County 13th of the state's 88 counties and first among urbanized counties (i.e., counties with populations over 200,000 and civilian labor force greater than 100,000) and this trend continued in 2010 (Table 3). Only Lucas County in July and Lorain County in September had monthly unemployment rates that exceeded

Table 3

Month (2010)	*Trumbull Unemployment Rate (%)*	*Rank (1-88)*	*Urbanized Counties Exceeding Trumbull's Rate*
January	14.3	30	none
February	14.5	26	none
March	14.7	17	none
April	12.7	29	none
May	11.8	27	none
June	12.2	24	none
July	12.0	26	Lucas, 12.1%
August	11.4	19	none
September	10.8	25	Lorain, 10.9%
October	11.0	27	none
November	11.0	24	none
December			

Data source: Ohio Dept of Job and Family Services, Office of Workforce Development
http://jfs.ohio.gov/releases

Trumbull's through the first eleven months of 2010. In both cases, the difference was one–tenth of one percentage point. In the last three years, the county has experienced large–scale plant closings (Delphi Corporation), temporary layoffs along with permanent reductions in force (General Motors Lordstown Assembly), and numerous work force reductions and business closures (e.g., restaurants, super markets, automobile dealerships, etc.).

Poverty and unemployment have well-established relationships with stressors and high-risk behaviors. Increases in poverty and unemployment predictably lead to increases in our community's behavioral health needs, including a wide range of substance abuse and mental health problems. The recent decision by Congress not to extend unemployment benefits is expected to heighten these needs, which are expressed in a variety of ways. Some persons

seek behavioral health services outside the ADAMHS systems (e.g., family doctors, clergy), some seek services from the ADAMHS system, some receive services involuntarily (e.g., "pink slips," emergency hospital admissions), while many others engage in no overt help–seeking behavior. This last category includes persons with untreated addictions or mental illnesses and some contemplating, attempting, or completing suicide.

In their now–classic study of the impact on the Mahoning Valley of Youngstown Sheet and Tube Corporation's closing on "Black Monday" (September 19, 1977), Terry Buss and Stevens Redburn made an important discovery:

> …increased threats to the mental well–being of a community do not automatically dictate an increased need for the existing services of the community's mental health service providers. Although it is likely that mental health service agencies will be a useful resource for such communities, it is uncertain whether they should have the primary role in responding to an increase in mental needs produced in economic crisis.*

In addition to traditional outreach approaches, we have attempted to use a variety of non–traditional strategies to reach newly–distressed members of our community. These have drawn heavily on our community partnerships, including Trumbull County's Housing Collaborative, Transportation Planning Committee, Domestic Violence Task Force, Community Corrections Planning Board, Human Services Planning Committee, Crisis Intervention Team project, Early Childhood Mental Health Initiative, Family and Children First Council, Sahara Club (local "dry" social club), Salvation Army, the Trumbull Advocacy and Protective Network (senior citizen's "cluster"), and several community outreach events organized by United Auto Workers Local 1112 ("Throwing a Lifeline to Valley Workers').

The other element of the "perfect storm" is the financial crisis gripping Ohio's behavioral health system. Funding cuts we have received to the tune of nearly two million dollars and the removal of the Board's ability to audit and collect outcomes have resulted in a runaway train of Medicaid billing and potentially fraudulent practices on the part of Medicaid providers in that our data show fewer recipients receiving treatment but the numbers of treatment episodes provided per client at a sharp incline. There is also a consistently sharp incline in treatment for the non-SMD population in both diagnosis and services provided. Core providers who previously served the indigent population are rationing care and terminating treatment after two missed sessions. Other agencies are being approached for treatment as a result but the majority of providers will not provide indigent care. Most of these are for-profit providers who primarily bill Medicaid both inside and outside of the county. This leads us to conclude that the SMD, indigent population that is not being served continues to grow.

Reduced funding from state (ODMH, ODADAS) and local (levy) sources has dramatically affected our systems of care and made the help–seeking process more complicated for many individuals and families in our community. Compared to FY2009, fewer non–Medicaid persons were served in FY2010 and they received less service (Table 4). At the same time, there was a 43 percent increase in the number of Trumbull County residents who received Medicaid-eligible services from out of county providers. The average value (median of claims) for Medicaid-eligible, out-of-county claims increased by 176 percent during this period, from $603 to $1665.

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* Terry F. Buss and F. Stevens Redburn, *Shutdown At Youngstown: Public Policy for Mass Unemployment* (Albany: SUNY Press, 1983), p. 43.

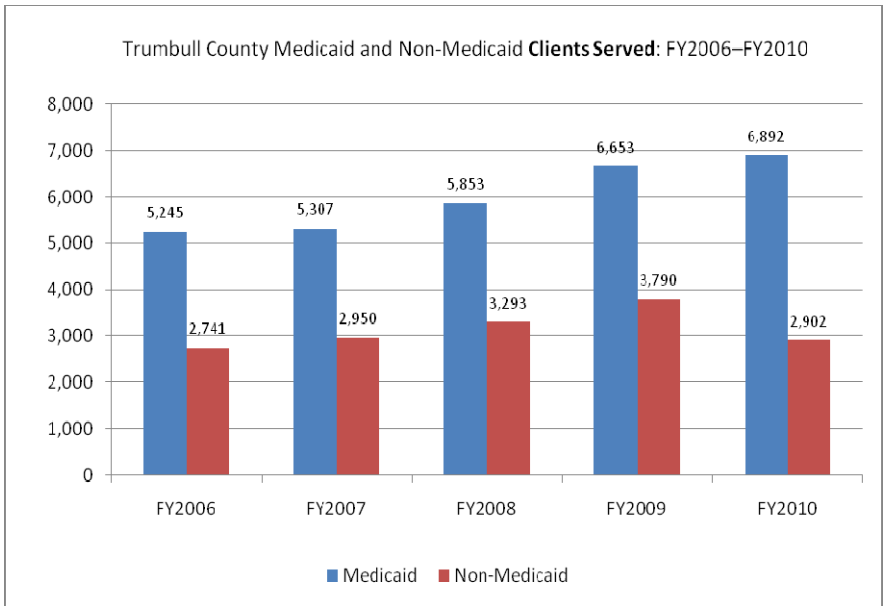
Table 4

	IN COUNTY				*OUT OF COUNTY*			
	Medicaid		*Non-Medicaid*		*Medicaid*		*Non-Medicaid*	
	Client Count	Median of claims	*Client Count*	*Median of claims*	*Client Count*	*Median of claims*	*Client Count*	*Median of claims*
FY2009	6137	$478	3878	$309	856	$603	34	$154
FY2010	6230	$388	2971	$288	1225	$1,665	131	$154

Note: Some persons receive both Medicaid and Non-Medicaid services

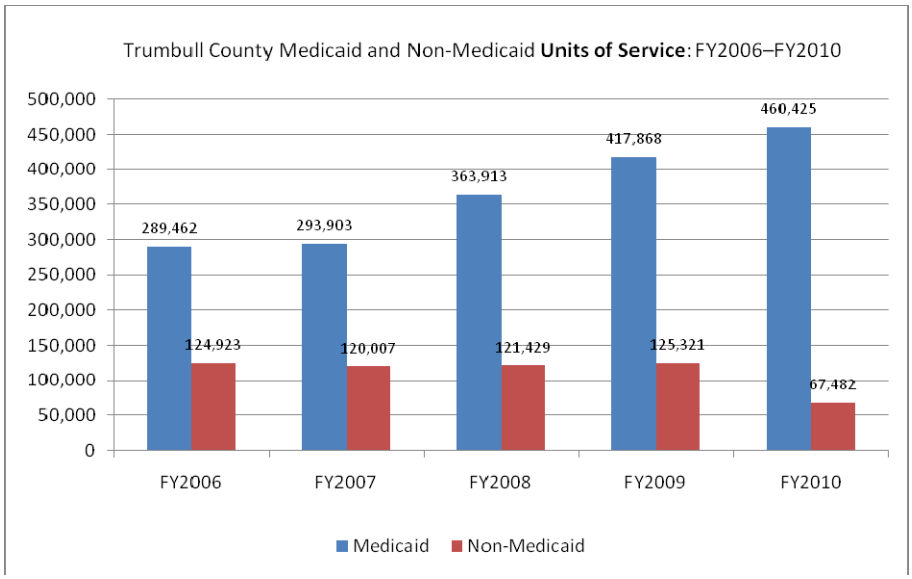
Data source: MACSIS claims data: Heartland East Reports JEM09.C78.SFY.2009.PR.JUL.PDF and JEM09.C78.SFY.2010.PR.JUL.PDF

Table 5



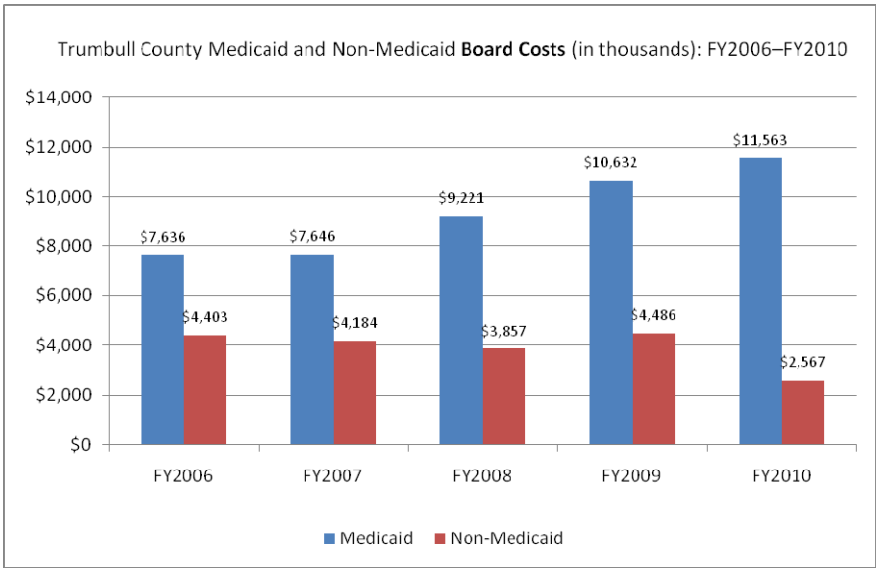
DATA SOURCE: MACSIS Data Warehouse, Oct. 2, 2010 extract [macsisdatamart.mh.state.oh.us]

Table 6



DATA SOURCE: MACSIS Data Warehouse, Oct. 2, 2010 extract [macsisdatamart.mh.state.oh.us]

Table 7



DATA SOURCE: MACSIS Data Warehouse, Oct. 2, 2010 extract [macsisdatamart.mh.state.oh.us]

Tables 5 through 7 display five-year trends in persons served, units of service, and board costs comparing for each indicator Medicaid and Non-Medicaid patterns. The sharp rise in all three indicators as they pertain to Medicaid is mirrored by not-as-sharp declines in the corresponding non-Medicaid indicators. The fact that Medicaid has risen faster than non-Medicaid has fallen reflects a number of factors, most notably our system's ability to improve efficiency and to economize at many points in the system. We are fast approaching the vanishing point on such efforts, however.

Historically, our most ambitious effort may have been the discount reimbursement rate experiment for clinical services to non-Medicaid recipients (FY2006). Other cost-saving initiatives have included consolidation of services, utilization of hospitals outside of the county, re-negotiation with providers for transportation, socialization, inpatient, and other services, and strategic elimination of programs and services.

Internally at the Board we have made many changes. Some are small, like duplex printing in black ink and efforts to go paperless in data entry, giving up Board-purchased beverages, and using email over regular mail whenever possible. Others have identified major cost savings (e.g., freezing staff salaries, staff giving up Board-funded cell phones, filling a full-time vacancy with a part-time worker, and not filling another vacancy at all). We are looking into other possible savings through joint purchasing, better insurance rates, and a review of costly memberships and subscriptions. The staff took a 5 percent wage reduction in FY2010 and a wage freeze in FY2011. Two positions have not been filled and use of consultants has been reduced significantly. Our administrative costs are less than 5 percent with only 9.5 staff members. A more complete inventory of Board and provider cost–saving efforts can be found on pages 18 to 20 of our FY2010-11 Community Plan.

Implications of Health Care Reform on Behavioral Health Services

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

The primary implication of the recently enacted health care reform legislation on the Board's system of care is the significant erosion of funding available to pay for services provided to non-Medicaid eligible clients due to the projected expansion of Medicaid. The system of care is already stressed to the breaking point because providing match for Medicaid-covered services is the first priority. Medicaid coverage was expanded in SFY2008 and SFY2009 to cover more pregnant women and children as included with the Healthy Start, Healthy Families and the Children's Buy-In programs. The annual increase in Medicaid treatment cost to the Board was over $900,000 from SFY 2009 to SFY 2010. This number represents a 9% increase and required a match amount of nearly $240,000 ($340,000 without the eFMAP). Analyzing data for non Medicaid eligible persons **currently served** that will be eligible for Medicaid under the new law, indicates a Medicaid payout of $65,000 annually. However, the cost related to the influx of persons who are currently not in our system that will seek treatment upon Medicaid eligibility is not known. The U.S. Census Bureau indicated that over 45 million persons in the United States were without health insurance coverage in 2008. The Congressional Budget Office (CBO) projects from its March 2010 report, that by 2019, 33 million persons in the United State will be covered by health insurance. It is clear that not all persons will have health insurance even though the law will be firmly in place by 2014. It is not clear from which economic background these persons who are not covered come. There may well be a need for flexible funds that are not encumbered to pay Medicaid match to pay for their treatment costs as not everyone will be eligible for the expanded Medicaid program.

In order for the behavioral health system of care to be successful, funding must be available to provide Prevention and Education programming for behavioral health concerns. A system focused on behavioral wellness must be fostered and allowed to grow in order to create a

health community. The Board recognizes the importance of Prevention and Education programming for behavioral health concerns, but cannot ensure the provision of these needed services due to the erosion of flexible funding encumbered as Medicaid match.

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

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

Trumbull is Ohio's only perfectly square county, measuring 25 miles along each border and comprising 625 square miles, divided into 25 square townships, containing six cities and seven villages, located on the Pennsylvania border and roughly bounded by the Youngstown, Cleveland and Akron corridors. The county's population, which peaked in 1980 at about 242,000, currently stands at about 210,000, thirteenth largest of Ohio's 88 counties. Racial and ethnic minorities comprise about 11 percent of Trumbull County's population, compared with about 16 percent statewide. African-Americans represent the county's largest minority population at about 8.2 percent, compared with about 11 percent statewide. About 23 percent of Trumbull County's population is comprised of children under the age of 18; the comparable proportion for the state as a whole is about 25 percent. Finally, about 16 percent of Trumbull County's population are seniors 65 years of age and older, compared to about 13 percent statewide.

A distinctive mix of urban and rural cultures and communities characterizes Trumbull County. In the southern part of the county, the cities of Warren, Niles, Girard and Hubbard, along with Weathersfield and Liberty Townships and McDonald Village form an urban belt that continues into Mahoning County and forms the core of the Youngstown-Warren Metropolitan Statistical Area, Ohio's seventh largest. Concentrated in this region are most of the county's major employers, including General Motors' Lordstown Assembly Complex, WCI Steel, Forum Health, Humility of Mary Health Partners, Giant Eagle, West Corporation and Sears Holdings/K-Mart. Virtually all of these enterprises have experienced closures and/or lay-offs in the past several years. In September 2010, Trumbull's unemployment rate was at 10.8 percent, the 25th highest among Ohio's counties.

The northern part of Trumbull County is largely agriculture and woodland, containing many of the county's 990 farms and dominated by the Grand River and Mosquito Lake Wildlife Management Areas, Mosquito Lake State Park and Mosquito Lake, one of Ohio's largest lakes. The northwestern part of the county houses a portion of the Geauga Settlement, the fourth largest Amish community in North America. The villages of Middlefield (Geauga County) and Mesopotamia (Trumbull County) form the hub of the settlement, which also extends into Ashtabula and Portage Counties. Trumbull County is the only ADAMHS, ADAS or CMH Board Area in Ohio with significant African-American and Amish communities.

The County's population has decreased 4.6 percent since 1990. The following indicators contribute to risk factors for abusing alcohol, tobacco and other drugs:

- Only 44% of the population earns a high school diploma or equivalent
- 10% graduate from college and another 4.4% earn a graduate degree
- In 2000, 40% of persons 16 years of age and over were unemployed
- 10.6% live in poverty

Tables 3-1 and 3-2 display breakdowns by age group, gender, and race for persons who received alcohol/other drug and mental health treatment services for the six-year period FY2005 to FY2010. Perhaps the most significant trend is what appears to be a decline of approximately 500 in the total number of persons receiving mental health care in FY2010. Other noteworthy trends include the following:

- A slight but significant decline in the number of African Americans receiving AoD services
- A notable decline in the number of seniors receiving MH services
- A steady increase in the number and proportion of women receiving AoD services
- Virtually no change in the number of children/adolescents receiving AoD services but a decline in their proportion

Table 3-1: Characteristics of Persons Receiving AoD Treatment Services, FY2005–FY2010

	FY2005		***FY2006***		***FY2007***		***FY2008***		***FY2009***		***FY2010***	
	N	***%***	***N***	***%***	***N***	***%***	***N***	***%***	***N***	***%***	***N***	***%***
AGE												
<18	110	9.9	80	7.6	97	8.3	89	7.1	100	6.6	99	6.4
18-64	998	90.1	978	92.4	1075	91.7	1163	92.8	1403	93.3	1438	93.5
>64	0	0.0	1	0.1	0	0.0	1	0.1	1	0.1	1	0.1
TOTAL	1108	100.0	1059	100.0	1172	100.0	1253	100.0	1492	100.0	1568	100.0
SEX												
Female	436	39.4	429	40.5	465	39.8	510	40.8	642	43.0	659	43.0
Male	672	60.6	630	59.5	704	60.2	739	59.2	849	56.9	875	57.0
TOTAL	1108	100.0	1059	100.0	1169	100.0	1249	100.0	1492	99.9	1568	100.0
RACE												
White	899	82.8	857	82.7	964	83.0	1053	85.0	1262	85.3	1303	85.4
Black	177	16.3	172	16.6	188	16.2	175	14.1	209	14.1	213	14.0
Other	10	0.9	7	0.7	9	0.8	11	0.9	9	0.6	10	0.7
TOTAL	1086	100.0	1036	100.0	1161	100.0	1239	100.0	1483	100.0	1568	100.0

DATA SOURCE: MACSIS Data Warehouse, Oct. 2, 2010 extract [macsisdatamart.mh.state.oh.us]

Table 3-2: Characteristics of Persons Receiving MH Treatment Services, FY2005–FY2010

	FY2005		FY2006		FY2007		FY2008		FY2009		FY2010	
	N	%	N	%	N	%	N	%	N	%	N	%
AGE												
<18	2,340	34.8	2,388	36.4	2,446	35.7	2,607	33.9	3,040	34.0	3,083	36.6
18-64	4,164	61.9	4,042	61.6	4,249	62.1	4,831	62.9	5,616	62.8	5,198	61.8
>64	220	3.3	133	2.0	151	2.2	241	3.1	290	3.2	135	1.6
TOTAL	6,724	100.0	6,563	100.0	6,846	100.0	7,679	100.0	8,946	100.0	8,416	100.0
SEX												
Female	3,174	47.6	3,093	47.5	3,231	47.6	3,676	48.3	4,228	47.6	3,923	47.1
Male	3,493	52.4	3,417	52.5	3,550	52.4	3,938	51.7	4,650	52.4	4,404	52.9
TOTAL	6,667	100.0	6,510	100.0	6,781	100.0	7,614	100.0	8,878	100.0	8,327	100.0
RACE												
White	5,536	84.1	5,436	84.4	5,631	83.7	6,321	83.8	7,415	84.1	6,932	84.0
Black	1,015	15.4	971	15.1	1,066	15.8	1,186	15.7	1,351	15.3	1,257	15.2
Other	35	0.5	32	0.5	30	0.4	40	0.5	50	0.6	65	0.8
TOTAL	6,586	100.0	6,439	100.0	6,727	100.0	7,547	100.0	8,816	100.0	8,254	100.0

DATA SOURCE: MACSIS Data Warehouse, Oct. 2, 2010 extract [macsisdatamart.mh.state.oh.us]

Table 3-3 displays Treatment Episode Data Set (TEDS) information on diagnosis for persons served in FY2008-09-10. TEDS data are reported to SAMHSA and are tracked in the MACSIS data warehouse. The three-year data make clear that, while cannabis and alcohol were Trumbull County's most popular substances of abuse, opiates have become Trumbull County's most expensive-to-treat drug problem. Per capita costs for FY2010 for opiates were over $4,100 compared to $1,037 for cannabis and $472 for alcohol.

Table 3-3: Treatment Episode Data Set (TEDS) Diagnoses, FY2010-09-08

Trumbull County	**FY2010 Data: TEDS Diagnosis**				
	Client Count	*Units*	*Board Cost*	*Allowed Amount*	*HSReimb*
CANNABIS	362	17,959	$375,434	$379,811	$174,144
ALCOHOL	329	6,385	$155,360	$156,689	$31,336
UNSPECIFIC DRUG	291	6,011	$137,085	$137,852	$35,693
OPIATE	277	45,987	$1,153,463	$1,156,242	$662,370
COCAINE	172	6,983	$173,544	$174,257	$61,240
POLYSUBSTANCE	79	3,180	$80,451	$80,499	$36,849
MISSING/UNKNOWN	31	849	$173,549	$173,549	$0
BARBITURATE	24	3,274	$73,544	$73,693	$44,434
PSYCHOGENIC	9	283	$8,629	$8,629	$5,058
HALLUCINOGEN	8	28	$1,399	$1,399	$879
ALL OTHER DIAG	8,121	407,145	$10,936,335	$11,041,409	$5,452,737
TEDS Diag	**9,027**	**498,084**	**$13,268,792**	**$13,384,030**	**$6,504,741**

Trumbull County	FY2009 Data: TEDS Diagnosis				
	Client Count	*Units*	*Board Cost*	*Allowed Amount*	*HSReimb*
CANNABIS	413	19,110	$373,362	$380,629	$189,151
ALCOHOL	383	9,888	$225,279	$225,970	$57,420
UNSPECIFIC DRUG	305	6,051	$148,158	$148,823	$30,268
COCAINE	229	12,734	$252,559	$253,380	$89,432
OPIATE	217	32,133	$829,977	$830,411	$557,676
POLYSUBSTANCE	90	3,347	$90,075	$90,521	$43,853
BARBITURATE	17	1,242	$29,875	$30,056	$8,774
PSYCHOGENIC	9	315	$8,971	$9,260	$6,255
HALLUCINOGEN	6	92	$2,869	$2,977	$944
AMPHETAMINE	1	882	$10,731	$10,731	$7,538
MISSING/UNKNOWN	1	6,682	$616,517	$616,517	$0
ALL OTHER DIAG	8,806	450,712	$12,530,052	$12,763,685	$6,541,498
TEDS Diag	**9,743**	**543,189**	**$15,118,424**	**$15,362,961**	**$7,532,810**

Trumbull County	FY2008 Data: TEDS Diagnosis				
	Client Count	*Units*	*Board Cost*	*Allowed Amount*	*HSReimb*
CANNABIS	350	15,740	$337,406	$341,856	$133,041
ALCOHOL	332	10,422	$226,900	$227,842	$53,753
COCAINE	277	13,795	$306,359	$311,047	$97,495
UNSPECIFIC DRUG	213	4,995	$115,501	$116,619	$17,914
OPIATE	152	24,077	$575,173	$576,352	$320,614
POLYSUBSTANCE	110	4,865	$145,584	$147,018	$64,724
PSYCHOGENIC	12	517	$13,465	$14,273	$8,214
BARBITURATE	11	371	$7,948	$7,948	$1,768
HALLUCINOGEN	6	77	$3,473	$3,473	$688
MISSING/UNKNOWN	1	7,229	$641,601	$641,601	$0
ALL OTHER DIAG	7,701	403,254	$10,705,926	$10,875,333	$4,986,170
TEDS Diag	**8,525**	**485,342**	**$13,079,336**	**$13,263,362**	**$5,684,382**

DATA SOURCE: MACSIS Data Warehouse, July 3, 2010 extract

The facilitators of the Trumbull County Suicide Prevention Coalition participate in the Northeast Ohio Prevention/Crisis Collaboration. This group meets on a quarterly basis and shares information regarding programming, fundraising and awareness campaigns. The Trumbull Coalition has also been working collaboratively with the Mahoning and Columbiana County's Suicide Prevention Coalitions to provide educational programs to increase the awareness and decrease the stigma associated with mental illness so as to encourage people to obtain help when needed. In helping to determine the target populations on which to focus, the Trumbull County Suicide Prevention Coalition continues to work closely with the Coroner's office in obtaining real time data. Table 3-4 presents the number of suicides by age and year.

Table 3-4: Trumbull County Suicides by Age Group, 2006–2010

Year	*<15*	*15-24*	*25-34*	*35-44*	*45-54*	*55-64*	*65-74*	*75-84*	*85+*	*Total*
2006	0	5	3	10	11	7	0	1	1	38
2007	0	10	6	8	7	4	3	3	0	41
2008	0	4	7	11	8	0	3	1	0	34
2009	1	1	10	4	7	4	2	1	0	30
2010 (to 8/30)	0	1	3	1	3	4	3	1	0	16

The coroner's office also provides data regarding the gender, possible reason for suicide and method of suicide. One of the trends this year is the large percentage of suicides by males who are war vets. In our collaboration with the VA in Trumbull County, there is outreach being done in order to connect the veterans with resources in which to assist them through times of transition and depression. There is psychiatric staff available locally at the VA which will hopefully help to decrease this trend.

Finally, the TCMHRB is on the Steering Committee of a grant application project to build and provide services and housing for homeless veterans with mental illnesses and/or addictions. Because the need is so great and the population so large, if funded, this will be the third such facility in Northeastern Ohio supported by the Veterans Administration.

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

Question 4: Describe major achievements.

a. Our use of state hospitals fell to an all-time low in FY2010 (total days: 3,049; average daily resident population: 8.4).
b. Services for youth and young adults in transition were expanded and coordinated by a steering committee which included youth and family members as key stakeholders.
c. A Family Dependency Court was established in Juvenile Court in partnership with CSB, AoD treatment providers, and other child and family serving systems. The Board, Family Court, and TC CSB provide funding along with a state judicial grant.
d. WRAP (Wellness Recovery Action Plan) training was held for members of the Amish community in Trumbull County and was described in an article in the Autumn 2010 issue of the *Copeland Center Mental Health Recovery* newsletter. [see pages 3, 6 & 14: http://mentalhealthrecovery.com/newsletter/MEC_News_Autumn%202010.pdf
e. Trumbull County's Crisis Intervention Team (CIT) program trained its 100th law enforcement officer in FY2010.

f. Additional Shelter + Care housing vouchers were acquired from HUD by Coleman Behavioral Health providing access for more persons in recovery to decent, affordable housing.
g. The Crossroads housing facility was restructured programmatically to allow women in recovery from AD/MH disorders access to new funding sources.
h. The Trumbull County Family Wraparound program continued its innovative cross–system operations to achieve positive results for high risk children and their families.
i. TICTT (Trumbull Intensive Community Treatment Team) continued to achieve positive results for adults with severe and persistent mental illness using the Assertive Community Treatment (ACT) model.

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

a. We have reduced indigent care services.
b. We have reduced vocational services including supported employment and our partnership with Burdman Group on the Pathways II initiative was discontinued
c. We have reduced or eliminated other non-Medicaid services (e.g., transportation, drop-in center) due to funding cuts and increased Medicaid costs
d. We have shelved plans for the new crisis/diversion facility, also due to funding cuts and increased Medicaid costs.

The major barrier in each of these cases is financial—a simple lack of discretionary funds. Since we cannot limit Medicaid services in any way, we have been forced to reduce or eliminate non–Medicaid services in order to keep expenditures in line with revenues. Earmarked for reduction are clinical services for persons who are not Medicaid eligible (a., above) as well as non–clinical services for all persons (b. and c., above). In addition, all capital construction projects have been shelved and the Board has begun exploring options for divesting itself of properties with significant maintenance and upkeep requirements.

II. Needs Assessment

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

SECTION II: NEEDS ASSESSMENT

Process the Board used to assess behavioral health needs

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

The process the TCMHRB uses to determine current behavioral healthcare needs are multifaceted (see Table 6-1). Administrative staff meet weekly to review needs and progresses in the system of care. Monthly meetings occur with the four core provider agencies and quarterly meetings are held with all Trumbull County providers. Heartland East reports that include treatment provided by diagnosis, length of stay, and cost are reviewed. Other data reviewed include capacity at board-funded housing units, indigent needs determined by terminations, referrals and waiting lists, and Medicaid vs. Non-Medicaid costs, services provided and diagnosis are part of the packet reviewed. Mean, median, mode, graphs and longitudinal reports are provided and reviewed.

The goals and objectives of the community plan are shared with and determined by the Addictions and Mental Health Program Committee that meets monthly. The administrative team of the board prioritizes needs and works with all sectors of the community to ensure an efficient, effective and quality system of care. The goals set in the community plan are revisited and services are "purchased" based upon both predetermined and newly established needs. Consistent with the Board's vision statement "we work to build a system of care that has the best services, are recipient-driven and encourage people to participate in their own care." We also fund services based upon performance measures and outcomes although it has become more and more difficult to measure outcomes since state agencies have lifted all outcome requirements.

Since submission of the previous community plan, Board staff has a new Executive Director, Fiscal Director and staff Accountant and one position was not filled. One–third of the Board's 18 members were appointed in 2010 and the Board structure, meetings and By Laws have all changed. Two new non-Board members have been appointed to the Addictions and Mental

Health Program Standing Committee of the Board consistent with ORC section 340.022. Each standing committee of the board is actively involved in needs assessment and determining how to meet those needs.

This Board has always put a strong emphasis on community involvement and collaboration. We are the fiscal agent for the Trumbull County Family and Children First Council, Help Me Grow, and Alliance for Substance Abuse Prevention Coalition. We actively participate in all levels of the Trumbull Adult Protective Network (TAPN) and Board staff sit on many committees including the Child Fatality Review Board, Department of Jobs and Family Services Review Board, Family Dependency Court, Transportation Committee, Wraparound, Homeless Coalition and Domestic Violence Coalition, to name a few. Board staff meet with core providers, forensic providers and hospital personnel bi-weekly to determine gaps in the system and to problem solve. Since formal outcomes and auditing of provider agency billings and treatment processes are no longer allowable, it is through this informal system of community involvement, relationships and meetings that many behavioral healthcare needs are determined.

Table 6-1: Evaluation / QI Areas, Methodologies and Sources of Data

FUNCTIONAL EVALUATION / QUALITY IMPROVEMENT AREAS	*METHODS/DATA SOURCES*										
	MACSIS Data Warehouse and Heartland East	*ODADAS OSAM and SEOW Data*	*ODMH PCS Data*	*Ohio Labor Market Data*	*US Census Data & SAMHSA Reports*	*Theory-Based Models*	*Board Tracking Systems*	*Board Studies*	*Provider Studies*	*MUI Reports & Consumer Grievances*	*Qualitative Approaches*
Needs Assessment	X	X	X	X	X	X	X	X	X	X	X
Patterns of Use	X		X		X		X	X	X		
Consumer & Family Feedback								X	X	X	X
Community Feedback								X	X		X
Service & Program Outcomes	X		X		X	X	X	X	X		X
Cost analysis	X		X			X	X	X	X		
Utilization Review	X		X			X	X	X	X		X
Organizational/Systems Analysis	X	X		X	X	X	X	X	X	X	X

Findings of the needs assessment

Question 7: Describe the findings of the needs assessment identified through quantitative and qualitative sources. In the discussion of findings please be specific to:

a. Adult residents of the district hospitalized at the Regional Psychiatric Hospitals (ADAMHS/CMH only);

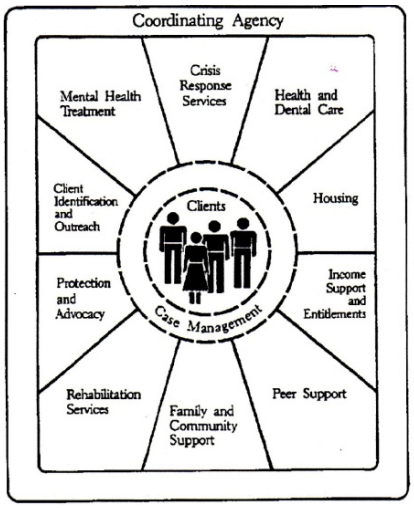
As noted earlier, our state-hospital utilization (admissions and LOS) was at an all-time low in FY2010. Twice per month, the Board along with our core agencies have a teleconference with the social work staff at the Heartland Behavioral Healthcare (and with Northcoast Behavioral Healthcare before our switch to HBHC). In addition, Trumbull County has a liaison from Burdman Group who also attends team meetings at Heartland on alternate weeks of the teleconference. Through this continuous communication, along with provider knowledge of those patients who have open cases, we know that medication management, housing, transportation and case management are the top needs of persons who have been hospitalized.

Many times, the clients who are re-hospitalized at the Regional Psychiatric Hospital do so because of their non-compliance with medication and/or services. Trumbull County Probate Court attempts to hold clients (and providers) responsible for the clients remaining compliant, but there is little leverage. Transportation has been and continues to be a huge barrier and a great need in Trumbull County, as there is no public transportation available. There is an active Transportation Coalition currently working together to try to build a county transportation resource, however, this has been a very slow process. This is an issue that has also contributed to some non-compliance with treatment recommendations when patients are stepped down from the Regional Psychiatric Hospital, as clients often times have no means to attend their follow up appointments. Another transportation issue is that of the cost of transporting clients to and from the Regional Psychiatric Hospital. Many times, the clients admitted to the hospital have no funding or coverage for transportation, which then becomes the financial responsibility of the Board. In addition, most clients' families do not have the financial resources in which to pick the client's up from the Psychiatric Hospital upon discharge, so this too becomes the responsibility of the Board. Due to the distance of the hospital, the increase in the numbers of patients admitted, as well as the increase in fuel, insurance, upkeep, etc., more levy dollars have been needed to cover this resource. As more funding is utilized for transportation, other areas have had decreased allocations.

Regarding the housing issue, Trumbull County is quite limited in the number of group home spots available, which can sometimes be an issue regarding placement post discharge. This has been identified both through quantitative and qualitative sources, as many Trumbull County consumers are living in group homes/adult care facilities in other counties due to the limited availability in Trumbull County. At this time, there are five Adult Care Facilities in Trumbull County, and to date, there are currently 38 clients living in out-of-county ACF's.

b. Adults with severe mental disability (SMD) and children and Youths with serious emotional disturbances (SED) living in the community (ADAMHS/CMH only);

(Adults with SMD) Although it was created more than two decades ago, the National Institute of Mental Health's Community Support System (CSS) model* captures all the basic needs of adults with severe mental disabilities who are living in the community. The CSS model places the client at the center, "surrounded" by case management, with an array of clinical, support and related services radiating from the core. Twenty years' experience might lead advocates to challenge some features of the model, for example, the unrealistically high expectations the model seems to place on case management or the relative size of some of the service wedges. Still this model provides a sound, basic framework for assessing what is available and what is still needed in local community support systems.



In Trumbull County as elsewhere in Ohio, the degree to which *case management* and *mental health treatment* (assessment, medication, counseling) services are available depends greatly on whether or not the individual has Medicaid. In early 2010, Ohio's human services agencies collaborated on the *Balancing and Beyond* project that was aimed at updating the state's Olmstead Act plan. In conjunction with this project, an analysis of FY2009 data from the MACSIS data warehouse (01/02/10 extract) was conducted by Board staff. Among the findings were the following:

- Approximately 70,000 Ohioans with severe mental disabilities (i.e., classified as "SMD" by the MACSIS Data Warehouse) in FY2009 relied on non-Medicaid sources for all or part of their mental health care.
- As a group, these persons received substantially less service than the approximately 130,000 Ohioans with these disorders who *are* eligible for Medicaid.

For example, 16,438 severely mentally disabled Ohioans with schizophrenia who were Medicaid eligible received on average 119.4 units of community psychiatric supportive treatment (CPST) service during FY2009. Their counterparts who were not eligible for Medicaid received an average of 65.6 units, 45 percent less.

The 2004 *Ohio Access* report summarized the situation thusly:

As recommended by the President's New Freedom Commission on Mental Health, gaining federal flexibility (e.g., in Medicaid's requirements) may be necessary to prevent the elimination of mental health care for individuals with serious mental illness who are not eligible for Medicaid. (p. 20)

In a November 1, 2010 letter to the Director of Ohio's Office of Budget and Management

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* Beth A. Stroul, *Community Support Systems for Persons with Long-Term Mental Illnesses: Questions and Answers*. (Rockville, MD: National Institute of Mental Health, 1988)

which accompanied ODMH's FY2012 budget proposal, Director Stephenson states:

Many Ohioans without Medicaid eligibility cannot access any mental health services, and those with Medicaid eligibility often cannot access the full range of services (both Medicaid and non–Medicaid) necessary to function safely in the community.

Clearly, there is unequal access to clinical services by persons with severe mental illnesses based on Medicaid eligibility. And clearly, there is reduced availability of crucial services that are not eligible for Medicaid coverage (e.g., housing, employment, transportation, etc.). Sadly, we are less able today to address the full range of needs of persons with severe mental illnesses living in our community than we were twenty, ten or even five years ago. We know what is needed but we are not fully able to provide it.

(Children with SEDs) For over 15 years the TCMHRB has adhered to the values and principles of the Child and Adolescent Service System Program (CASSP.) The program emphasizes the provision of individualized, family-focused, culturally-competent, and strengths-based services through an organized, multi-agency, community-based system of care. The TCMHRB believes in an integrated system of care that includes the two core values of the CASSP model:

1. Services for children must be driven by the needs of the child and his/her family.
2. Children with emotional disturbances should receive services that are community-based.

Trumbull County has experienced success in maintaining youth in the least restrictive environment through the utilization of the National Wraparound Initiative model of high-fidelity wraparound. During fiscal year 2009, twenty-five youth at high risk of out-of-home placement, were able to remain in their homes or in the homes of relatives through the utilization of the Wraparound process. That same year, out of the ten children residing in residential facilities at the beginning of the fiscal year, three were able to move to less restrictive home environments and seven children (four enrolled children and their three siblings) in foster care were able to move to either biological homes, relative homes or adoptive homes.

Despite these successes there continue to be dozens of youth in Trumbull County that do not reside within a family due to their behavioral challenges. Evidence based programs such as Intensive Home Based treatment (IHBT) and Multi Systemic Therapy (MST) have proven to be among the most successful interventions for treating youth within the community. Due to a lack of available funding, neither of these programs are available to Trumbull County youth and families. The county has seen a rapid growth in Medicaid eligible children as local businesses and factories have closed their doors and an increasing number of parents are being laid off or terminated from their jobs. Funds that once were available for non Medicaid eligible programs, such as IHBT and MST, are now being dedicated to meeting the TCMHRB Medicaid match requirement. TCMHRB continues to allocate the majority of Children's Community Behavioral Health (CCBH) funds to High Fidelity Wraparound so that fewer children have to leave their homes and fewer parents have to relinquish custody of their children to receive treatment. The Boards ability to continue to contribute these funds in the upcoming fiscal years is at jeopardy due to further looming budget cuts.

c. Individuals receiving general outpatient community mental health services (ADAMHS/CMH only);

Throughout Trumbull County, as the increase of joblessness, foreclosures and homelessness occurred, so did the increase in persons searching for outpatient community mental health services for depression and anxiety along with those persons self-medicating with drugs and alcohol. For those residents who are covered by Medicaid, there is little change in service availability, including individual and family therapy, cpst, and medication/somatic intervention. Per most of the local agencies who accept Medicaid, indication is that most Medicaid clients can be served. The population of Trumbull County residents who are also seeking services but have either Medicare, commercial insurance or who are indigent find it much more difficult to access services. This is due to commercial insurance limits regarding number of contacts, co-payment requirement and lack of coverage for CPST. For Medicare recipients, many agencies will not take Medicare due to the poor reimbursement rate, yet we know that this population has one of the highest suicide rates and is one of the groups most likely to abuse prescription medications. According to ODADAS, Trumbull is among 20 Ohio counties with the highest rates of prescription drug deaths. For those residents who are indigent, with the limited funding allocation available to agencies, services are being rationed.

Recent months have seen more calls, complaints and concerns to agencies and to the Board than ever before regarding the need for services yet funding is not available. This problem continues to increase due to the levy funds now being utilized to meet the match of the Medicaid providers, and a decreased amount of funding being available for those residents with inadequate coverage or lack of coverage but in need of services. In FY2010, $117,975 **had** to be used to match Medicaid.

d. Availability of crisis services to persons without Medicaid and/or other insurance. (ADAMH/CMH only)

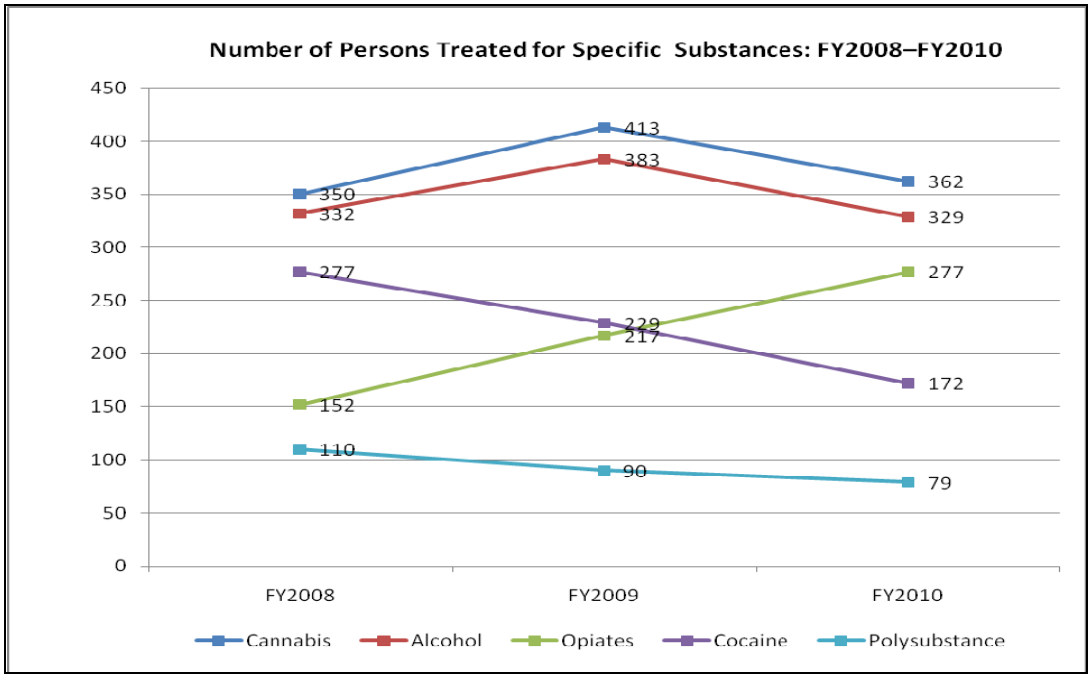
Through the Coleman Access Center (our crisis pre-screening agency for persons without Medicaid and/or other insurance), a “real-time” data base is continuously updated containing information related to crisis calls, information and referral calls, crisis pre-screenings, investigative reports, probates, dispositions and hospitalizations. Numerous queries have been accessed and reviewed in order to identify various issues. In addition, the Access Center “utilization manages” inpatient psychiatric hospitalization with regional hospitals with whom we have a contract, so we have data regarding number of “indigent” clients admitted, lengths of stay and discharge planning.

Coleman Access Center staff is available 24/7 via the local hospital emergency departments, the Access Center office and/or via telephone. The findings from the needs assessment regarding the crisis services offered in Trumbull County indicate that all non-insured/non-Medicaid persons who present to the local Emergency Departments, Access Center and/or call Coleman for crisis services are served in some capacity. These interventions can include: information/referral, face-to-face assessments, telephone intervention, investigative reports and probates. All staff are trained in de-escalation/suicide prevention techniques, risk assessments, mental status evaluation, community resource availability, CPR, and voluntary/involuntary hospitalization procedures.

Over the past year, an out of county Medicaid-only provider, Travco, offered "free" prescreening services to one of the local hospital systems with the caveat that they would only offer free prescreens if they were contracted to do all of the Medicaid clients as well. The "free" prescreens that are completed by this provider include all insurances, Workman's Compensation and Medicare. This introduction of a second prescreening/crisis agency to our system of care has caused confusion and chaos from the inception and this continues. Data gathered from the Medicaid prescreens completed indicates possible abuse of Medicaid billings, as well as poor communication with the Trumbull County System of Care, inappropriate placements and redundant screenings. While the availability of crisis services for those persons without Medicaid and/or other insurance has been available as needed, the increasing costs of Medicaid crisis screenings caused by the out of county provider is causing potential budget cuts to Coleman due to decreased available funding.

e. Adults, children and adolescents who abuse or are addicted to alcohol or other drugs (ADAMHS/ADAS only)

Table 3-3 on page 15 contains Treatment Episode Data Set (TEDS) diagnostic data on persons served during FY2008–09–10. The graph below displays the TEDS data for the "top five" substances abused during this period.



These patterns make clear the fact that, while marijuana and alcohol remain steadily at the top of the abused–substance hierarchy, opiates have shown the greatest increase in the past two fiscal years. As noted in several places in this plan, our continuum of care has a number of missing elements, including ambulatory and social de-tox, and several levels of residential treatment, while other levels of care are available on in other counties (e.g., MAT).

We lack a number of elements in our continuum of care including sleep-off and de-tox centers, residential options (short, medium, and long term care), in-county medication-assisted treatment for opiate addiction, and “genuine” Dual Disorder Integrated Treatment.

The American Alcohol and Drug Survey (ADA) was administered to 6th, 8th and 10th graders in three Trumbull County school districts this past spring. The three schools were chosen because combined they represent an urban district, a rural district and a suburban district. The results are displayed in Figures 1 and 2.

Figure 1 shows that the perception of parental disapproval among 6th graders decreased from the previous year surveyed in all three areas (alcohol by 7%, tobacco by 4% and marijuana by 3%.) Perception of parental disapproval among 8th graders stayed fairly close to the previous year’s surveyed. Perception of parental disapproval among 10th graders decreased in all three areas (alcohol by 8%, tobacco by 6% and marijuana by 5%.)

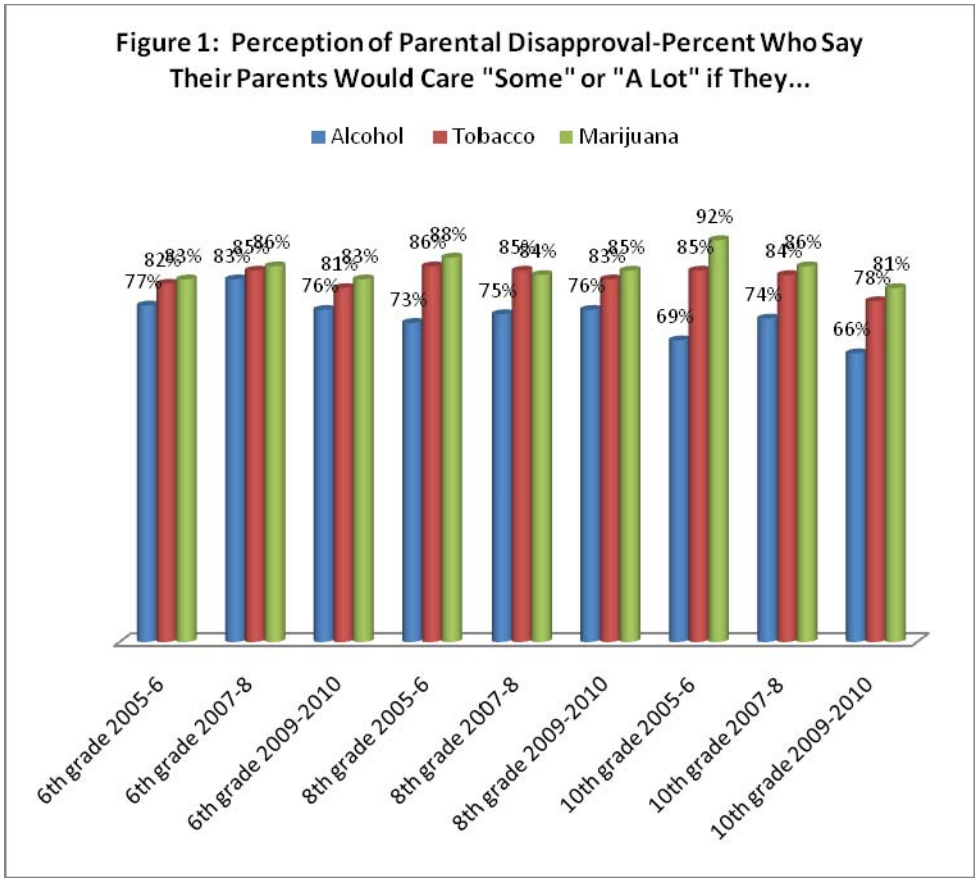


Figure 2 shows that the perception of risk has remained steady among 6th graders for all three years they were surveyed. The perception of risk among 8th graders decreased for both tobacco (by 7%) and marijuana (by 15%.) The perception of risk decreased in all three areas (alcohol by 2%, tobacco by 9% and marijuana by 16%) among 10th graders from the previous year

surveyed.

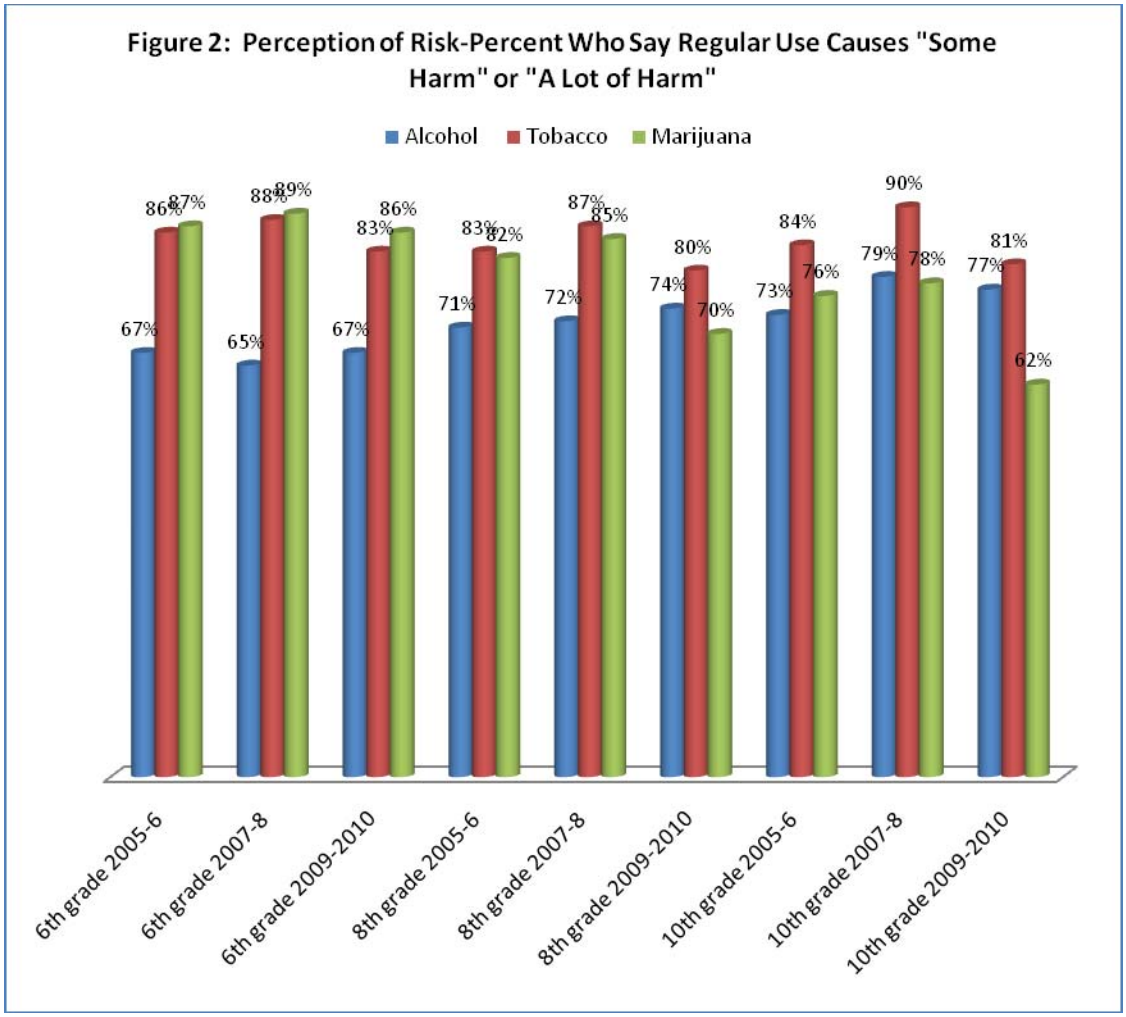
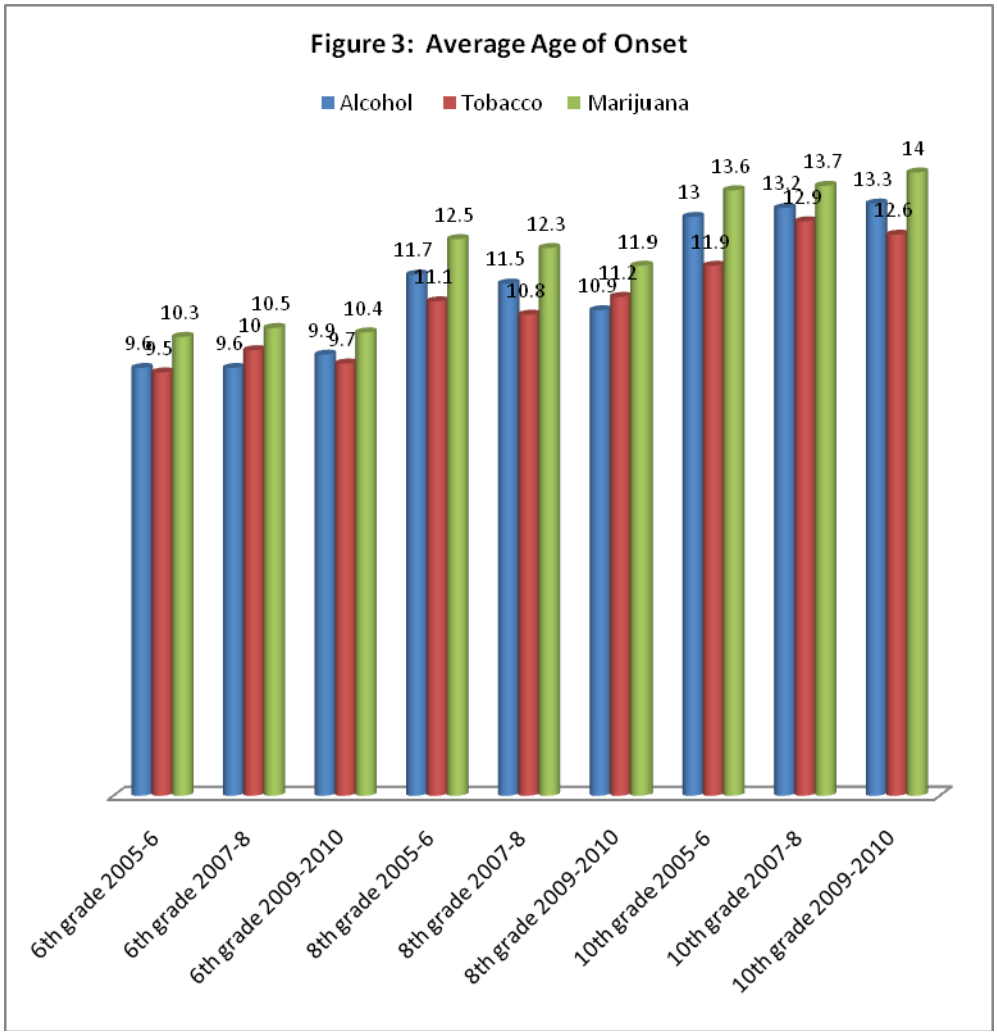


Figure 3 shows that the average age of students in the 6th grade who have started using alcohol, tobacco, or marijuana is comparable to previous years. For 8th graders the average age of onset decreased slightly for both alcohol and marijuana than the previous year's surveyed. The average age of onset for tobacco use in 10th graders decreased slightly. The average age of onset for marijuana use for the same grade level increased slightly. There was no significant change for age of onset for alcohol use in this grade level.



In summary, the two biggest changes from the previous year's survey are:

- Perception of parental disapproval has declined
- Perception of risk has declined

f. Children and Families receiving services through a Family and Children First Council;

Many children who receive services through the Trumbull County Family and Children First Council are involved in the county's high fidelity wraparound initiative. During fiscal year 2009, all thirty eight children who received paid services as a result of their Wraparound plans had a mental health diagnosis and received mental health services.

During the initial phase of Wraparound, a strengths, needs and culture discovery is conducted with families to identify areas of particular strength and areas where assistance is needed to support the families in keeping children safe in their own homes. This information helps in the development of strength-based, individualized plans that are unique to each family's circumstance. In developing and sharing the discovery with Wraparound team members and members of the Wraparound Oversight Committee, a picture of common

needs emerges. During regular meetings of Wraparound teams, family needs are reviewed, revised, adapted and shared.

The Wraparound Coordinator and the Family and Children First Council Coordinator maintain records and data on enrolled families and are able to discern common needs and themes among families. These are shared in the annual Wraparound report prepared by the Wraparound Coordinator and the Council Coordinator. The TCMHRB is the fiscal agent and employer/contractor of the FCFC, Wraparound Initiative, and staff.

Some common needs presented by Wraparound facilitators when requesting funding for family plans include:

- Respite
- Parent coaching/mentoring
- Therapeutic foster care
- Recreational activities
    - Dance lessons
    - Tae Kwon Do
    - Memberships to youth organizations
- Utility assistance
- Car repair
- Home furnishings
- Evaluations, assessments, therapy
- Safety devices, e.g. door locks, window alarms

These are all supports that may make the difference between a successful outcome for families dealing with the mental health needs of their children and prolonged out-of-home placements.

A troublesome, unmet need for families being served by the Family and Children First Council is the lack of case management for families who have private insurance. Medicaid is a generous provider of case management, a critical piece of the mental health treatment puzzle, but local mental health providers are not able to provide it for privately insured families. In some instances, this not only means no case management but also no Wraparound facilitation since the facilitation is provided by mental health case managers in the local system of care. In FY2011, the TCMHRB earmarked $15,000 to Valley Counseling Services and $10,000 to Homes for Kids to pay for Wraparound facilitation for children. One provider used up their entire allocation in the first three months.

The Council uses other methods to obtain information about needs within our community. In August of 2010, the Council served as a focus group and identified the following:

- Need to build consensus about value of education in Trumbull County
- Preventive care for physical health
- Prenatal care
- Dental care for Medicaid recipients
- Violence prevention
- Treatment for trauma
- Transportation remains a barrier for many in the community.

In October of 2010, the Trumbull County Family and Children First members attended a retreat and identified the following additional concerns:

- Youth and young adults in transition. These young people have unique needs that should be addressed.
- Establishing a Bridges Out of Poverty initiative
- Prevention and treatment for tobacco use

Families enrolled in the county's Help Me Grow program and Wraparound initiative often request assistance with basic necessities including food, diapers, and money for gasoline. Most are already accessing available resources, but due to unemployment and underemployment, find it hard to provide for their children.

Finally, school personnel recently shared the following needs:

- School supplies for the neediest children
- Exercise and nutrition opportunities for children
- Parenting workshops
- Assistance in implementing HB 1's Child Abuse Safety and Prevention training

g. Persons with substance abuse and mental illness (SA/MI)

Data from the Board's tracking systems indicate that 54.5 to 65.2 percent of persons served in each of the last five years at Riverbend Treatment Center, our crisis, diversion, and step-down facility, have had co-existing disorders (see Table 7G). In addition to the services listed in section b., above, most persons with co–occurring addictions and severe mental illness should benefit from integrated dual disorder treatment (IDDT), a well–established, evidence–based practice. At present, a modified version of IDDT, Dual Disorder Capability for Addiction Treatment (or DDCAT), is available through Community Solutions Association, our primary provider of substance abuse services. The agency has recently entered into a new partnership with Coleman Behavioral Health one of the goals of which is the establishment of full IDDT services.

Table 7G: Riverbend Treatment Center Utilization

	FY2011	*FY2010*	*FY2009*	*FY2008*	*FY2007*
ADMISSIONS	191	555	528	526	533
Monthly avg	47.8	46.3	44.0	43.8	44.4
DISCHARGES	191	561	522	527	534
Monthly avg	47.8	46.8	43.5	43.9	44.5
SAMI (N)	99	295	320	327	348.0
SAMI (%)	51.8	52.6	61.3	62.0	65.2

DATA SOURCE: TCMHRB tracking system; FY2011 data are through October 2010

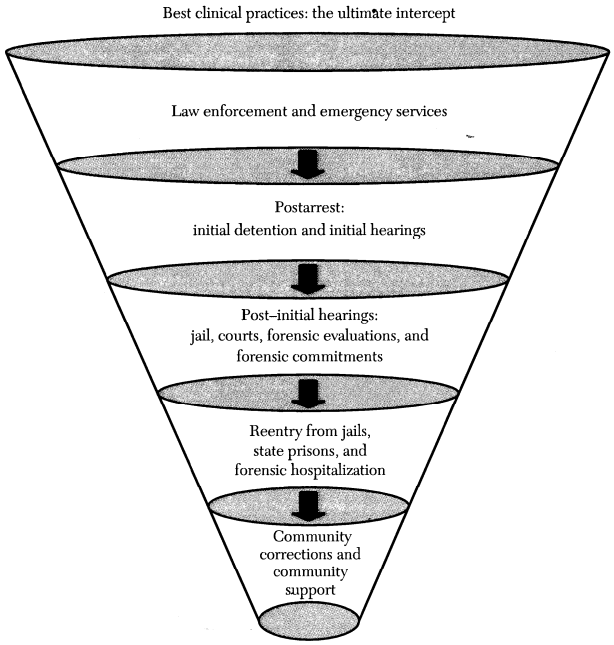
h. Individuals involved in the criminal justice system (both adults and children)

The "sequential intercept" (SI) model provides a comprehensive framework for structuring programs designed for persons with mental illness who are involved with the criminal justice

system.* SI envisions "…a series of 'points of interception' or opportunities for an intervention to prevent individuals with mental illness from entering or penetrating deeper into the criminal justice system" (p. 544). Figure 1 depicts these "points of interception" as a series of filters at which interventions could occur. They are: (1) community best practices used proactively, (2) pre–arrest, (3) post–arrest, (4) post–hearing, (5) re–entry, and (6) community corrections and community

Figure 1

The Sequential Intercept Model viewed as a series of filters



supports. Although we were not using the SI model in the 1990s, we had a more complete system of "filters" in place then than are presently in place. A major component was Project Linkage, a diversion and early intervention project that was jointly funded by ODMH, ODADAS, ODR&C, and ODYS. Project Linkage funded AD/MH workers in district, municipal and common pleas courts in Trumbull County to provide AD/MH assessments and pre–sentence treatment recommendations. Some vestiges of Project Linkage can be found in a few courts in the county today. Our current SI "filters" also include:

- Crisis Intervention Team training for law enforcement: over 100 Trumbull County police and corrections have completed the training since 2006, including Capt. Joseph Marhulik of the Warren City Police Department who was Ohio CIT Officer of the Year in 2008, and Capt. Toby Meloro of the Liberty Township Police Department, Ohio CIT Officer of the Year in 2009. Staff from all four of our core providers and several Medicaid–only agencies have have participated in CIT
- Court liaisons from Community Solutions Association in Municipal and District Courts
- Trumbull County Drug Court, staffed by Community Solutions Association
- Forensic evaluations by the Forensic Psychiatric Center of Northeast Ohio

* Mark Munetz and Patricia Griffin, Use of the sequential intercept model as an approach to decriminalization of people with serious mental illness, *Psychiatric Services*, April 2006, pp. 544–549.

- Services for residents of NEOCAP, a community based correctional facility located in Warren from Valley Counseling Services and Community Solutions Association
- Forensic monitoring of NGRI and ISTU acquittees also by the Forensic Psychiatric Center of Northeast Ohio
- The ODMH's Community Linkages program to transition persons with mental illnesses who are leaving the state's correctional system and are not under supervision; we have provided community connections for close to 50 individuals since FY2008
- Forensic case management, including assertive community treatment when indicated, by the Trumbull Intensive Community Treatment Team (TICTT) program at Burdman Group

We believe that with appropriate modifications the SI model can apply to juveniles and to persons with addictions or substance abuse disorders. To fully address the needs of all of these populations would require a fully developed sequential intercept system of care. This would include many of the same non–Medicaid eligible services (e.g., housing, transportation, employment) discussed elsewhere in this Plan that are insufficiently available to all persons with mental illnesses. At present, we lack the financial resources to implement a truly comprehensive SI system.

i. Veterans, including the National Guard, from the Iraq and Afghanistan conflicts

As indicated in the response to Question #3, one of the suicide trends identified is that of Veterans. Trumbull County Mental Health and Recovery Board has had opportunities in which to collaborate with our local VA, and outreach and referral occur between provider agencies and the Veteran's Administration. The VA in both Trumbull and Northern Mahoning Counties has psychiatric staff, including psychiatrists, nurses and social workers. Through a collaborative effort, interaction and communication occur within the behavioral health community and the VA as is needed. In addition, Trumbull 211 and Help Hotline Crisis Center (211) provide information and referral services specifically designed to meet the needs of this special population. Through 211 as well as the National Suicide Prevention Lifeline, any calls from veterans are immediately transferred to the VA for services. The local VA indicates that they are now receiving between 2 – 3 calls per day.

Question 8: ***<u>Access to Services</u>***

a. Identify the major issues or concerns for individuals attempting to access behavioral health prevention and treatment services in the Board area. In this response please include, when applicable, issues that may exist for clients who are deaf or hard of hearing, veterans, ex-offenders, problem gamblers, and individuals discharged from state Regional Psychiatric Hospitals and released from state prisons without Medicaid eligibility.

Routine mental health services, such as diagnostic assessments, case management, and individual therapy are generally accessible in Trumbull County at this time for those customers who have Medicaid or insurance. The areas of concern regarding lack of accessibility include timeliness of appointments with the psychiatrists due to the limited number of practicing doctors in this area. There also is a lack of resources and funding for

detoxification and rehabilitation for adults. Due to this unmet need, many adults present to the local emergency departments and are placed on medical floors (with a huge price tag) or on psychiatric units, which do not have the programs to address these problems/issues. In addition, there is a lack of housing for this population to continue to assist in the recovery process.

Trumbull County has some very high acuity clients who have housing needs that are unmet, including structured group home living. This is an unmet need of level of care in our community, and we find that many of our clients end up in the Emergency Departments of local hospitals, as well as being hospitalized because of lack of structure and monitoring in their living environments.

For those customers who are ineligible for Medicaid, or have been denied Medicaid and are appealing the decision, the services available to them are practically non-existent, unless they are: 1) being discharged from the State Psychiatric Hospital; or, 2) forensic clients. These populations are high priority and will receive the intervention services necessary, as long as the local funding is available.

An additional obstacle in accessing services is the non-availability of public transportation. There is no public transit system within the county, which impedes the obtaining of services. One way the AoD and MH community has dealt with this is by having case managers transport clients and utilizing taxi service. Both of these options are quite expensive and inefficient for our system, as it takes funding out of direct care services. A transportation collaborative was initiated in 2009 with various organizations and agencies (mental health, alcohol and drug, schools, JFS, group homes, Area Agency on Aging, Trumbull County Office of Elderly Affairs, etc.) and together, a grant was obtained to provide for a transportation coordinator. Currently, with the grant funded coordinator, another grant is being proposed in order to provide for Mobility Management throughout Trumbull County. Unfortunately, transportation priorities have continued to focus on seniors, so many AD/MH clients are unable to access existing resources.

b. Please discuss how the Board plans to address any gaps in the crisis care services indicated by OAC 5122-29-10(B). (ADAMHS/CMH only);

There are currently no gaps in services, however, with having both Coleman Professional Services as the Board's identified provider for crisis services and an out-of-county provider contracted by the local hospital system, there are problems regarding communication, poor collaboration and redundant services provided by the out-of-county provider. In addition, there has been such havoc caused by poor documentation and poor follow-up by this same provider that the local probate court system has become quite distressed about the situation. During the past year, as well as currently, the Board has been attempting to work with the hospital system in order to only have one provider as the identified crisis care services agency, however, the hospital system has not been cooperative nor have they been working as a community partner. Continued work is being done to engage the hospital system as a partner and presenting data to them as to the benefit of only having one provider.

c. Please discuss how the Board identified and prioritized training needs for personnel providing crisis intervention services, and how the Board plans to address those needs in SFY 2012-13. (ADAMHS/CMH only);

As described in past *Community* Plans, crisis intervention training needs are identified through the Board's Continuous Quality Improvement structures and processes for children and adults. Clinical training needs are addressed by the Board's designated provider of crisis services, Coleman Behavioral Health, which has provided these services in northeastern Ohio for many years. Legal and administrative needs are addressed via periodic Health Officer training sessions, conducted by staff from the Board and Trumbull County Probate Court. The following needs have been identified and are addressed in an ongoing manner:

- Clarification of procedures for transportation of persons in crisis between the Access Center, community hospitals and regional state psychiatric hospitals.
- Clarification of procedures for determining residency and for serving persons in crisis who are from outside Ohio (e.g., Pennsylvania, on our eastern border).
- Clarification of procedures for determining residency and for serving persons from outside Trumbull County.
- Clarification of procedures for determining residency and for serving persons who reside in Adult Care Facilities both inside and outside of Trumbull County.
- Clarification of procedures for determining residency and for serving Trumbull County residents who are in crisis in another county (e.g., Mahoning).

Workforce Development and Cultural Competence

Question 9: Workforce Development and Cultural Competence*:

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

With the exception of psychiatrists, providers report no major difficulties in recruiting and retaining appropriately credentialed staff. In recent years we have participated in many meetings with core providers, Medicaid-only providers, and hospitals in Trumbull and other counties to address the shortage of psychiatry. This is felt in particular at the community inpatient level, where a very small number of psychiatrists are responsible for admission, continued stay, and discharge decisions. The situation is exacerbated by the closure in recent years of two of the three psychiatric units in the county (St. Joseph and Northside Hospitals), leaving only one unit in Warren (Trumbull Memorial) and one in Youngstown (St. Elizabeth).

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

As noted in previous Community Plans, Trumbull County is the only county in Ohio with significant African–American and Amish communities. In the 1990s and into the early years of the new millennium, we had active outreach programs in both communities. Today, both programs have been reduced to the basics and the TCMHRB relies on trainings sponsored by providers—sometimes to comply with accreditation requirements—to address cultural competency issues. Providers have also assumed responsibility for providing staff training in a number of related areas, including working with persons with hearing impairments, low-income individuals and families (Bridges Out Of Poverty), non–English speaking persons, and seniors. The Trumbull Advocacy and Protective Network, a cluster-like collaborative focusing on senior citizen issues, sponsors an annual training series dealing with such topics as compliance and abuse of prescription medications, hoarding and animal hoarding, bereavement and loss issues, minority aging issues, and many other topics.

Capital Improvements

Question 10: Capital Improvements:

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

Current capital construction needs include:

- Sleep–off center
- De–tox center including capacity for ambulatory and social de-tox.
- Center for addressing current gaps in the AoD treatment continuum, including short–term and long–residential treatment for addictions and dual disorders
- Supportive housing for SMD and AoD populations
- Base services unit/front door providing a single point of entry for the entire system of care including de-tox, crisis care, hospital step-down/residential care, and dual–diagnosis treatment in an integrated, campus environment
- Locked residential treatment facility
- Adult mental health center

At present and for the foreseeable future, we are unable to provide local match for capital projects of any significance.

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

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

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

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

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

We began with an inventory of priorities from FY2010-11, a projection of likely funding amounts and sources for FY2012-13, and a projection of likely expenditures, including but not limited to Medicaid match. We factored in community feedback on services like Assertive Community Treatment and Wraparound that keep consumers out of more restrictive (and expensive) environments. The process came to this: “Of those things that are important to our system of care, which **must** we provide? (i.e., Medicaid match) Of discretionary programs and services, which can we afford and which may have to be abandoned, at least temporarily?”

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

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

A. Behavioral Health Capacity Goals

1. Promote and sustain the use of “evidenced-based” policies, practices, strategies, supportive housing, peer support, and other programs
2. Increase the use of data to make informed decisions about planning and investment

B. Alcohol and Other Drug Prevention Priorities

1. Evidenced-Based Practice
2. Stigma Reduction

C. Mental Health Prevention Priorities:

1. Suicide Prevention
2. Stigma Reduction activities
3. Crisis Intervention Training (CIT) and other Jail Diversion Activities

D. Alcohol and Other Drug Prevention Goals

1. Programs that increase the number of customers who experience positive family management;
2. Programs that increase the number of customers who demonstrate school bonding and educational commitment;

E. Mental Health Prevention Goals

1. Strengthen families by targeting problems, teaching effective parenting and communication skills, and helping families deal with disruptions (such as divorce) or adversities such as parental mental illness or poverty.
2. Suicide prevention coalitions that promote development of community resources to reduce suicide attempts.

F. ODADAS Treatment and Recovery Services Goals

1. Increase the number of customers who are abstinent at the completion of the program.
2. Increase the number of customers who are gainfully employed at the completion of the program.
3. Increase the number of customers who incur no new arrests at the completion of the program.
4. Increase the number of customers who live in safe, stable, permanent housing at the completion of the program

G. ODMH Treatment and Recovery Support Goals

1. Increase Access to Housing, including Supportive Housing
2. Decrease number and duration of state hospital treatment episodes

Access to Services

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

The major access issue is expected to continue to revolve around persons—virtually all adults—without insurance who are not eligible for Medicaid. This is the "indigent population." To cope with the rising tide of demand for indigent care and the receding tide of resources, our primary provider of care to this population, Valley Counseling Services, adopted the following policy and practice guidelines at the beginning of FY2011:

1. Valley will no longer provide med/som services for those clients who have a primary AOD diagnosis.
2. All Board funded (indigent) clients who request services or are referred for services at Valley will be seen for a Diagnostic Assessment. This is a change from FY '10 in that we've been triaging prior to the DA and referring many clients to other providers of free care. Diagnostic Assessments for Board funded clients will be available in our Transitional Assessment (no appointment) Clinics which will be held Tuesday and Thursday mornings from 8:30 AM to 12:30 PM. Refer clients for services as you've always done in the past.
3. Our Assessment staff will determine level of care and range of services appropriate for clients during the assessment.
4. Priority for med/som services will be made for those coming out of the hospital or Riverbend. We'll be stretching our med som dollars by providing med som groups for clients who have been stabilized on their meds for some time.
5. Clients with serious biologically based mental illnesses and PTSD, for whom individual counseling is deemed appropriate, will receive it. Clients with less serious disorders who could benefit from counseling will be referred to our Depression or Anxiety Groups which will meet twice a week. Counseling will only be available at our Adult Office.
6. We will continue to place the most resources into providing case management services. This will be available at our Adult and Southeast Offices. Only indigent clients coming out of the hospital or Riverbend Treatment Center, on the payeeship or clearly eligible for entitlements will be eligible for CPST services.
7. In many cases there will be a longer period of time between services as a result of fewer resources but as dictated by medical necessity.

In October 2010, several modifications/additions were made:

- As our depression and anxiety groups have been more successful than we predicted, we will be able to shift more Board funded clients into the group therapies from individual. We will consolidate our groups at the Adult Office by 11/1 to further manage costs and assure access.
- With the shift to group therapy, we will be able to make individual therapy available for Level 1 clients (only) at the AO and improve access for them. [*Staffperson*] will see these clients on Wednesdays on a 30 minute schedule to maximize his availability and reduce the impact of their high no show rate.
- [*Psychiatrist*] will see Board funded clients on Wednesdays at the AO only by 11/1. This will help control costs and make Bernice's med/som group more readily available to this group. [*Staffperson's*] services for clients at the AO can also help meet the needs of this

group at AO and further control costs. AO nurses will manage these client's nursing needs from AO on Wednesdays.

- We will be unable to make HEARTS [transitional youth CPST group] and REACH [adult CPST group] available to Board funded clients until they receive Medicaid. We are doing our best to find funds to support scholarships for this group.
- We will continue to evaluate service provision on a 60 to 90 day cycle and adjust as needed to maximize our ability to reach as many clients as we can who need services.

Our immediate goal and objectives for indigent-care access are:

GOAL: Sustain the Board's capacity to provide basic treatment services to the indigent population for as long as possible

Objective 1: Monitor the delivery of indigent-care services (persons, units, costs)

Objective 1: Consider alternative models for delivering indigent-care services

Workforce Development and Cultural Competence

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

GOAL 1: Identify trends and issues in the use of substance abuse and mental health services (including state hospitals) by members of linguistic and cultural minority communities

OBJECTIVE 1.1: Compare utilization of community mental health, community substance abuse, and state hospital services by minority populations in FY2009, 2010, 2011

OBJECTIVE 1.2: Review data from client satisfaction surveys and other sources for appropriate feedback from minority populations

OBJECTIVE 1.3: Identify any special issues pertaining to existing programs which target minority communities (African–American, Amish, hearing impaired, etc.)

GOAL 2: Identify training and related activities conducted by providers to enhance cultural competence

OBJECTIVE 2.1: Conduct and analyze data from provider survey

GOAL 3: Identify training and related needs felt by providers related to cultural competence

OBJECTIVE 3.1: Conduct and analyze data from provider survey

GOAL 4: Develop a plan for addressing issues and needs identifies in Goals 1-3

OBJECTIVE 4.1: Review findings from survey at Adult and Youth CQI meetings;

OBJECTIVE 4.2: Develop common strategy for Board, providers and other stakeholders with current financial constraints

ORC 340.033(H) Goals

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

In recent years, approximately 75% of referrals to the Trumbull County Children Services Board have included reference to the caregiver's drug or alcohol abuse as part of the concern for children. After attending the "Ohio Summit on Children" in May 2008, attendees from the Trumbull County Children's Services Board, Trumbull County Family Court, Trumbull County Mental Health and Recovery Board and the Trumbull County Family and Children First Council felt that they had found a potential solution to helping parents regain custody of their children quickly and enabling them to provide safe, permanent homes through the use of Family Dependency Treatment Drug Court. This special docket court began running in June of 2009 with support from a grant through the Ohio Supreme Court and treatment provided by contract agencies of the Trumbull County Mental Health and Recovery Board.

The mission of the Family Dependency Treatment Court (FDTC) is to improve the safety and welfare of children while supporting the recovery of their parents from alcohol and drug abuse, through comprehensive treatment services and judicial supervision.

Parent(s) are eligible for FDTC when an abuse, neglect or dependency case is filed by Trumbull County CSB or a private individual in Trumbull County Family Court and parental substance abuse was an underlying cause for the removal or Protective Supervision Order (PSO) regarding the child(ren). There are no eligibility criteria based on children's characteristics. Potential client information is presented to the FDTC Team at an admission team meeting. The Magistrate may approve the admission on a case by case basis, based upon the Team members' recommendations.

Although entrance into the FDTC is voluntary, continued participation becomes Court ordered. Participants progress through a series of graduated phases, receive rewards and sanctions based on their performance, and make a minimum commitment of one year to the program.

HIV Early Intervention Goals

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

Not applicable.

Addressing Needs of Civilly and Forensically Hospitalized Adults

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

Trumbull County continues to contract with the Forensic Psychiatric Center of Northeast Ohio to provide forensic monitoring and case management to our adults who are forensically hospitalized and the Burdman Group provides liaisons for those clients who are civilly committed to the state hospitals. The Forensic monitor attends the county Continuous Quality Improvement meetings on a regular basis and discussion includes discharge planning and community plans. For persons who are discharged on conditional release, both the Forensic Monitor and Burdman Group work with the client in order to provide the most appropriate level of treatment. Regarding the hospitalization of non-violent misdemeanants residing in the state hospital, Trumbull County has not found an increase in this population, nor are we anticipating that this will begin to occur. If this trend does start to occur, we plan to continue the tag-team approach with the Forensic Center and the Burdman Group.

NOTE: Trumbull County has *not* experienced a noteworthy increase in the number or proportion of non–violent misdemeanants residing in state hospitals.

Implications of Behavioral Health Priorities to Other Systems

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

Needs that are either low on the board's priority list or are not a current priority of the board will certainly impact other systems. The consequential costs will impact hospitals, the child welfare system, the department of rehabilitation and correction, department of youth services, and businesses, among others. Hospitals will realize increased emergency room visits and hospitalizations as community resources become more scarce. The Ohio Business Roundtable sees depression as one of the top three health issues affecting businesses today. When this depression goes untreated, businesses will incur more expenses in loss of employee time and productivity. Child welfare statistics report that 80% of youth in foster care have at least one parent with a substance abuse disorder. As treatment becomes harder to obtain, children are destined to remain in foster care for longer periods of time. The rehabilitation system has already seen negative implications. As one county sheriff recently told the media, "People with mental illness often return to prison for mostly nonviolent crimes that are really just symptoms of untreated mental illness." With budget cuts continuing to diminish services, prisons are often one of the few places where people with mental illness are able to get a bed and three meals a day. The Ohio Association of Behavioral Health Authorities reports that over 50% of all inmates at the Ohio Department of Rehabilitation and Correction have a substance abuse disorder, and 56% have a diagnosable mental illness. 75% of youth in the Ohio Department of Youth Services have a substance abuse disorder; 35% have a diagnosable mental illness. Of the single

individuals experiencing homelessness, 40% will have a severe and persistent mental illness, and 32% will be addicted to alcohol and/or other drugs. Without the availability of proper community care, homelessness, crime, domestic violence, and other societal harms will increasingly plaque our neighborhoods.

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

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

Should there be a reduction in state funding of 10 percent of the Board's allocation, along with the continual increase in Medicaid billings in Trumbull County (per the projections of Heartland East), the impact to the priorities and goals of Trumbull County's system of care will be wide-spread. The services and populations that are currently funded with levy dollars will be affected immediately, as the levy funding will be needed for Medicaid Match. The specific programs and populations that will go without funding include:

Program	*Population*
Guardianship and Protective Services Help Hotline Crisis Center	Trumbull County residents with a mental illness in need of guardianship services but have no funding source or family This impacts 13 clients
Salvation Army Drop-in Center Niles Trumbull Transit System	A 5-day/week, 2 hour/day social/recreational program for Trumbull County SMD consumers funded by Trumbull County Mental Health and Recovery Board, as are 3 days of transportation. The program has helped maintain many mental health clients in the community by providing a structured program for them to look forward to and attend. If any signs/symptoms of decompensation are noted by the program coordinator, he contacts the client's case manager directly. This impacts approximately 30 clients
Jail Based Services	Originally, the Access Center prescreeners would be contacted by the jail if an inmate had been flagged as being suicidal, having an identified mental illness or possibly being mentally ill. The prescreeners would assess

	the inmate and make recommendations. As the jail was finding that more inmates were in need of on-going mental health/drug and alcohol intervention, it was agreed upon to shift funding to the jail system, which was then combined with other funding, in order for them to employ a social worker to provide these services. The benefit of this change was to increase the number of hours that a staff person was available to provide services to inmates so as to more effectively serve their mental health needs (including after-care planning and follow up). This impacts service availability to inmates in need of mental health intervention and hundreds of inmates potentially could be affected.
Forensic Monitoring	In order to adequately provide services to the forensic population of Trumbull County, levy funding is utilized to collaboratively contract with the Forensic Psychiatric Center of NE Ohio. Both Ashtabula and Columbiana Counties also partner with this collaboration, therefore not only are the Trumbull County clients impacted, but so are the other two counties' clients. This impacts 14 persons in Trumbull County.
Medical and Dental Services – One Health Ohio	Statistically, those consumers diagnosed with a mental illness have a lifespan of 25 years less than the general population. In order to help combat this problem, the TCMHRB has been working collaboratively with One Health Ohio, a federally qualified health clinic in order to provide medical services to those clients most in need. Medical vouchers are provided to clients via their case managers, in order for the consumers to obtain medical care at no cost. The reimbursement for the cost of the voucher/cost per visit ($15) is then paid for by the TCMHRB to One Health Ohio. The impact will be over 1,3000 medical visits per year that mental health clients will not have available at no cost.
Ravenwood Mental Health Center	Mental Health services to the Amish population in northern Trumbull County will no longer be available.
Help Hotline Crisis Center – WRAP/Bridges	The WRAP and Bridges program currently available in Trumbull County will no longer occur; in addition, the programs were offered to the Amish population in Trumbull County,

	which will also cease to exist.
Transportation	As indicated with the Salvation Army Drop-in Center, transportation for that program will no longer exist even if the Salvation Army would be able to find alternative funding for the Drop-in Center. In addition, transportation for clients to their mental health center appointments will no longer be available, including for clients involved in a partial hospitalization program for adults and one for transitional aged youth. The impact of this is approximately 50 clients total.
Neil Kennedy Recovery Clinic	The agency provides core treatment services for those consumers with primary AOD or AOD/MH intervention needs. The impact to this population will then cause additional hospital emergency department visits due to the continued usage of aod substances.
Burdman Group Coleman Behavioral Health Community Solutions Association Valley Counseling Services	The Core 4 providers in Trumbull County will all have services impacted due to the decrease in levy funding for the indigent population. The specific services impacted will include direct care for those clients who have no other source of payment (Medicaid, Medicare or insurance), and who generally have multiple needs. The decisions as to which programs/services will be cut will be determined collaboratively with the provider agencies.
Trumbull County Mental Health and Recovery Board	Funding cuts to operations and the community budget will impact the planning and collaborative partnerships built within Trumbull County, which ultimately fragment client services. In addition, issues, problems and ultimate resolutions regarding client services will no longer be handled in a planful, problem-solving manner but will be more crisis oriented and reactionary. It is the belief of the TCMHRB to be proactive rather than reactive in order to provide the most effective and efficient services to the consumers in Trumbull County. The TCMHRB employs just 9.5 employees. Four of these employees attend more than twenty community and Board meetings each month. Administrative overhead for the Board is less than 5 percent. Reductions will result in layoffs and many community partnerships will

	be severed as a direct result of these funding cuts.

IV. Collaboration

A. Key Collaborations
B. Customer and Public Involvement in the Planning Process
C. Regional Psychiatric Hospital Continuity of Care Agreements
D. County Commissioners Consultation Regarding Child Welfare System

SECTION IV: COLLABORATION

Key collaborations and related benefits and results

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

The Trumbull County Mental Health and Recovery Board has consistently displayed a high degree of collaboration among community mental health organizations, schools, the county children services board, family court, the Board of Developmental Disabilities, along with other community stakeholders. One way in which collaboration efforts manifest themselves is through the Trumbull County Family Children First Council's Wraparound Oversight Committee. The committee consists of representatives from every service provider and parent advocates within the system of care. The Wraparound Oversight Committee has adopted the High Fidelity Wraparound Model with more than 36 service provider staff members being trained in the model. FY 2009 saw 37 children receive services through the wraparound process, with a majority of the youth involved in 2 or more systems throughout the county. When including siblings, who also benefit, sixty one children were involved. All enrolled children received mental health services. The successes of the Wraparound Oversight Committee for FY 2009 included 7 children (4 enrolled children and their 3 siblings) in foster care being able to move to either biological homes, relative homes or adoptive homes. Twenty-five (25) children were able to remain in their own homes or in the homes of relatives despite being at high risk of out-of-home placement. Of the 10 children who were in residential facilities at the beginning of the fiscal year, 3 were able to move to less restrictive home environments.

Another major collaboration of the Trumbull County Mental Health and Recovery Board are the Continuous Quality Improvement (CQI) meetings, held for both the adult system, and children's system, facilitated by Board staff. The adult CQI meetings are attended by contract mental health, and alcohol and other drug agencies, Trumbull County's forensic monitor, local psychiatric hospital administrator, Trumbull County Board of Developmental Disabilities (on as needed basis), social work staff at Heartland Behavioral Healthcare. The Children's CQI

meetings are attended by all contract agencies in Trumbull County that serve the Mental Health and Substance Abuse needs of youth and their families. This collaboration has resulted in better communication regarding treatment and discharge planning for those patients at Heartland, improved client transition back to the community, better understanding by Heartland staff/social workers as to resources available in Trumbull County and a more stream-lined referral process for the social workers in completing discharge planning. The collaborative meetings have enabled positive working relationship between all entities and non-confrontational, more productive problem solving/issue resolving.

The Trumbull County Mental Health and Recovery Board currently has four contracts with private hospitals to provide inpatient psychiatric care for indigent Trumbull County clients. Each year, the contracts are renewed, and regular dialogue occurs between a Board representative and hospital representative to deal with any issues or concerns. In addition, one of the local hospital representatives participates in our Continuous Quality Improvement meetings and also attends our quarterly System Integration meeting.

Another system in which collaboration has occurred is with our local jail. Originally, as part of the development of the LifeLines Access Center, if an inmate was flagged as being suicidal, having an identified mental illness or possibly being mentally ill, a pre-screener would assess the inmate. As the jail was finding that more inmates were in need of on-going mental health/drug and alcohol intervention, it was agreed upon to shift resources to the jail system in order for them to employ a social worker to provide these services. The benefit of this change has been an increased number of hours that a staff person is available to provide services to inmates. This more effectively serves their mental health needs including after-care planning and follow up.

The Trumbull County Mental Health and Recovery Board continues to be a major partner in the Trumbull Advocacy and Protective Network collaborative, a network of Trumbull County representatives from social services, government, medicine, law enforcement, the courts, etc. who serve seniors and share the common desire to provide system-level integration and coordination of programs, case-level coordination and integration of services and training/cross-training of service providers and network members. TAPN provides on-going trainings for providers and the community at-large focusing on issues/resources/interventions for seniors. A Clinical Committee meets on a monthly basis to discuss clinical issues, support fund requests and to share resource information. Various speakers are asked to present to update/inform group of programs in the community for seniors. The clinical committee also addresses the special needs of older adults who are being served by more than one system and whose situation warrants extraordinary interventions. The ongoing benefits of this collaborative is continuous updates on resource availability for seniors, which then leads to appropriate referrals to seniors for interventions, which then leads to improvement in senior living.

The Family Dependency Treatment Court is a collaborative project of the Trumbull County Family Court, Trumbull County Children Services Board and the Trumbull County Mental Health and Recovery Board. In abuse, neglect or dependency cases where children have been or are in danger of being removed from the care of the parent(s) due to the alcohol or drug issues of the parent, the parent may be referred to the specialized docket of the Family Dependency Treatment Court at any stage of the proceedings. Participants are referred for and receive addiction and mental health services, including counseling and case-management, medication management, if appropriate, and drug screens by provider agencies. So far all recipients are

Medicaid eligible so the TCMHRB has paid $70,000 in Medicaid eligible services for the participants to date.

An award was received by the Supreme Court of Ohio in 2009 for $40,000 to support a coordinator under the project. The coordinator tracks referrals, provides limited case-management for referents, completes public relations, reporting and team development. The project was funded in full for two years, 2009 and 2010. The three systems agreed in the original application to sustain the project with a three-way split in subsequent years beginning in calendar year 2011 with a $3,333 cost for each, which continues to double until the project is fully funded locally. Without additional money from the state, this and other local initiatives are at risk of being defunded.

Involvement of customers and general public in the planning process

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

Consumers and family members are important participants in a number of Board–sponsored or supported initiatives including:

a. Mahoning–Trumbull Recovery Project
b. Alliance for Substance Abuse Prevention
c. Trumbull County Family and Children First Council
d. Trumbull County Family Wraparound Oversight Committee
e. Crisis Intervention Team Steering Committee
f. Crisis Intervention Team training providers
g. Youth and Young Adults in Transition Committee
h. Tri–County Suicide Prevention Collaborative

To the extent that these endeavors rely on non–Medicaid funding from the Board (for example, a., e., and f.), they are at risk for partial or total funding cuts as was the case with the Northeast Ohio Collaborative's Consumer Quality Review Team project, which lost its ODMH funding several years ago.

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

Prior to the implementation of the Continuity of Care Agreement, there has been collaboration and communication between the Board, providers and designated hospitals so as to continuously work to improve the continuity of care for our consumers.

For the past several years, Trumbull County's work with the state hospitals (Northcoast Behavioral Healthcare until 11/09 and Heartland Behavioral Healthcare since 11/09) has been continuously improving. We accomplish this by having open communication between the hospital staff, providers and the Board. Our pre-screening agency has met with the staff of both hospital systems, both locally and at the hospitals, in order to clarify the needs at both ends. When transferring from NCBH to HBHC, it was requested of the state hospital to provide the pre-screeners with a list of routine hospital labs in order to help expedite the admissions process. To date, there have been very few problems cited by either the prescreening agency or the hospital as to the types of referrals, the documentation or waiting time for transfers. Whenever a problem does arise from either the community side or the hospital side, there is immediate communication to resolve the issue. Once a county resident is admitted, there is discussion between the hospital and community through our bi-weekly telephone conferences, which consist of the hospital social workers, Board and Board providers. In addition, there is a liaison from Burdman Group/Riverbend who goes to the hospital the other two weeks of each month to help coordinate discharge planning and transportation. The Continuity of Care Agreements were actually signed and executed after many of the current processes were in place, so this document has been utilized as an adjunct training reference. In addition, prior to the signing of the document, the Board had distributed it to our Core 4 providers in order for them to comment or question anything in which they wanted additional clarification. All entities have a copy of the agreement and are aware of the expectations within the agreement. Any new pre-screeners hired are oriented to the expectations outlined in the agreement along with the process.

Through the last several years, we have significantly improved our collaboration by the open and honest communication and follow-through of all stake-holders. In addition, it is believed that the same sentiment holds true from the hospital side, should they be contacted for comment. We all have the same goal in mind, which is to provide the best care possible for our most compromised consumers.

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

Funds available for parents/caregivers in the child welfare system

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

Section 340.033 (H) of the ORC states: *"When the board sets priorities and develops plans for the operation of alcohol and drug addiction programs under division (A)(2) of this section, the board shall consult with the county commissioners of the counties in the board's service district regarding the services described in section 340.15 of the Revised Code and shall give a priority to those services, except that those services shall not have priority over services provided to pregnant women under programs developed in relation to the mandate established in section 3793.15 of the Revised Code. The plans shall identify funds the board and public children services agencies in the board's service district have available to fund jointly the services*

described in section 340.15 of the Revised Code."

Further, Section 340.15 indicates *that "a public children services agency that identifies a child by a risk assessment conducted pursuant to section 5153.16 of the Revised Code as being at imminent risk of being abused or neglected because of an addiction of a parent, guardian, or custodian of the child to a drug of abuse or alcohol shall refer the child's addicted parent, guardian, or custodian and, if the agency determines that the child needs alcohol or other drug addiction services, the child to an alcohol and drug addiction program certified by the department of alcohol and drug addiction services under section 3793.06 of the Revised Code. A public children services agency that is sent a court order issued pursuant to division (B) of section 2151.3514 of the Revised Code shall refer the addicted parent or other caregiver of the child identified in the court order to an alcohol and drug addiction program certified by the department of alcohol and drug addiction services under section 3793.06 of the Revised Code. On receipt of a referral under this division and to the extent funding identified under division (A) of section 340.033 of the Revised Code is available, the program shall provide the following services to the addicted parent, guardian, custodian, or caregiver and child in need of alcohol or other drug services:*
(1) If it is determined pursuant to an initial screening to be needed, assessment and appropriate treatment;
(2) Documentation of progress in accordance with a treatment plan developed for the addicted parent, guardian, custodian, caregiver, or child;
(3) If the referral is based on a court order issued pursuant to division (B) of section 2151.3514 of the Revised Code and the order requires the specified parent or other caregiver of the child to submit to alcohol or other drug testing during, after, or both during and after, treatment, testing in accordance with the court order.
(B) The services described in division (A) of this section shall have a priority as provided in the alcohol and drug addiction services plan established pursuant to section 340.033 of the Revised Code. Once a referral has been received pursuant to this section, the public children services agency and the alcohol or drug addiction program shall, in accordance with 42 C.F.R. Part 2, share with each other any information concerning the persons and services described in that division that the agency and program determine are necessary to share. If the referral is based on a court order issued pursuant to division (B) of section 2151.3514 of the Revised Code, the results and recommendations of the alcohol and drug addiction program also shall be provided and used as described in division (D) of that section. Information obtained or maintained by the agency or program pursuant to this section that could enable the identification of any person described in division (A) of this section is not a public record subject to inspection or copying under section 149.43 of the Revised Code."

Services coordinated with the Trumbull County Children Services Board for individuals involved in both of our systems of care are many. Both this Board and the TCCSB are active participants on the Trumbull County Family and Children First Council, Trumbull County Department of Jobs and Family Services Oversight Council, Child Fatality Review Board, Wraparound and Family Court Program. Through these and other community committees individuals and families are identified as benefitting by drug and/or alcohol treatment and related services and information sharing and formal referrals are made as appropriate. Community Solutions, our largest treatment and prevention provider for ATOD services in the county, receives court-ordered individuals to engage in treatment programs that include individual and group counseling, alcohol and drug screens and parenting classes. They also provide an array of prevention services including some that specifically target reducing alcohol, tobacco and drug use by

children and adolescents. All of these programs are funding by this Board using ODADAS and levy dollars. Although the County Commissioners are mandated members of the Family and Children First Council, they have only been to one meeting in the past six years. They do approve the budget of this Board and the Trumbull County Children Services Board as well as the Family Court, so they are made aware of services offered consistent with this statute even they are not formally a part of the planning process.

V. Evaluation of the Community Plan

A. Description of Current Evaluation Focus
B. Measuring Success of the Community Plan for SFY 2012-2013
C. Engagement of Contract Agencies and the Community
D. Milestones and Achievement Indicators
E. Communicating Board Progress Toward Goal Achievement

SECTION V: EVALUATION OF THE COMMUNITY PLAN

Ensuring an effective and efficient system of care with high quality

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

Appendix C of the Community Plan Guidelines identifies six "evaluation criteria" that Boards use "to address the quality, efficiency of services." Three deal with traditional program evaluation concerns (patterns of use, outcomes, community acceptance) and three deal with varieties of cost analysis (including cost-effectiveness and cost-efficiency). Each of the criteria is briefly discussed below with reference to some specific successes and challenges. The reader is referred to table 6-1 on page 21 of this Community Plan for a visual cross-classification of the Board's Evaluation and Quality Improvement activities, methodologies and data sources and to Attachments 1 through 8.

Patterns of Service Use

SUCCESSES..... Earlier section of this Community Plan have featured patterns of use data drawn from a variety of sources, including MACSIS/claims, PCS/state hospital, and the Board's tracking systems. Attached are some representative examples. Attachments 1-3 are state hospital monitoring reports using data from the Patient Care System. Attachment 4 is prepared

for us by Heartland East and uses MACSIS claims data to track client counts and board costs (total and per capita) by residency (in county, out of county) and Medicaid status. Attachment 5 is another Heartland East report which tracks persons served by age, gender, and race, and includes breakdowns by “top ten” diagnoses for adults and children. This report is also run separately for persons served by out of county providers. Finally, Attachment 6 is a monitoring report for Riverbend Center and uses data from our in–house tracking systems.

CHALLENGES..... When we view the MACSIS reports sequentially, we see a clear trend for Medicaid-eligible persons to receive increasing amounts of service. Without the ability to review clinical records and related documentation, however, we cannot connect increased use with increased need. At the same time, a declining pattern of use describes the non-Medicaid population.

Cost Analyses

SUCCESSES..... MACSIS/claims data are used in a wide variety of costs analyses, some of which have been referenced in earlier parts of this Community Plan as well as in Attachments 4 and 5 discussed under Patterns of Use, above. Attachment 7 draws on FY2009 MACSIS claims data for CPST service only, assembled from the Data Warehouse. It lists our five largest child-serving providers, based on number of children and adolescents who received CPST service in that year and lists the number of clients and units of service delivered, and the “per capita” amount of service, which is the number of units divided by the number of clients. There is wide variation in per capita units for the providers in the aggregate (range 8.7 to 97.2 units per capita for all diagnoses combined). When separated by diagnosis, this trend becomes even more pronounced. For example, the 114 children with a diagnosis of *adjustment* problem at Agency 34 received an average of 21.4 units of CPST service, while their 79 counterparts at Agency 19 received 47.6 units on average and the 28 at Agency 18 received 70.2 units.

Attachment 8 contains similar data on children’s CPST service but broadens the focus from Trumbull County providers only to the Top Five child-serving providers in the six Heartland East boards. For the purposes of Attachment 8, Board E is Trumbull County. The same five Trumbull providers included in Attachment 7 are also included in Attachment 8. The first page of Attachment 8 combines all diagnoses, while each of the five subsequent pages deals with a single diagnosis or diagnostic group. Again, the major finding is the great variation in the amount of CPST that is being provided to children with the same diagnosis.

CHALLENGES..... While the analysis of data in Attachments 7 and 8 would qualify as cost analyses, neither would meet criteria for *cost-effectiveness* or *cost-efficiency* studies, which require outcome indicators that can be combined with the demographic and cost variables. These we lack at present.

Consumer Outcomes

SUCCESSES..... In the absence of a universal system for tracking changes in resiliency, recovery, and quality of life indicators for persons receiving treatment services, the Board has come to rely on providers to assess the impact of their services. Several noteworthy studies have been completed in recent years including:

- Increased housing stability and reduced hospitalization among ACT clients
- Getting and keeping employment, wages, and benefits among supported employment clients

- Family stability, empowerment and reduced out-of-home placements among Wraparound children and families
- Improved sobriety, employment, housing stability and reduced incarceration among persons completing AoD treatment

CHALLENGES..... Valid and reliable measurement of the impact of services on consumers' symptoms, functioning, quality of life and recovery remains one of our greatest challenges. Good tracking and outcomes-management systems can be costly in terms of human and financial resources but without them, we cannot be sure how well we are doing in terms of consumer outcomes.

Community Acceptance

SUCCESS..... Partly in recognition of the importance of the Board's work in strengthening our community, we were awarded a grant from the Raymond John Wean Foundation earlier this year to support anti–stigma campaigns for addictions and mental illness and to promote the Board's new name. Our Crisis Intervention Team training program for law enforcement officials has been awarded several grants from the Newton Falls Post of the Veterans of Foreign Wars, the most recent in November 2010. We are regularly called on by community groups (e.g., Youngstown State University, Warren Republican Women's Club, Leadership Mahoning Valley) for speaking engagements or to participate in community events like the UAW's Community Outreach for displaced workers.

CHALLENGE ..... We have not conducted formal community–acceptance studies in a number of years. Instead, we rely on proxy measures like those mentioned under "successes."

Determining Success of the Community Plan for SFY 2012-2013

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

A. Behavioral Health Capacity Goals

GOAL A-1: Promote and sustain the use of "evidenced-based" policies, practices, strategies, supportive housing, peer support, and other programs

OUTCOME INDICATOR A-1: System-wide inventory of evidence-based policies, practices and strategies, including fidelity measures where applicable, to be published annually

GOAL A-2: Increase the use of data to make informed decisions about planning and investment

OUTCOME INDICATOR A-2: Utilization and financial reports created by Heartland East and Board staff will be reviewed at Board committee meetings, adult and children's CQI meetings, System Integration Meetings, and other planning meetings and documented in meeting minutes

D. Alcohol and Other Drug Prevention Goals

GOAL D-1: Programs that increase the number of customers who experience positive family management

OUTCOME INDICATOR D-1: Comparison of intake and subsequent scores on relevant instruments/scales/subscales for Wraparound and Family Dependency Court enrollees

GOAL D-2: Programs that increase the number of customers who demonstrate school bonding and educational commitment

OUTCOME INDICATOR D-2: Comparison of intake and subsequent scores on relevant instruments/scales/subscales for Wraparound and Youth Transition enrollees

E. Mental Health Prevention Goals

GOAL E-1: Strengthen families by targeting problems, teaching effective parenting and communication skills, and helping families deal with disruptions (such as divorce) or adversities such as parental mental illness or poverty.

OUTCOME INDICATOR E-1: Comparison of intake and subsequent scores on relevant instruments/scales/subscales for Wraparound and Early Childhood enrollees

GOAL E-2: Suicide prevention coalitions that promote development of community resources to reduce suicide attempts.

OUTCOME INDICATOR E-2: Tri–County Suicide Prevention Collaborative will sponsor three or more activities (e.g., speakers, trainings, public awareness campaigns) during the biennium

F. ODADAS Treatment and Recovery Services Goals

GOAL F-1: Increase the number of customers who are abstinent at the completion of the program.

OUTCOME INDICATOR F-1: Pre- and post- comparisons of persons in targeted programs

GOAL F-2: Increase the number of customers who are gainfully employed at the completion of the program.

OUTCOME INDICATOR F-2: Pre- and post- comparisons of persons in targeted programs

GOAL F-3: Increase the number of customers who incur no new arrests at the completion of the program.

OUTCOME INDICATOR F-3: Pre- and post- comparisons of persons in targeted programs

GOAL F-4: Increase the number of customers who live in safe, stable, permanent housing at the completion of the program

OUTCOME INDICATOR F-4: Pre- and post- comparisons of persons in targeted programs

G. ODMH Treatment and Recovery Support Goals

GOAL G-1: Increase Access to Housing, including Supportive Housing

OUTCOME INDICATOR G-1: Longitudinal tracking of participation in housing programs as monitored in new monthly housing report

GOAL G-2: Decrease number and duration of state hospital treatment episodes

OUTCOME INDICATOR 2.1: Longitudinal tracking of admissions, discharges, and lengths of stay as monitored in monthly state-hospital reports report

a. How will the Board engage contract agencies and the community in evaluation of the Community Plan for behavioral care prevention and treatment services?

The Board and core providers have a long history of collaboration on evaluative activities and we hope this will continue in the future to the extent that resources are available at both the Board and provider levels. While the Board cannot compel Medicaid-only providers to participate in evaluation activities, their participation will be encouraged.

b. What milestones or indicators will be identified to enable the Board and its key stakeholders to track progress toward achieving goals?

The Outcome Indicators that are discussed in Sections A through G of this question will be tracked.

c. What methods will the Board employ to communicate progress toward achievement of goals?

Updates on progress being made to achieve these goals will be communicated in a variety of ways, including meetings (Board, Committees, System Integration, Adult and Kids CQI, etc.), the Board's web site (www.TrumbullMHRB.org), and periodic written reports.

Portfolio of Providers and Services Matrix

Table 1: Portfolio of Alcohol and Drug Services Providers

Prevention Strategy and Level of Care	a. Provider Name	b. Program Name (Provider Specific)	c. Population Served	d. Prevention Level (Prevention only)	e. Evidence-Based Practice (EBP)	f. Number of sites	g. Located outside of Board area	h. Funding Source *(Check the box if yes)*		i. MACSIS UPI
				(Universal, Selected or Indicated)	(List the EBP name)		(Check the box if yes)	**ODADAS**	**Medicaid Only**	
PREVENTION										
Information Dissemination	Community Solutions Assoc	Trumbull County Alliance for Substance Abuse Prevention (ASAP)	County-wide	Universal		1	☐Yes ☒No	☒Yes ☐No	☐Yes ☒No	10503
Alternatives	Community Solutions Assoc	W.O.N.E	High School students in Warren City School District	Universal		1	☐Yes ☒No	☒Yes ☐No	☐Yes ☐No	10503
Alternatives	Neil Kennedy Recovery Clinic – Prevention Partners Plus	P.A.N.D.A2	7th-12th grade students in Liberty and Mineral Ridge School Districts and their families	Universal		2	☒Yes ☐No	☒Yes ☐No	☐Yes ☒No	1365
Education	Community Solutions Assoc	Classroom and Education	4th-12th grade students in Trumbull County	Universal	Steps to Respect Project Alert	4	☐Yes ☒No	☒Yes ☐No	☐Yes ☒No	10503
Education	Neil Kennedy Recovery Clinic – Prevention Partners Plus	P.A.N.D.A2	7th-12th grade students in Liberty and Mineral Ridge School Districts and their families	Universal		2	☒Yes ☐No	☒Yes ☐No	☐Yes ☒No	1365
Community-Based Process	Community Solutions Assoc	Trumbull County Alliance for Substance Abuse Prevention (ASAP)	County-wide	Universal		1	☐Yes ☒No	☒Yes ☐No	☐Yes ☒No	10503
Community-Based Process	Neil Kennedy Recovery Clinic – Prevention Partners Plus	P.A.N.D.A2	7th-12th grade students in Liberty and Mineral Ridge School Districts and their families	Universal		2	☒Yes ☐No	☒Yes ☐No	☐Yes ☒No	1365
Environmental	Community Solutions Assoc	Trumbull County Alliance for Substance Abuse	County	Universal		1	☐Yes ☒No	☒Yes ☐No	☐Yes ☒No	10503

		Prevention (ASAP)								
Problem Identification and Referral							☐Yes ☐No	☐Yes ☐ No	☐Yes ☐No	
PRE-TREATMENT (Level 0.5)							☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	
OUTPATIENT (Level 1)										
Outpatient	Community Solutions Assoc	Drug Court	Adults with SA diagnosis			1	☐Yes ☒No	☒Yes ☐No	☐Yes ☒No	10503
	Community Solutions Assoc	Primary Care	Adults with AoD dependency			1	☐Yes ☒No	☒Yes ☐No	☐Yes ☒No	10503
Intensive Outpatient	Neil Kennedy Recovery Clinic	IOP	Adolescents with SA diagnosis			1	☒Yes ☐No	☐Yes ☐No	☒Yes ☐No Out of county	1365
	New Start Treatment Center	IOP	Adults with SA diagnosis			1	☐Yes ☒No	☒Yes ☐No	☐Yes ☒No	6876
Day Treatment	Neil Kennedy Recovery Clinic	Day Treatment	Adolescents with SA diagnosis			1	☒Yes ☐No	☐Yes ☐No	☒Yes ☐No Out of county	1365
COMMUNITY RESIDENTIAL (Level 2)										
Non-Medical	Meridian Community Care	NORCAT	Multiple Counties			1	☒Yes ☐No	☒Yes ☐No	☒Yes ☐No Out of county	1366
Medical							☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	
SUBACUTE (Level 3)										
Ambulatory Detoxification							☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	
23 Hour Observation Bed							☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	
Sub-Acute Detoxification	Meridian Community Care	MAT	Multiple Counties			1	☒Yes ☐No	☒Yes ☐No	☒Yes ☐No Out of county	1366
ACUTE HOSPITAL DETOXIFICATION (Level 4)										
Acute Detoxification							☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	

Table 2: Portfolio of Mental Health Services Providers

Promising, Best, or Evidence-Based Practice	a. Provider(s) Name(s)	b. MACSIS UPI(s)	c. Number of Sites	d. Program Name	e. Funding Source (Check all that apply as funding source for practice)				f. Population Served (please be specific)	g. Estimated Number in SFY 2012	h. Estimated Number in SFY 2013
					Medicaid + Match	GRF (Not as Medicaid Match)	Levy (Not as Medicaid Match)	Other (Not as Medicaid Match)			
Integrated Dual Diagnosis Treatment (IDDT)					Yes No	Yes No	Yes No	Yes No			
Assertive Community Treatment (ACT)	Burdman Group – TICTT	10088	1		Yes	Yes	Yes	No	SMD	112	112
TF-CBT					Yes No	Yes No	Yes No	Yes No			
Multi-Systemic Therapy (MST)					Yes No	Yes No	Yes No	Yes No			
Functional Family Therapy (FFT)					Yes No	Yes No	Yes No	Yes No			
Supported Employment	Burdman Group	10088	1		No	No	No	No	SMD		
Supported Employment	Coleman	12623	1		No	No	No	Yes	SMD/ Other disabilities	40 / 35	40 / 35
Supportive Housing	Burdman Group – Riverbend	10088	1		No	Yes	No	Yes	SMD	400	400
Wellness Management & Recovery (WMR)					Yes No	Yes No	Yes No	Yes No			
Red Flags					Yes No	Yes No	Yes No	Yes No			
EMDR	PsyCare	10327	1		Yes	No	No	No			
EMDR	Valley Counseling	13030	1		Yes	Yes	Yes	No			
EMDR	Homes for Kids	11022	1		Yes	No	No	No	Children/adolescents		
Crisis Intervention Training (CIT)	Trumbull Cty MHRB	NA	1		No	No	No	Yes	Law enforcement	20	20

Therapeutic Foster Care	Homes for Kids	11022	1		No	No	No	Yes	Through 18 years		
Therapeutic Pre-School	Warren City Schools	NA	1		No	No	No	No	Preschool aged		
Transition Age Services	Valley Counseling	13030	1	TAY	Yes	No	No	No	18 - 22		
Transition Age Services	Coleman	12623	1	TAY	Yes	Yes	Yes	No	18 - 22	25	25
Integrated Physical/Mental Health Svces					Yes No	Yes No	Yes No	Yes No			
Ohio's Expedited SSI Process	Coleman	12623	1		No	Yes	Yes	No	SMD	20	30
Ohio's Expedited SSI Process	Valley Counseling	13030	2		No	Yes	Yes	No	SMD	10	15
Medicaid Buy-In for Workers with Disabilities	Coleman	12623	1		Yes	Yes	Yes	No	SMD	5	10
Medicaid Buy-In for Workers with Disabilities	Valley Counseling	10120	1		Yes	Yes	Yes	No	SMD	6	10
Consumer Operated Service					Yes No	Yes No	Yes No	Yes No			
Peer Support Services					Yes No	Yes No	Yes No	Yes No			
MI/MR Specialized Services					Yes No	Yes No	Yes No	Yes No			
Consumer/Family Psycho-Education	Help Hotline/WRAP	NA	1	WRAP	No	No	Yes	No	Amish Adult consumers	20	20

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?

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

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

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

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

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

ODMH 2012 Community Plan Adult Housing Categories

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

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

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

Housing Categories	Definition	Examples	***Number of SPMI/SMI*** ***(Please include Forensic & Sex Offender Sub-Populations)***	Number of Units	Number of Beds
Crisis Care	Provision of short-term care to stabilize person experiencing psychiatric emergency. Offered as an alternative to inpatient psychiatric unit. Staff 24 hours' day/7 days a week. Treatment services are billed separately.	• Crisis Bed • Crisis Residential • Crisis Stabilization Unit	**Total #: 560**	1	12
			Forensic #: Set asides: 0 (population is eligible but no beds are "set aside")	0	0
			Sex Offender #: Set asides: 0 (population is eligible but no beds are "set aside")	0	0
ODMH Licensed Residential Care	Includes room and board, and personal care 24/7 if specified in license. Rules in program or service agreement attached to housing are applicable. Treatment services are billed separately. Usually agency operated and staffed; provides 24-hour supervision in active treatment oriented or structured environment.	• Licensed as Type I, II or III (Residential Facility Care) • Residential Support • Supervised Group Living • Next-Step Housing from psychiatric hospital and/or prison	**Total #: 0**	0	0
			***Forensic #: Set asides* 0**	0	0
			***Sex Offender #: Set asides* 0**	0	0

	Type 1: Room & Board; Personal Care; Mental Health Services Type 2: Room & Board; Personal Care Type 3: Room and Board				
ODH Licensed Residential Care	Includes room and board, and personal care 24/7 if specified in license. Rules in program or service agreement attached to housing are applicable. Treatment services are billed separately. Usually operator owned and staffed; provides 24-hour supervision in structured environment.	• Adult Care Facilities • Adult Family Homes • Group Homes	**Total #:62**	5	62
			Forensic #:0 (population is eligible but no beds are "set aside")		
			Sex Offender #:0 *(population is eligible but no beds are "set aside")*		
Respite Care	Short-term living environment, it may or may not be 24-hour care. Reasons for this type of care are more environmental in nature. May provide supervision, services and accommodations. Treatment services are billed separately	• Placement during absence of another caretaker where client usually resides • Respite Care	**Total #:0**	0	0
			Forensic #:		
			Sex Offender #:		

Temporary Housing	Non–hospital, time limited residential program with an expected length of occupancy and goals to transition to permanent housing. Includes room and board, with referral and access to treatment services that are billed separately.	• Commonly referred to and intended as time-limited, short term living • Transitional Housing Programs • Homeless county residence currently receiving services • Persons waiting for housing • Boarding Homes • YMCA/YWCA (not part of a supportive housing program)	**Total #:150**	1	24
			Forensic #:0 (population is eligible but no beds are "set aside")		
			Sex Offender #:0 *(population is eligible but no beds are "set aside")*		
Board / Agency Owned Community Residence	Person living in an apartment where they entered into an agreement that is NOT covered by Ohio tenant landlord law. Rules in program or service agreement attached to housing. Refers to financial sponsorship and/or provision of some degree of on-site supervision for residents living in an apartment dwelling. Treatment services are billed separately.	• Service Enriched Housing • Apartments with non-clinical staff attached • Supervised Apartments • No leases: NOT covered by Ohio tenant landlord law	**Total #:0**		
			Forensic #:		
			Sex Offender #:		

Permanent Supportive Housing (Subsidized Supportive Housing) with Primary Supportive Services On-Site	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.)	• HAP • Housing as Housing • Supervised Apartments • Supportive Housing • Person with Section 8 or Shelter Plus Care Voucher • Tenant has lease **Supportive Services staff primary offices are on-site and their primary function are to deliver supportive services on-site; these staff many accompany residents in the community to access resources.**	**Total #:20**	1	18
			Forensic #: 0 *(population is eligible but no beds are "set aside")*		
			Sex Offender #: 0 *(population is eligible but no beds are "set aside")*		
Permanent Supportive Housing (Subsidized Supportive Housing) with Supportive Services Available	Person living in an apartment where they entered into a lease with accordance to Ohio tenant landlord law or a mortgage and, in instances where ODMH allocated funds have been used, an exit strategy for the subsidy has been developed. Treatment services are billed separately. (The landlord may be a housing agency that provides housing to mental health consumers.)	• HAP • Housing as Housing • Supervised Apartments • Supportive Housing • Person with Section 8 or Shelter Plus Care Voucher • Tenant has lease • **Supportive Services staff <u>primary</u> <u>offices</u> are <u>not</u> <u>on-site</u>; supportive serve staff may come on-site to deliver**	**Total #: 25 known plus a large and unknown number of others (there is no mechanism for capturing this information on all consumers)**	2	20
			Forensic #: 0 (population is eligible but no beds are "set aside")		

		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.	***Sex Offender #: 0 (population is eligible but no beds are "set aside")***		
Independent Community Housing (Rent or Home Ownership)	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.	• Own home • Person with Section 8 Voucher (not Shelter Plus Care) • Adult with roommate with shared household expenses • Apartment without any public assistance • Housing in this model is not connected to the mental health system in any way. Anyone can apply for and obtain this housing.	**Total #: Not known, no mechanism for capturing this information**		
			Forensic #: 0 (population is eligible but no beds are "set aside")		
			Sex Offender #: 0 (population is eligible but no beds are "set aside")		

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 Board may request a waiver from this policy for the use of state funds. Complete this form providing a brief explanation of services to be provided and a justification for this requested waiver. **Medicaid-eligible recipients receiving services from hospital-based programs are exempt from this waiver.**

A. HOSPITAL	ODADAS UPID #	ALLOCATION
Laurelwood Hospital	6912	$50,000

Rationale: Historically, approximately half of all inpatient episodes have involved persons with a primary or secondary substance abuse disorder but only ODMH and levy resources have supported this level of care. If approved, existing pre–screening and after care structures and procedures will be used to insure continuity of care.

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 Board requesting this waiver must complete this form and provide a brief explanation of the services to be provided

B.AGENCY	ODADAS UPID #	SERVICE	ALLOCATION
Community Solutions Association, Trumbull 211 program	10503	Hotline, referral & information	$25,000

Rationale: Originally a separate agency known as Contact Community Connection, Community Solutions Association's Trumbull 211 program is Trumbull County's 24/7/365 information, referral and crisis hotline service. Although Trumbull 211 provides vital linkages for all behavioral health services, it is currently supported with ODMH and levy funding only.

SFY 2012 & 2013 ODMH Budget Templates

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

FY 2012

Community Plan Budget Template

Board Name: Trumbull County Mental Health and Recovery Board

SFY: 2012

HCPCS Procedure	Category	State 401 Forensic Monitoring	State 401 Forensic Centers	State 404 Children's CCBH/Base	State 404 BHJJ	State 408 Comm	State 505 ECMH Consult	State 505 SE Consortium	State Other Funds	Federal Child Care Quality CFDA 93.596	Federal Block Grant (forensic portion) CFDA 93.958	Federal Block Grant (Base) CFDA 93.958	Federal Title XX CFDA 93.667	Federal PATH CFDA 93.150	Federal Other	Reimbursement FFP SCHIP CFDA 93.767 Medicaid CFDA 93.778	Local Levy	Local Other	Total Board Spending	MEMO: State Funds Medicaid Match for Medicaid Clients	MEMO: Local Funds Medicaid Match for Medicaid Clients	MEMO: Reimbursement FFP used for Medicaid Match for Medicaid Clients	Notes
	BALANCES:																						
	Beginning Mental Health Fund Balance[1]	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 2,698,161	$ -	$ 2,698,161				
	PRIOR PERIOD ADJUSTMENTS (Explain in the Note column)																0		0				
	Restated MH Beginning Fund Balance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2,698,161	0	**$ 2,698,161.00**				
	REVENUES:																						
	Total Mental Health Revenues	5,518	0	112,245	0	3,253,220	4,000	0	115,400	43,192	2,675	122,271	143,599	0	464,015	6,875,894	3,300,000	19,611	**$ 14,461,640.00**				CFDA #14.235, CFDA #14.238, ODODD
	BOARD ADMINISTRATION:																						
	Salaries, Fringes, and Operating						200		5,360	2,159					2,000		722,290	14,611	746,620				
	Board Capital Expenditures																		0				
	BOARD SERVICES TO OTHER BOARDS OR AGENCIES:																						
	Agency Salaries, Fringes, and Operating																139,085		139,085				
	Agency Capital Expenditures																		0				
	EXPENSES:																						
90862	Pharmacologic Mgt. ***(Medication/Somatic)***			3,660		476,341						34,236				1,006,777	431,690		1,952,704	480,001	93,968	1,006,777	
H0031	Mental Health Assessment (non-physician) ***(Diag. Assess.)***			1,402		182,422						11,004				385,560	143,098		723,486	183,824	35,986	385,560	
90801	Psychiatric Diagnostic Interview (Physician) ***(Diag. Assess.)***			617		80,353						3,668				169,832	49,991		304,461	80,970	15,851	169,832	
H0004	BH Counseling and Therapy (Ind.) ***(Ind. Counseling)***			7,455		970,060						18,341				2,050,285	376,892		3,423,033	977,515	191,364	2,050,285	
H0004	BH Counseling and Therapy (Gp.) ***(Gp. Counseling)***			375		48,808						3,668				103,159	42,090		198,100	49,183	9,628	103,159	
S9484	Crisis Intervention MH Services ***(Crisis Intervention)***			384		49,924						13,450				105,518	29,849		199,125	50,308	9,849	105,518	
S0201	Partial Hospitalization, less than 24 hr. ***(Partial Hospitalization)***			1,684		219,119										463,122	43,226		727,151	220,803	43,226	463,122	
H0036	Community Psychiatric Supportive Treatment (Ind.) ***(Ind. CPST)***			7,181		934,457						34,236				1,975,037	524,771		3,475,682	941,638	184,340	1,975,037	
H0036	Community Psychiatric Supportive Treatment (Gp.) ***(Gp. CPST)***			2,242		291,736						3,668				616,604	98,925		1,013,175	293,978	57,551	616,604	
	Board Support for Medications																		0				
H0040	Assertive Community Treatment *(Clinical Activities)*																		0				
M1910	Assertive Community Treatment *(Non-Clinical Activities)*																		0				
H2016	Intensive Home-Based Treatment *(Clinical Activities)*																		0				
M1810	Intensive Home-Based Treatment *(Non-Clinical Activities)*																		0				
H0030	Behavioral Health Hotline Service (Hotline)																		0				
H0046	Other MH Svcs., not otherwise specified **(hlthcare)**[2]																		0				
M3140	Other MH Svcs.**(non-hlthcare)**[2]	0	0	87,245	0	0	3,800	0	24,640	41,033	0	0	0	0	0	0	94,000	5,000	255,718				**OCTF**
H0038	Self-Help/Peer Svcs. (Peer Support)																		0				
M1440	Adjunctive Therapy																		0				
M1540	Adult Education																		0				
M4120	Consultation																		0				
M3120	Consumer Operated Service																		0				
M1620	Employment / Vocational																		0				
M4130	Information and Referral																		0				
M4140	Mental Health Education																		0				
M1430	Occupational Therapy Svc																		0				
M4110	Prevention																		0				
M1530	School Psychology																		0				
M1550	Social & Recreational Svc																		0				
M2240	Community Residence																		0				
M2280	Crisis Care (Crisis Bed)																		0				
M2250	Foster Care																		0				
M2200	Residential Care (Residential Treatment/Residential Support)												143,599		97,767		497,801		739,167				CFDA #14.235, CFDA #14.238, ODODD
M2270	Respite Care (Respite Bed)																		0				
M2260	Subsidized Housing								85,400						364,248		72,098		521,746				
M2290	Temporary Housing																58,351		58,351				
**	Forensic Evaluation	5,518									2,675						8,713		16,906				
**	PASARR																		0				
**	Inpatient Psychiatric Service (Private hospital only)																432,500		432,500				
	Total Mental Health Expenditures	$ 5,518	$ -	$ 112,245	$ -	$ 3,253,220	$ 4,000	$ -	$ 115,400	$ 43,192	$ 2,675	$ 122,271	$ 143,599	$ -	$ 464,015	$ 6,875,894	$ 3,765,370	$ 19,611	**$ 14,927,010**	**$ 3,278,220**	**$ 641,763**	**$ 6,875,894**	
	Net Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(465,370)	0	(465,370)				
	Ending Mental Health Fund Balance	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 2,232,791	$ -	**$ 2,232,791**				
	Non-Mental Health Revenue								222,954						703,488	1,441,011	322,330	24,000	2,713,783				
	Non-Mental Health Expenditures								222,954						703,488	1,441,011	791,604	24,000	3,183,057				
	Net Non-Mental Health								0						0	0	(469,274)	0	(469,274)				

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

NOTES (refer to **Instructions**):

1. Beginning Balance (Prior Ending Balance) for the Community Plan Budget is the amount shown as "Unspent Funds" on the prior SFY Community Plan.

2. Enter Totals here and details on sheet titled "Other MH Svcs Detail".

FY 2013

Community Plan Budget Template

Board Name: Trumbull County Mental Health and Recovery Board

SFY: 2013

HCPCS Procedure	Category	State 401 Forensic Monitoring	State 401 Forensic Centers	State 404 Children's CCBH/Base	State 404 BHJJ	State 408 Comm	State 505 ECMH Consult	State 505 SE Consortium	State Other Funds	Federal Child Care Quality CFDA 93.596	Federal Block Grant (forensic portion) CFDA 93.958	Federal Block Grant (Base) CFDA 93.958	Federal Title XX CFDA 93.667	Federal PATH CFDA 93.150	Federal Other	Reimbursement FFP SCHIP CFDA 93.767 Medicaid CFDA 93.778	Local Levy	Local Other	Total Board Spending	MEMO: State Funds Medicaid Match for Medicaid Clients	MEMO: Local Funds Medicaid Match for Medicaid Clients	MEMO: Reimbursement FFP used for Medicaid Match for Medicaid Clients	Notes
	BALANCES:																						
	Beginning Mental Health Fund Balance[1]	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,763,517	$ -	$ 1,763,517				
	PRIOR PERIOD ADJUSTMENTS (Explain in the Note column)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0				
	Restated MH Beginning Fund Balance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1,763,517	0	**$ 1,763,517.00**				
	REVENUES:																						
	Total Mental Health Revenues	5,518	0	112,245	0	3,253,220	4,000	0	115,400	43,192	2,675	122,271	143,599	0	464,015	7,306,705	3,300,000	19,611	**$ 14,892,451.00**				CFDA #14.235, CFDA #14.238, ODOD
	BOARD ADMINISTRATION:																						
	Salaries, Fringes, and Operating						200		5,360	2,159					2,000		678,005	14,611	702,335				
	Board Capital Expenditures																		0				
	BOARD SERVICES TO OTHER BOARDS OR AGENCIES:																						
	Agency Salaries, Fringes, and Operating																139,085		139,085				
	Agency Capital Expenditures																		0				
	EXPENSES:																						
90862	Pharmacologic Mgt. ***(Medication/Somatic)***			3,660		476,341						34,236				1,069,856	431,020		2,015,113	480,001	129,930	1,069,856	
H0031	Mental Health Assessment (non-physician) ***(Diag. Assess.)***			1,402		182,422						11,004				409,718	145,253		749,799	183,824	49,759	409,718	
90801	Psychiatric Diagnostic Interview (Physician) ***(Diag. Assess.)***			617		80,353						3,668				180,472	52,355		317,465	80,970	21,918	180,472	
H0004	BH Counseling and Therapy (Ind.) ***(Ind. Counseling)***			7,455		970,060						18,341				2,178,746	427,786		3,602,388	977,515	264,600	2,178,746	
H0004	BH Counseling and Therapy (Gp.) ***(Gp. Counseling)***			375		48,808						3,668				109,623	42,253		204,727	49,183	13,312	109,623	
S9484	Crisis Intervention MH Services ***(Crisis Intervention)***			384		49,924						13,450				112,130	129,302		305,190	50,308	13,618	112,130	
S0201	Partial Hospitalization, less than 24 hr. ***(Partial Hospitalization)***			1,684		219,119										492,139	59,768		772,710	220,803	59,768	492,139	
H0036	Community Psychiatric Supportive Treatment (Ind.) ***(Ind. CPST)***			7,181		934,457						34,236				2,098,783	558,394		3,633,051	941,638	254,889	2,098,783	
H0036	Community Psychiatric Supportive Treatment (Gp.) ***(Gp. CPST)***			2,242		291,736						3,668				655,238	116,462		1,069,346	293,978	79,576	655,238	
	Board Support for Medications																		0				
H0040	Assertive Community Treatment *(Clinical Activities)*																		0				
M1910	Assertive Community Treatment *(Non-Clinical Activities)*																		0				
H2016	Intensive Home-Based Treatment *(Clinical Activities)*																		0				
M1810	Intensive Home-Based Treatment *(Non-Clinical Activities)*																		0				
H0030	Behavioral Health Hotline Service (Hotline)																		0				
H0046	Other MH Svcs., not otherwise specified (**hlthcare**)[2]																		0				
M3140	Other MH Svcs.(**non-hlthcare**)[2]	0	0	87,245	0	0	3,800	0	24,640	41,033	0	0	0	0	0	0	94,000	5,000	255,718				**OCTF**
H0038	Self-Help/Peer Svcs. (Peer Support)																		0				
M1440	Adjunctive Therapy																		0				
M1540	Adult Education																		0				
M4120	Consultation																		0				
M3120	Consumer Operated Service																		0				
M1620	Employment / Vocational																		0				
M4130	Information and Referral																		0				
M4140	Mental Health Education																		0				
M1430	Occupational Therapy Svc																		0				
M4110	Prevention																		0				
M1530	School Psychology																		0				
M1550	Social & Recreational Svc																		0				
M2240	Community Residence																		0				
M2280	Crisis Care (Crisis Bed)																		0				
M2250	Foster Care																		0				
M2200	Residential Care (Residential Treatment/Residential Support)												143,599		97,767		497,801		739,167				CFDA #14.235, CFDA #14.238, ODOD
M2270	Respite Care (Respite Bed)																		0				
M2260	Subsidized Housing								85,400						364,248		72,098		521,746				
M2290	Temporary Housing																58,351		58,351				
**	Forensic Evaluation	5,518									2,675						8,713		16,906				
**	PASARR																		0				
**	Inpatient Psychiatric Service (Private hospital only)																432,500		432,500				
	Total Mental Health Expenditures	$ 5,518	$ -	$ 112,245	$ -	$ 3,253,220	$ 4,000	$ -	$ 115,400	$ 43,192	$ 2,675	$ 122,271	$ 143,599	$ -	$ 464,015	$ 7,306,705	$ 3,943,146	$ 19,611	**$ 15,535,597**	**$ 3,278,220**	**$ 887,370**	**$ 7,306,705**	
	Net Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(643,146)	0	(643,146)				
	Ending Mental Health Fund Balance	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,120,371	$ -	**$ 1,120,371**				
	Non-Mental Health Revenue								222,954						703,488	1,592,384	322,330	24,000	2,865,156				
	Non-Mental Health Expenditures								222,954						703,488	1,592,384	691,253	24,000	3,234,079				
	Net Non-Mental Health								0						0	(0)	(368,923)	0	(368,923)				

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

NOTES (refer to **Instructions**):

1. Beginning Balance (Prior Ending Balance) for the Community Plan Budget is the amount shown as "Ending Mental Health Fund Balance" on the prior SFY Community Plan.

2. Enter Totals here and details on sheet titled "Other MH Svcs Detail".

Additional ODMH Requirements
(Formerly Community Plan – Part B)

Notification of Election of Distribution – SFY 2012

The Trumbull County Mental Health and Recovery Board has decided the following:

__X__ The Board plans to elect distribution of 408 funds.

_____ The Board plans not to elect distribution of 408 funds

Signed: _____

April J. Caraway, Executive Director
Trumbull County Mental Health and Recovery Board

Date: _____

While boards understand that a certain amount of unpredictability around funding assumptions for the next biennium are a normal process of the community plan, there are several key pieces of information and unresolved policy considerations from the departments that do not allow the community plan to be the useful document and management tool that it was designed to be. Many of these issues revolve around state psychiatric hospitals. At this time, we have not yet received written information about the state psychiatric hospital per diem rate. Governing board members want to know how much a service costs before they decide how much to buy and approve the plan in the form of a resolution. ODMH has also recently announced an intention to eliminate our risk sharing agreement for hospital bed days (SCUD). As we have shared with ODMH staff, boards simply cannot move forward in bed day planning without a way to address risk. There are serious issues to negotiate around hospitals and a process for doing that is dictated in our 1999 settlement agreement. These are crucial factors that impact a board's decision to opt in or out, which under statute is not linked with the community plan and is a decision boards have until May 1 of next year to make.

Finally, the funding assumption guidance has been very confusing, ranging from flat funding to a 10% cut, while the budget the ODMH director submitted eradicated state funding for the community mental health system of care and proposed drastic changes in hospital operations that would have significant and dire consequences. The community plan asks boards to elect distribution of 408 funds without the per diem, budget, or how to logically plan for bed days. Boards want the community plan process to be useful and meaningful. Regrettably, in the absence of critical information, this community plan offers little in the way of utility. ***Our board reserves our rights under statute and the settlement agreement, including the ability to amend the community plan, negotiate the SCUD, and opt out of 408***.

—Preamble / Community Plan Footnote (see page 3)

State Hospital Inpatient Days

BOARD NAME: Trumbull County Mental Health and Recovery Board **2012 Planned Use of State Hospital Inpatient Days By Hospital/Campus**	
1. Regional Psychiatric Hospital Name	
Heartland Behavioral Healthcare (Massillon)	3,285
Total All State Regional Psychiatric Hospitals Inpatient Days	3,285

- When specifying a Regional Psychiatric Hospital, please indicate a particular campus.

Signed _____

April J. Caraway, Executive Director
Trumbull County Mental Health and Recovery Board

CSN Services

I anticipate renewing contracts for CSN services.

_____ Yes

__X__ No

While boards understand that a certain amount of unpredictability around funding assumptions for the next biennium are a normal process of the community plan, there are several key pieces of information and unresolved policy considerations from the departments that do not allow the community plan to be the useful document and management tool that it was designed to be. Many of these issues revolve around state psychiatric hospitals. At this time, we have not yet received written information about the state psychiatric hospital per diem rate. Governing board members want to know how much a service costs before they decide how much to buy and approve the plan in the form of a resolution. ODMH has also recently announced an intention to eliminate our risk sharing agreement for hospital bed days (SCUD). As we have shared with ODMH staff, boards simply cannot move forward in bed day planning without a way to address risk. There are serious issues to negotiate around hospitals and a process for doing that is dictated in our 1999 settlement agreement. These are crucial factors that impact a board's decision to opt in or out, which under statute is not linked with the community plan and is a decision boards have until May 1 of next year to make.

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—Preamble / Community Plan Footnote (see page 3)

Board Membership Catalog for ADAMHS/ADAS/CMHS Boards

Board Name	Date Prepared
Trumbull County Mental Health and Recovery Board	12/16/10

Board Member: Luonuansuu, James G.

Mailing Address (street, city, state, zip): 10 E. Liberty Street, Newton Falls, OH 44444

Telephone (include area code): 330-872-5932

Occupation: Dispatcher

Term: 10/20/2009 – 06-30-2013

Appointment: ODMH | Sex: M | Ethnic Group: Caucasian

Officer | Hispanic or Latino (of any race)

Representation: select all that apply:

Mental Health	Alcohol Other Drug Addiction
X Consumer	☐ Consumer
☐ Family Member	☐ Family Member
☐ MH Professional	☐ Professional
☐ Psychiatrist	X Advocate
☐ Other Physician	

Board Name	Date Prepared
Trumbull County Mental Health and Recovery Board	12/16/10

Board Member: Massucci, Teresa M.

Mailing Address (street, city, state, zip): 2416 Andrews Dr., N.E., Warren, OH 44481

Telephone (include area code): 330-399-4240

Occupation: Program Coordinator

Term: 08/18/2009 – 06/30/2013

Appointment: ODMH | Sex: F | Ethnic Group: Caucasian

Officer: Board President | Hispanic or Latino (of any race)

Representation: select all that apply:

Mental Health	Alcohol Other Drug Addiction
☐ Consumer	☐ Consumer
☐ Family Member	☐ Family Member
☐ MH Professional	☐ Professional
☐ Psychiatrist	X Advocate
☐ Other Physician	

Board Name	Date Prepared
Trumbull County Mental Health and Recovery Board	12/16/10

Board Member: Wilson, John L.

Mailing Address (street, city, state, zip): 3921 Bradley Brownlee Road, Cortland, OH 44410

Telephone (include area code): 330-856-4268

Occupation: Administrator/Education

Term: 07/01/2008 – 06/30/2012

Appointment: ODMH | Sex: M | Ethnic Group: Caucasian

Officer: Board Treasurer | Hispanic or Latino (of any race)

Representation: select all that apply:

Mental Health	Alcohol Other Drug Addiction
☐ Consumer	☐ Consumer
☐ Family Member	☐ Family Member
X MH Professional	☐ Professional
☐ Psychiatrist	☐ Advocate
☐ Other Physician	

Board Membership Catalog for ADAMHS/ADAS/CMHS Boards

Board Name	Date Prepared
Trumbull County Mental Health and Recovery Board	12/16/10

Board Member	Appointment	Sex	Ethnic Group
Pavone, Larry R.	ODMH	M	Caucasian

Mailing Address (street, city, state, zip)
433 Viola Avenue
Hubbard, OH 44425

Telephone (include area code)
330-534-5518

Occupation
Juvenile Corrections

Term
11-16-2010 – 06-30-2014

Officer

Hispanic or Latino (of any race)

Representation: select all that apply:

Mental Health	Alcohol Other Drug Addiction
☐ Consumer	☐ Consumer
☐ Family Member	☐ Family Member
X MH Professional	☐ Professional
☐ Psychiatrist	☐ Advocate
☐ Other Physician	

Board Name	Date Prepared
Trumbull County Mental Health and Recovery Board	12/16/10

Board Member	Appointment	Sex	Ethnic Group
Klein, Cynthia D.	ODADAS	F	Caucasian

Mailing Address (street, city, state, zip)
13 9th Street
Niles, OH 44446

Telephone (include area code)
330-544-0398

Occupation
Permanently Disabled

Term
06-16-2007 – 06-30-2011

Officer

Hispanic or Latino (of any race)

Representation: select all that apply:

Mental Health	Alcohol Other Drug Addiction
☐ Consumer	☐ Consumer
☐ Family Member	X Family Member
☐ MH Professional	☐ Professional
☐ Psychiatrist	X Advocate
☐ Other Physician	

Board Name	Date Prepared
Trumbull County Mental Health and Recovery Board	12/16/10

Board Member	Appointment	Sex	Ethnic Group
Norman, Sharon A.	ODADAS	F	Caucasian

Mailing Address (street, city, state, zip)
180 Elm Road, N.E.
Warren, OH 4448

Telephone (include area code)
330-399-8015

Occupation
Self -Employed

Term
06-16-2007 – 06-30-2011

Officer

Hispanic or Latino (of any race)

Representation: select all that apply:

Mental Health	Alcohol Other Drug Addiction
☐ Consumer	X Consumer
☐ Family Member	☐ Family Member
☐ MH Professional	☐ Professional
☐ Psychiatrist	☐ Advocate
☐ Other Physician	

Board Membership Catalog for ADAMHS/ADAS/CMHS Boards

Board Name	Date Prepared
Trumbull County Mental Health and Recovery Board	12/16/10

Board Member	Appointment	Sex	Ethnic Group
Barnes, William, Jr.	ODADAS	M	African-American

Mailing Address (street, city, state, zip)
4620 Kinsman
Newton Falls, OH 44444

Telephone (include area code)
330-442-4278

Occupation
Minister

Term
11/20/2007 – 06-30-2011

Officer

Hispanic or Latino (of any race)

Representation: select all that apply:

Mental Health	Alcohol Other Drug Addiction
☐ Consumer	X Consumer
☐ Family Member	☐ Family Member
☐ MH Professional	☐ Professional
☐ Psychiatrist	☐ Advocate
☐ Other Physician	

Board Name	Date Prepared
Trumbull County Mental Health and Recovery Board	12/16/10

Board Member	Appointment	Sex	Ethnic Group
Amicucci, Edward	ODADAS	M	Caucasian

Mailing Address (street, city, state, zip)
8528 Hunter Trail, S.E.
Warren, OH 44484

Telephone (include area code)
330-856-4485

Occupation
Psychologist/Retired

Term
07-21-2009 – 06-30-2013

Officer

Hispanic or Latino (of any race)

Representation: select all that apply:

Mental Health	Alcohol Other Drug Addiction
☐ Consumer	☐ Consumer
☐ Family Member	☐ Family Member
☐ MH Professional	X Professional
☐ Psychiatrist	☐ Advocate
☐ Other Physician	

Board Name	Date Prepared
Trumbull County Mental Health and Recovery Board	12/16/10

Board Member	Appointment	Sex	Ethnic Group
Drumm, Noelle L.	County Commissioners	F	Caucasian

Mailing Address (street, city, state, zip)
305 Grant Street
McDonald, OH 44437

Telephone (include area code)
330-530-2417

Occupation
Telemarketer

Term
07/01/2007 – 06-30-2011

Officer
Vice-President

Hispanic or Latino (of any race)

Representation: select all that apply:

Mental Health	Alcohol Other Drug Addiction
☐ Consumer	☐ Consumer
X Family Member	☐ Family Member
☐ MH Professional	☐ Professional
☐ Psychiatrist	☐ Advocate
☐ Other Physician	

Board Membership Catalog for ADAMHS/ADAS/CMHS Boards

Board Name	Date Prepared
Trumbull County Mental Health and Recovery Board	12/16/10

Board Member	Appointment	Sex	Ethnic Group
Werner, Nancy Werner	County Commissioners	F	Caucasian

Mailing Address (street, city, state, zip)
227 Meadowbrook, S.E.
Warren, OH 44483

Telephone (include area code)
330-393-0661

Occupation
Permanently Disabled

Term
07-01-2008 – 06-30-2012

Officer

Hispanic or Latino (of any race)

Representation: select all that apply:

Mental Health	Alcohol Other Drug Addiction
X Consumer	☐ Consumer
☐ Family Member	☐ Family Member
☐ MH Professional	☐ Professional
☐ Psychiatrist	☐ Advocate
☐ Other Physician	

Board Name	Date Prepared
Trumbull County Mental Health and Recovery Board	12/16/10

Board Member	Appointment	Sex	Ethnic Group
Basciano, Rocco	County Commissioners	M	Caucasian

Mailing Address (street, city, state, zip)
300 Stonecreek Lane
Warren, OH 44484

Telephone (include area code)
330-856-6066

Occupation
Physician

Term
07-01-2008 – 06-30-2012

Officer

Hispanic or Latino (of any race)

Representation: select all that apply:

Mental Health	Alcohol Other Drug Addiction
☐ Consumer	☐ Consumer
☐ Family Member	☐ Family Member
☐ MH Professional	☐ Professional
☐ Psychiatrist	☐ Advocate
X Other Physician	

Board Name	Date Prepared
Trumbull County Mental Health and Recovery Board	12/16/10

Board Member	Appointment	Sex	Ethnic Group
Furrie, Nicholas, Jr.	County Commissioners	M	Caucasian

Mailing Address (street, city, state, zip)
590 Niles-Vienna Road
Vienna, OH 44473

Telephone (include area code)
330-539-1920

Occupation
Minister

Term
07-01-2008 – 06-30-2012

Officer

Hispanic or Latino (of any race)

Representation: select all that apply:

Mental Health	Alcohol Other Drug Addiction
☐ Consumer	☐ Consumer
X Family Member	☐ Family Member
☐ MH Professional	☐ Professional
☐ Psychiatrist	☐ Advocate
☐ Other Physician	

Board Membership Catalog for ADAMHS/ADAS/CMHS Boards

Board Name	Date Prepared
Trumbull County Mental Health and Recovery Board	12/16/10

Board Member	Appointment	Sex	Ethnic Group
DiCristofaro, Kathryn E.	County Commissioners	F	Caucasian

Mailing Address (street, city, state, zip)
920 Hartzell Avenue
Niles, OH 44446

Telephone (include area code)
330-544-4223

Occupation
Teacher

Term
03-16-2010 – 06-30-2011

Officer

Hispanic or Latino (of any race)

Representation: select all that apply:

Mental Health	Alcohol Other Drug Addiction
☐ Consumer	☐ Consumer
X Family Member	X Family Member
☐ MH Professional	☐ Professional
☐ Psychiatrist	☐ Advocate
☐ Other Physician	

Board Name	Date Prepared
Trumbull County Mental Health and Recovery Board	12/16/10

Board Member	Appointment	Sex	Ethnic Group
Iannucci, Anthony A. Jr.	County Commissioners	M	Caucasian

Mailing Address (street, city, state, zip)
418 Main Avenue, S.W., Suite 205
Warren, OH 44481

Telephone (include area code)
330-841-2566

Occupation
Administrator/Attorney

Term
07-01-2009 – 06-30-2013

Officer

Hispanic or Latino (of any race)

Representation: select all that apply:

Mental Health	Alcohol Other Drug Addiction
☐ Consumer	☐ Consumer
☐ Family Member	☐ Family Member
☐ MH Professional	☐ Professional
☐ Psychiatrist	X Advocate
☐ Other Physician	

Board Name	Date Prepared
Trumbull County Mental Health and Recovery Board	12/16/10

Board Member	Appointment	Sex	Ethnic Group
Swegan, Jessie A.	County Commissioners	F	Caucasian

Mailing Address (street, city, state, zip)
1630 Newton Falls Portage Road
Newton Falls, OH 44444

Telephone (include area code)
330-872-5932

Occupation
Homemaker

Term
03-17-2009 – 06-30-2013

Officer
Board Secretary

Hispanic or Latino (of any race)

Representation: select all that apply:

Mental Health	Alcohol Other Drug Addiction
☐ Consumer	☐ Consumer
☐ Family Member	☐ Family Member
☐ MH Professional	☐ Professional
☐ Psychiatrist	X Advocate
☐ Other Physician	

Board Membership Catalog for ADAMHS/ADAS/CMHS Boards

Board Name Trumbull County Mental Health and Recovery Board	Date Prepared 12/16/10
Board Member Toles, Judith A.	Appointment: County Commissioners Sex: F Ethnic Group: African-American
Mailing Address (street, city, state, zip) 1175 Highland, S.W. P.O. Box 2376 Warren, OH 44484	Officer Hispanic or Latino (of any race) Representation: select all that apply:
Telephone (include area code) 330-553-0197	Mental Health ☐ Consumer X Family Member ☐ MH Professional ☐ Psychiatrist ☐ Other Physician Alcohol Other Drug Addiction ☐ Consumer ☐ Family Member ☐ Professional ☐ Advocate
Occupation Computer Tech	
Term 04-20-2010 – 06-30-2013	

Board Name Trumbull County Mental Health and Recovery Board	Date Prepared 12/16/10
Board Member Roth, Debra E.	Appointment: County Commissioners Sex: F Ethnic Group: Caucasian
Mailing Address (street, city, state, zip) 3170 West Avenue, N.W. Warren, OH 44483	Officer Hispanic or Latino (of any race) Representation: select all that apply:
Telephone (include area code) 330-553-0045	Mental Health ☐ Consumer ☐ Family Member ☐ MH Professional ☐ Psychiatrist ☐ Other Physician Alcohol Other Drug Addiction ☐ Consumer ☐ Family Member ☐ Professional X Advocate
Occupation President of Community Grassroots Group	
Term 09-21-2010 – 06-30-2014	

Board Name Trumbull County Mental Health and Recovery Board	Date Prepared 12/16/10
Board Member Snelson, Ralph E.	Appointment: County Commissioners Sex: M Ethnic Group: Caucasian
Mailing Address (street, city, state, zip) 3913 E. Market Street Warren, OH 44481	Officer Hispanic or Latino (of any race) Representation: select all that apply:
Telephone (include area code) 330-856-1433	Mental Health ☐ Consumer ☐ Family Member ☐ MH Professional ☐ Psychiatrist ☐ Other Physician Alcohol Other Drug Addiction ☐ Consumer ☐ Family Member ☐ Professional X Advocate
Occupation Dentist	
Term 11-16-2010 – 06-30-2014	

Board Forensic Monitor and Community Linkage Contacts

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

Name	***Street Address***	***City***	***Phone Number***	***Email***
Vincent Arduin	Forensic Psychiatric Center of Northeast Ohio, 5212 Mahoning Avenue, Suite 317	Youngstown, OH 44515	330-792-1918	forensicctrvfa@choiceonemail.com

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

Name	***Street Address***	***City***	***Phone Number***	***Email***
Richard Bassett	Coleman Behavioral Health, 552 N. Park Avenue	Warren, OH 44481	330-392-1128	richard.bassett@Coleman-BH.com

INSERT ADDITIONAL BOARD APPENDICES AS NEEDED

TRUMBULL COUNTY
Mental Health and Recovery Board
PREVIOUSLY TRUMBULL LIFELINES

State Hospital Utilization FY2011

Planned use, actual use, and Adjustment Method for Variance (AMV) projection
(data for November are official)

Month	Monthly Net Days Planned	Monthly Net Days Used	Monthly Percent Used	YTD[1] Net Days Planned	YTD[1] Net Days Used	YTD[1] Net Days + or -	YTD[1] Percent Used	Projected Payback (Refund)
Jul-10	264	271	102.8	264	271	8	102.8	$0
Aug	264	211	80.1	527	482	-45	91.5	($43,121)
Sep	255	288	112.9	782	770	-12	95.4	$0
Oct	264	268	101.7	1,046	1,038	-8	99.3	$0
Nov	255	267	104.7	1,301	1,305	5	100.3	$0
Dec	264			1,564				
Jan-11	264			1,828				
Feb	238			2,066				
Mar	264			2,329				
Apr	255			2,584				
May	264			2,848				
Jun	255			3,103				

FY2011 AMV Projection[2]	
PROJECTED DAYS AT CURRENT RATE:	3,112 (+9)
PROJECTED PAYBACK (REFUND):	$0

[1] YTD: Year To Date

[2] Actual utilization within 250 days (+ or -) of planned net days incurs neither a payback nor a refund (i.e., refund: < 2,853 days; payback: > 3,353 days)

ATTACHMENT 2 (Page 1 of 1)

TRUMBULL COUNTY
Mental Health and Recovery Board
PREVIOUSLY TRUMBULL LIFELINES

ODMH Hospitals FY2011
Length of stay data for discharges
(Net resident days only)

	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10
OPENING CENSUS	7	6	10	8	9	9
ADMISSIONS	13	10	9	11	9	
DISCHARGES	14	6	11	10	9	
TOTAL LOS	238	68	222	146	339	
MEAN LOS	17.0	11.3	20.2	14.6	37.7	
MEDIAN LOS	12.0	7.0	14.0	9.0	13.0	
DAYS THIS MONTH	271	211	288	268	267	
AVG DAILY RES POP	8.7	6.8	9.6	9.9	8.9	
UTILIZATION (%)	102.8	80.1	112.9	116.8	104.7	

	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11
OPENING CENSUS						
ADMISSIONS						
DISCHARGES						
TOTAL LOS						
MEAN LOS						
MEDIAN LOS						
DAYS THIS MONTH						
AVG DAILY RES POP						
UTILIZATION (%)						

	FY2011	FY2010	FY2009	FY2008	FY2007	FY2006	FY2005	FY2004
ADMISSIONS	52	104	98	75	116	112	91	77
MO. AVG	10.4	8.7	8.2	6.3	9.7	9.3	7.6	6.4
DISCHARGES	50	105	99	70	116	120	87	76
MO. AVG	10.0	8.8	8.3	5.8	9.7	10.0	7.3	6.3
TOTAL LOS	1,013	6,800	3,136	2,265	4,029	3,010	6,932	1,847
MIN LOS	2	1	1	1	1	1	1	1
MAX LOS	201	4,164	230	156	1,046	261	3,038	256
MEAN LOS	20.3	64.8	31.7	32.4	34.7	25.1	79.7	24.3
MEDIAN LOS	11.5	16.0	21.0	21.0	15.0	14.0	19.0	14.0
TOTAL DAYS	1,305	3,049	3,661	3382	4,103	3,922	3,764	3,657
MO. AVG	261	254	305	282	342	327	314	305
PLANNED UTIL (%)	124.8	87.9	118.0	115.5	118.3	119.4	124.8	118.4
AVG DAILY RES POP	8.529	8.4	10.0	9.2	11.2	10.7	10.3	10.1
BED CAP	8.5	9.5	8.5	8.0	9.5	9.0	9.0	8.5
PAYBACK ADRP	9.185	10.186	9.18	8.68	10.18	9.68	9.68	9.2
REFUND ADRP	7.815	8.816	- -	- -	- -	- -	- -	- -

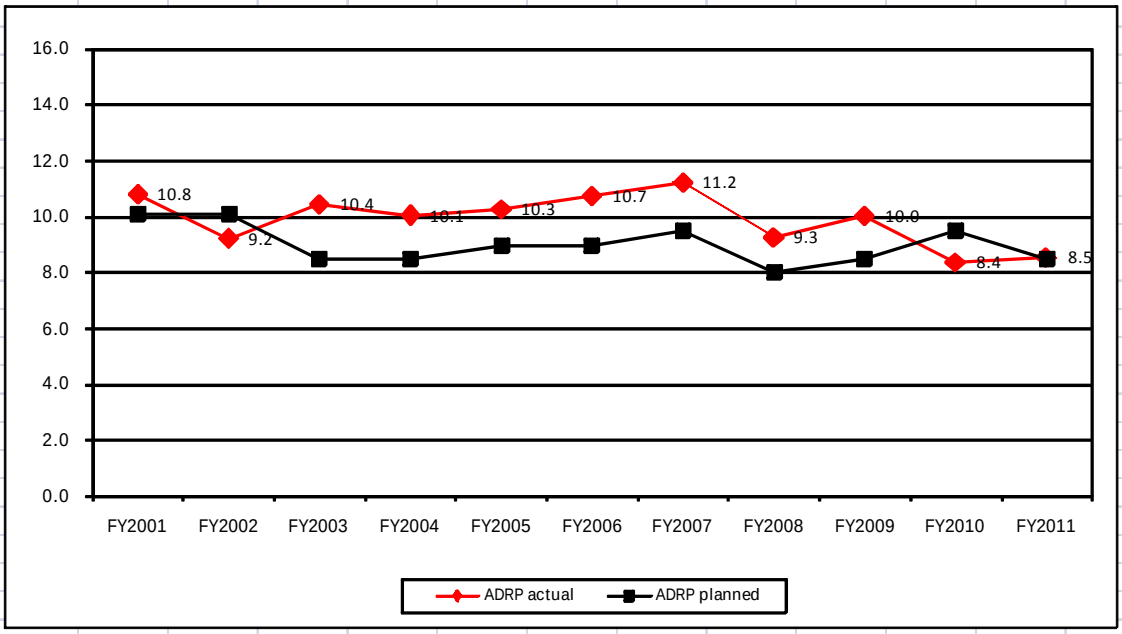
ATTACHMENT 3 (Page 1 of 1)

TRUMBULL COUNTY
Mental Health and Recovery Board
PREVIOUSLY TRUMBULL LIFELINES

State Hospital Utilization FY2001–FY2011

Net Resident Days, Average Daily Resident Population (ADRP), SCUD/AMV, and Per Diems

Mo	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	Mo ADRP
Jul	324	284	239	291	327	422	228	222	340	378	271	9.8
Aug	281	326	212	377	307	288	360	277	317	330	211	9.6
Sep	255	392	263	277	369	234	276	291	244	236	288	9.5
Oct	351	323	289	289	335	349	321	311	268	257	268	9.9
Nov	374	375	307	253	294	284	303	298	386	156	267	10.0
Dec	341	305	247	247	277	320	319	260	261	212		9.0
Jan	299	232	349	352	316	274	447	192	394	251		10.0
Feb	334	149	370	323	249	247	365	183	308	152		9.5
Mar	404	256	448	335	298	434	482	280	267	297		11.3
Apr	357	271	327	338	221	429	378	395	294	289		11.0
May	319	281	376	286	290	335	375	400	283	237		10.3
Jun	314	225	385	307	465	306	249	288	289	267		10.3
Actual:												
Days	3,953	3,370	3,812	3,675	3,748	3,922	4,103	3,382	3,661	3,049	1,305	
ADRP*	10.8	9.2	10.4	10.1	10.3	10.7	11.2	9.3	10.0	8.4	8.5	
Planned:												
Days	3,696	3,696	3,103	3,103	3,285	3,285	3,468	2,920	3,103	3,468	3,103	
ADRP*	10.1	10.1	8.5	8.5	9.0	9.0	9.5	8.0	8.5	9.5	8.5	
SCUD/AMV	OVER	REFUND	PAYBACK	PAYBACK	PAYBACK	PAYBACK	PAYBACK	PAYBACK	PAYBACK	REFUND		
Amount	$0	$59,319	$113,419	$155,805	$78,273	$127,323	$129,899	$81,049	$107,504	$77,175		
PER DIEM:	$334	$351	$353	$441	$446	$472	$481	$481	$481	$525	$535	



Heartland East Reporting Services

Heartland East

Trumbull County Mental Health and Recovery Board

Client Count, Board Costs, and Per Capita Board Costs by Residency and Medicaid Status, SFY2010

	IN COUNTY								OUT OF COUNTY											
Provider	Medicaid				Non-Medicaid				Medicaid				Non-Medicaid				Totals			
	Client Count	Board Cost	Per Capita	Median of Claims	Client Count	Board Cost	Per Capita	Median of Claims	Client Count	Board Cost	Per Capita	Median of Claims	Client Count	Board Cost	Per Capita	Median of Claims	Client Count	Board Cost	Per Capita	Median of Claims
VALLEY COUNS - 10120	2,905	$2,709,953	$933	$367	1,671	$563,132	$337	$182	0	$0	$0	$0	0	$0	$0	$0	4,285	$3,273,085	$764	$325
BURDMAN TRUMBULL - 10088	240	$613,867	$2,558	$692	467	$1,036,414	$2,219	$1,485	0	$0	$0	$0	0	$0	$0	$0	508	$1,650,281	$3,249	$1,930
HOMES FOR KI - 11022	463	$1,222,154	$2,640	$1,821	8	$852	$106	$0	0	$0	$0	$0	0	$0	$0	$0	464	$1,223,005	$2,636	$1,821
PSYCARE-BELM - 10327	1,305	$1,127,291	$864	$599	0	$0	$0	$0	0	$0	$0	$0	0	$0	$0	$0	1,305	$1,127,291	$864	$599
MERIDIAN SER - 01366	0	$0	$0	$0	0	$0	$0	$0	233	$1,082,461	$5,265	$3,924	0	$0	$0	$0	221	$1,082,461	$4,898	$3,924
F & C VALLEY - 13030	2,079	$975,013	$469	$203	0	$0	$0	$0	0	$0	$0	$0	0	$0	$0	$0	2,079	$975,013	$469	$203
GREENTREE CN - 12402	465	$819,520	$1,762	$900	0	$0	$0	$0	0	$0	$0	$0	0	$0	$0	$0	465	$819,520	$1,762	$900
COMM SOLUTIO - 10503	413	$217,732	$527	$358	836	$535,307	$640	$328	0	$0	$0	$0	0	$0	$0	$0	1,149	$753,039	$655	$387
NEIL KENNEDY - 01365	244	$593,019	$2,430	$1,679	47	$71,552	$1,522	$1,344	0	$0	$0	$0	0	$0	$0	$0	284	$664,571	$2,340	$1,568
BELMONT PINE - 02532	340	$639,844	$1,882	$1,402	0	$0	$0	$0	0	$0	$0	$0	0	$0	$0	$0	340	$639,844	$1,882	$1,402
COLEMAN - HI - 12623	410	$230,482	$562	$189	718	$263,082	$366	$170	0	$0	$0	$0	0	$0	$0	$0	1,039	$493,564	$475	$185
CHURCHILL-CH - 02503	526	$335,873	$639	$440	0	$0	$0	$0	0	$0	$0	$0	0	$0	$0	$0	526	$335,873	$639	$440
COMPREH BH-M - 10985	0	$0	$0	$0	0	$0	$0	$0	113	$136,887	$1,211	$783	0	$0	$0	$0	113	$136,887	$1,211	$783
DIAG AND EVA - 10101	0	$0	$0	$0	0	$0	$0	$0	158	$129,209	$818	$540	0	$0	$0	$0	158	$129,209	$818	$540
TRAVCO BH CN - 12512	0	$0	$0	$0	0	$0	$0	$0	318	$105,599	$332	$154	9	$1,343	$149	$154	326	$106,941	$328	$154
SPEC CARE CO - 12184	152	$90,262	$594	$375	0	$0	$0	$0	0	$0	$0	$0	0	$0	$0	$0	152	$90,262	$594	$375
CNTR BH HEAL - 11232	0	$0	$0	$0	0	$0	$0	$0	90	$64,592	$718	$408	0	$0	$0	$0	90	$64,592	$718	$408
VILLAGE NETW - 02526	0	$0	$0	$0	0	$0	$0	$0	4	$64,338	$16,085	$14,833	0	$0	$0	$0	4	$64,338	$16,085	$14,833
COMP PSYCHIA - 12775	0	$0	$0	$0	0	$0	$0	$0	134	$60,707	$453	$260	0	$0	$0	$0	134	$60,707	$453	$260
TURNING PNT - 10103	0	$0	$0	$0	0	$0	$0	$0	47	$37,889	$1,802	$337	74	$14,117	$191	$154	116	$52,006	$448	$154
BEREA-202 E - 06871	0	$0	$0	$0	0	$0	$0	$0	4	$45,857	$11,464	$1,493	0	$0	$0	$0	4	$45,857	$11,464	$1,493
HLTH REC-ATH - 06755	0	$0	$0	$0	0	$0	$0	$0	1	$35,282	$35,282	$35,282	0	$0	$0	$0	1	$35,282	$35,282	$35,282

Heartland East Reporting Services

Heartland East

Provider	IN COUNTY								OUT OF COUNTY								Totals			
	Medicaid				Non-Medicaid				Medicaid				Non-Medicaid							
	Client Count	Board Cost	Per Capita	Median of Claims	Client Count	Board Cost	Per Capita	Median of Claims	Client Count	Board Cost	Per Capita	Median of Claims	Client Count	Board Cost	Per Capita	Median of Claims	Client Count	Board Cost	Per Capita	Median of Claims
RAVENWOOD MH - 01224	0	$0	$0	$0	0	$0	$0	$0	15	$17,704	$1,896	$492	30	$12,633	$421	$230	43	$30,336	$705	$370
COMM BEHAV H - 10030	0	$0	$0	$0	0	$0	$0	$0	24	$24,412	$1,017	$893	0	$0	$0	$0	24	$24,412	$1,017	$893
GLENBEIGH-RO - 06713	0	$0	$0	$0	0	$0	$0	$0	22	$24,157	$1,098	$782	0	$0	$0	$0	22	$24,157	$1,098	$782
SIGNATURE-AS - 08496	0	$0	$0	$0	0	$0	$0	$0	14	$19,695	$1,407	$282	1	$587	$587	$108	15	$20,282	$1,352	$282
BAIR FOUNDAT - 10522	0	$0	$0	$0	0	$0	$0	$0	9	$20,169	$2,241	$737	0	$0	$0	$0	9	$20,169	$2,241	$737
NEW DIREC-LA - 11180	0	$0	$0	$0	0	$0	$0	$0	2	$16,741	$8,371	$7,764	0	$0	$0	$0	2	$16,741	$8,371	$7,764
HORIZON HOUS - 06888	0	$0	$0	$0	0	$0	$0	$0	4	$16,720	$4,180	$2,321	0	$0	$0	$0	4	$16,720	$4,180	$2,321
NEW DIREC-PE - 01119	0	$0	$0	$0	0	$0	$0	$0	4	$15,067	$3,767	$276	0	$0	$0	$0	4	$15,067	$3,767	$276
PAINT CREEK - 06883	0	$0	$0	$0	0	$0	$0	$0	1	$13,722	$13,722	$13,722	0	$0	$0	$0	1	$13,722	$13,722	$13,722
CORNELL ABRA - 06967	0	$0	$0	$0	0	$0	$0	$0	1	$12,193	$12,193	$12,193	0	$0	$0	$0	1	$12,193	$12,193	$12,193
COMPASS REC - 12399	0	$0	$0	$0	0	$0	$0	$0	5	$11,151	$2,230	$662	0	$0	$0	$0	5	$11,151	$2,230	$662
WAY STATION - 11155	0	$0	$0	$0	0	$0	$0	$0	4	$8,769	$2,192	$155	0	$0	$0	$0	4	$8,769	$2,192	$155
CHILD ADVANT - 10036	0	$0	$0	$0	0	$0	$0	$0	13	$8,193	$630	$526	0	$0	$0	$0	13	$8,193	$630	$526
JEFF BH SYS - 07063	0	$0	$0	$0	0	$0	$0	$0	2	$8,099	$4,050	$3,833	0	$0	$0	$0	2	$8,099	$4,050	$3,833
BELLEFAIRE-F - 02447	0	$0	$0	$0	0	$0	$0	$0	2	$6,328	$3,164	$2,304	0	$0	$0	$0	2	$6,328	$3,164	$2,304
FAM SER-MAHO - 01363	0	$0	$0	$0	0	$0	$0	$0	8	$6,323	$790	$383	0	$0	$0	$0	8	$6,323	$790	$383
CHILD HOS ME - 10026	0	$0	$0	$0	0	$0	$0	$0	24	$6,050	$252	$156	0	$0	$0	$0	24	$6,050	$252	$156
NEW DIREC-DA - 12673	0	$0	$0	$0	0	$0	$0	$0	6	$5,751	$3,609	$316	0	$0	$0	$0	5	$5,751	$1,150	$316
CATH REGI-MA - 10104	0	$0	$0	$0	0	$0	$0	$0	11	$3,859	$351	$181	0	$0	$0	$0	11	$3,859	$351	$181
COMM SERV-ST - 10021	0	$0	$0	$0	0	$0	$0	$0	3	$3,733	$1,244	$130	0	$0	$0	$0	3	$3,733	$1,244	$130
COLEMAN - PO - 08215	0	$0	$0	$0	0	$0	$0	$0	8	$2,880	$360	$139	6	$710	$118	$108	14	$3,590	$256	$130
COUNSELING-C - 01051	0	$0	$0	$0	0	$0	$0	$0	5	$3,003	$601	$127	0	$0	$0	$0	5	$3,003	$601	$127
UNITED METH - 11028	0	$0	$0	$0	0	$0	$0	$0	1	$2,916	$2,916	$2,916	0	$0	$0	$0	1	$2,916	$2,916	$2,916
TOWNHALL II - 01452	0	$0	$0	$0	0	$0	$0	$0	6	$2,746	$944	$192	0	$0	$0	$0	5	$2,746	$549	$192

ATTACHMENT 4 (Page 3 of 4)

Heartland East Reporting Services

Heartland East

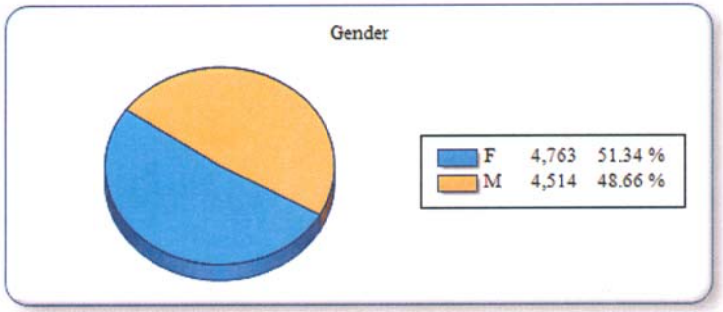
Provider	IN COUNTY								OUT OF COUNTY								Totals			
	Medicaid				Non-Medicaid				Medicaid				Non-Medicaid							
	Client Count	Board Cost	Per Capita	Median of Claims	Client Count	Board Cost	Per Capita	Median of Claims	Client Count	Board Cost	Per Capita	Median of Claims	Client Count	Board Cost	Per Capita	Median of Claims	Client Count	Board Cost	Per Capita	Median of Claims
SIGNATURE-WI - 06857	0	$0	$0	$0	0	$0	$0	$0	4	$2,665	$666	$274	0	$0	$0	$0	4	$2,665	$666	$274
RANJAN - CHA - 11032	0	$0	$0	$0	0	$0	$0	$0	2	$2,402	$1,201	$675	0	$0	$0	$0	2	$2,402	$1,201	$675
BURDMAN GP-M - 02891	1	$1,575	$1,575	$1,575	0	$0	$0	$0	0	$0	$0	$0	0	$0	$0	$0	1	$1,575	$1,575	$1,575
MENTAL HLTH - 10097	0	$0	$0	$0	0	$0	$0	$0	2	$971	$486	$438	2	$278	$139	$62	4	$1,249	$312	$216
PORTAGE PATH - 10027	0	$0	$0	$0	0	$0	$0	$0	3	$1,196	$399	$209	0	$0	$0	$0	3	$1,196	$399	$209
CLEVE TREATM - 01094	0	$0	$0	$0	0	$0	$0	$0	1	$1,087	$1,087	$1,087	0	$0	$0	$0	1	$1,087	$1,087	$1,087
PORTAGE PATH - 11131	0	$0	$0	$0	0	$0	$0	$0	0	$0	$0	$0	5	$1,050	$210	$46	5	$1,050	$210	$46
FAM REC-LISB - 01052	0	$0	$0	$0	0	$0	$0	$0	3	$953	$318	$135	0	$0	$0	$0	3	$953	$318	$135
NB MAH ITT C - 10381	0	$0	$0	$0	0	$0	$0	$0	1	$939	$939	$939	0	$0	$0	$0	1	$939	$939	$939
COMMUNITY MH - 10071	0	$0	$0	$0	0	$0	$0	$0	1	$821	$821	$821	0	$0	$0	$0	1	$821	$821	$821
COLEMAN - ST - 10697	0	$0	$0	$0	0	$0	$0	$0	3	$760	$253	$127	0	$0	$0	$0	3	$760	$253	$127
CENTURY-SOUT - 01290	0	$0	$0	$0	0	$0	$0	$0	0	$0	$0	$0	1	$665	$665	$665	1	$665	$665	$665
MURTIS TAYLO - 03042	0	$0	$0	$0	0	$0	$0	$0	1	$639	$639	$639	0	$0	$0	$0	1	$639	$639	$639
COMMUNITY MH - 10061	0	$0	$0	$0	0	$0	$0	$0	1	$638	$638	$638	0	$0	$0	$0	1	$638	$638	$638
APPLESEED - 01882	0	$0	$0	$0	0	$0	$0	$0	0	$0	$0	$0	1	$556	$556	$556	1	$556	$556	$556
NE OH BH-STA - 10024	0	$0	$0	$0	0	$0	$0	$0	1	$541	$541	$541	0	$0	$0	$0	1	$541	$541	$541
NETCARE - 02589	0	$0	$0	$0	0	$0	$0	$0	1	$21	$21	$14,833	2	$509	$255	$231	3	$530	$177	$21
F & C SERV-P - 10037	0	$0	$0	$0	0	$0	$0	$0	2	$511	$255	$195	0	$0	$0	$0	2	$511	$255	$195
METROHEALTH - 01110	0	$0	$0	$0	0	$0	$0	$0	2	$470	$235	$190	0	$0	$0	$0	2	$470	$235	$190
COMUNITY HEA - 01508	0	$0	$0	$0	0	$0	$0	$0	3	$452	$388	$60	0	$0	$0	$0	2	$452	$226	$60
SIX COUNTY-M - 06093	0	$0	$0	$0	0	$0	$0	$0	1	$450	$450	$450	0	$0	$0	$0	1	$450	$450	$450
JEWISH F/S-B - 04618	0	$0	$0	$0	0	$0	$0	$0	1	$435	$435	$435	0	$0	$0	$0	1	$435	$435	$435
BEECH BROK-L - 10205	0	$0	$0	$0	0	$0	$0	$0	1	$427	$427	$427	0	$0	$0	$0	1	$427	$427	$427
NEOHS - 06070	0	$0	$0	$0	0	$0	$0	$0	1	$422	$422	$422	0	$0	$0	$0	1	$422	$422	$422

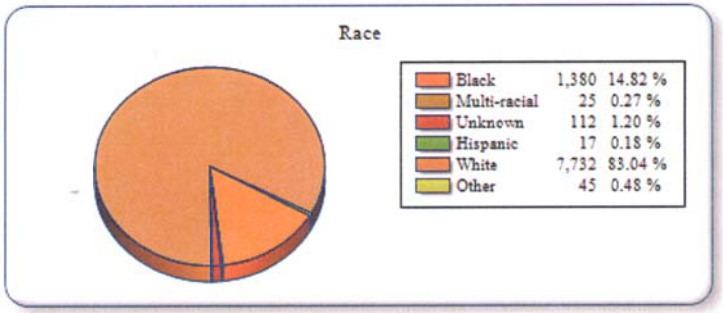
Heartland East Reporting Services

Provider	IN COUNTY								OUT OF COUNTY								Totals			
	Medicaid				Non-Medicaid				Medicaid				Non-Medicaid							
	Client Count	Board Cost	Per Capita	Median of Claims	Client Count	Board Cost	Per Capita	Median of Claims	Client Count	Board Cost	Per Capita	Median of Claims	Client Count	Board Cost	Per Capita	Median of Claims	Client Count	Board Cost	Per Capita	Median of Claims
FAMILY PRIDE - 12520	0	$0	$0	$0	0	$0	$0	$0	1	$375	$375	$375	0	$0	$0	$0	1	$375	$375	$375
LAKE RECOVER - 01017	0	$0	$0	$0	0	$0	$0	$0	1	$333	$333	$333	0	$0	$0	$0	1	$333	$333	$333
CATH CHAR-EU - 01121	0	$0	$0	$0	0	$0	$0	$0	1	$322	$322	$322	0	$0	$0	$0	1	$322	$322	$322
BUTL BH SERV - 07026	0	$0	$0	$0	0	$0	$0	$0	1	$267	$267	$267	0	$0	$0	$0	1	$267	$267	$267
COMM SUPPORT - 10033	0	$0	$0	$0	0	$0	$0	$0	2	$265	$133	$21	0	$0	$0	$0	2	$265	$133	$21
HITCHCOCK CN - 01100	0	$0	$0	$0	0	$0	$0	$0	1	$232	$232	$232	0	$0	$0	$0	1	$232	$232	$232
CRISIS CENTE - 01492	0	$0	$0	$0	0	$0	$0	$0	1	$201	$201	$201	1	$0	$0	$0	1	$201	$201	$201
UNISON BHG - 03340	0	$0	$0	$0	0	$0	$0	$0	1	$195	$195	$195	0	$0	$0	$0	1	$195	$195	$195
INTGRTED YOU - 11001	0	$0	$0	$0	0	$0	$0	$0	0	$0	$0	$0	1	$108	$108	$108	1	$108	$108	$108
QUEST REC SV - 01491	0	$0	$0	$0	0	$0	$0	$0	1	$104	$104	$104	0	$0	$0	$0	1	$104	$104	$104
LAKE HOSPITA - 12893	0	$0	$0	$0	0	$0	$0	$0	0	$0	$0	$0	1	$87	$87	$87	1	$87	$87	$87
SOUTHEAST IN - 06723	0	$0	$0	$0	0	$0	$0	$0	2	$64	$32	$21	0	$0	$0	$0	2	$64	$32	$21
COM COUNSEL- - 03392	0	$0	$0	$0	0	$0	$0	$0	1	$63	$63	$63	0	$0	$0	$0	1	$63	$63	$63
NEIGHBOR-MEN - 03458	0	$0	$0	$0	0	$0	$0	$0	1	$63	$63	$63	0	$0	$0	$0	1	$63	$63	$63
TOTALS:	9,543	$9,576,585	$17,435	$10,600	3,747	$2,470,339	$5,192	$3,509	1,345	$2,042,487	$159,596	$135,228	134	$32,641	$3,485	$2,509	14,052	$14,122,052	$173,017	$133,051
UNDUPLICATED TOTALS	6,274	$9,576,585	$1,526	$387	2,971	$2,470,339	$831	$286	1,229	$2,042,487	$1,662	$380	132	$32,641	$247	$154	9,329	$14,122,052	$1,514	$367

Heartland East Reporting Services

Profile of the 9,277 Trumbull County Mental Health and Recovery Board Clients (6,302 Adults, 2,975 Children) Served in SFY 2010 Through 10/4/2010





Top Ten Most Common Primary Diagnostic Groups for Adults

Diagnostic Group	Clients	Claims	Claims/Client	Total Cost	Avg Cost
Depressive Disorders	2,121	22,900	10	$1,757,512	$829
Bipolar Disorders	1,592	23,839	14	$1,896,472	$1,191
Anxiety Disorders	794	7,951	10	$572,366	$721
Schizophrenia/Other Psychotic	665	22,884	34	$1,492,010	$2,244
Alcohol Use Disorders	553	5,709	10	$405,809	$734
Opioid Use Disorders	437	37,166	85	$1,363,455	$3,120
Cannabis Use Disorders	328	3,935	11	$277,558	$846
Adjustment Disorders	281	1,845	6	$146,666	$522
Post-traumatic Stress Disorder	247	2,810	11	$235,668	$954
Attention-Deficit/Disruptive	194	2,351	12	$173,334	$893

Top Ten Most Common Primary Diagnostic Groups for Children

Diagnostic Group	Clients	Claims	Claims/Client	Total Cost	Avg Cost
Attention-Deficit/Disruptive	1,226	17,357	14	$1,304,107	$1,064
Adjustment Disorders	638	8,322	13	$632,891	$992
Conduct Disorders	503	8,111	16	$676,408	$1,345
Bipolar Disorders	457	9,030	19	$954,406	$2,088
Depressive Disorders	366	4,774	13	$381,124	$1,041
Pervasive Developmental	183	4,887	26	$365,877	$1,999
Post-traumatic Stress Disorder	148	2,607	17	$214,823	$1,452
Anxiety Disorders	126	1,089	8	$93,987	$746
Cannabis Use Disorders	69	1,514	21	$142,911	$2,071
Other Childhood Disorders	30	1,447	48	$100,349	$3,345

Report Name: LA02.C78.SFY.2010.PR.JUL.PDF *Page 1 of 2* *Run Date: 10/4/2010*

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Heartland East Reporting Services

Profile of the 9,277 Trumbull County Mental Health and Recovery Board Clients (6,302 Adults, 2,975 Children) Served in SFY 2010 Through 10/4/2010

	Medicaid		Non-Medicaid			Percent
Procedure	Units	Dollars	Units	Dollars	Total Dollars	of Dollars
AoD Assessment	799	$75,440.72	688	$65,548.42	$140,989.14	1.00 %
AoD Case Management	2,074	$144,423.13	897	$69,232.19	$213,655.32	1.51 %
AoD Crisis Intervention	14	$1,799.36	0	$0.00	$1,799.36	0.01 %
AoD Group Counseling	32,083	$288,399.23	9,076	$50,482.48	$338,881.71	2.40 %
AoD Individual Counseling	11,533	$248,224.49	8,936	$192,416.30	$440,640.79	3.12 %
AoD Intensive Outpatient	3,614	$491,710.56	233	$27,331.86	$519,042.42	3.67 %
AoD Medical/Somatic	1,058	$164,932.36	32	$5,619.29	$170,551.65	1.21 %
AoD Methadone Administration	25,447	$410,602.09	0	$0.00	$410,602.09	2.91 %
AoD Non-Acute Residential	0	$0.00	352	$38,004.77	$38,004.77	0.27 %
AoD Non-Hospital Residential w/Room &	0	$0.00	116	$9,039.88	$9,039.88	0.06 %
AoD Prevention	0	$0.00	2,859	$189,063.58	$189,063.58	1.34 %
AoD Room & Board	0	$0.00	54	$2,890.08	$2,890.08	0.02 %
AoD Screening Analysis	3,916	$225,435.11	16	$585.19	$226,020.30	1.60 %
AoD Sub-Acute Detox	0	$0.00	112	$25,009.60	$25,009.60	0.18 %
Diag. Assessment - Non-Physician	4,225	$526,954.94	965	$98,733.18	$625,688.12	4.43 %
Diag. Assessment - Physician	1,124	$232,923.48	149	$29,777.56	$262,701.04	1.86 %
MH Crisis Intervention	886	$136,603.39	832	$124,981.53	$261,584.92	1.85 %
MH Group Counseling	14,945	$141,209.04	3,919	$32,120.09	$173,329.13	1.23 %
MH Group CSP	88,936	$869,321.91	4,356	$42,732.36	$912,054.27	6.45 %
MH Individual Counseling	127,698	$2,840,325.53	8,534	$170,729.96	$3,011,055.49	21.30 %
MH Individual CSP	128,393	$2,717,986.65	15,338	$323,644.94	$3,041,631.59	21.52 %
MH Medical/Somatic	7,570	$1,385,346.63	2,029	$317,321.44	$1,702,668.07	12.05 %
MH Residential Care	0	$0.00	892	$64,287.84	$64,287.84	0.45 %
MH Subsidized Housing	0	$0.00	4,625	$64,198.60	$64,198.60	0.45 %
Partial Hospitalization	5,557	$645,114.92	0	$0.00	$645,114.92	4.56 %
Residential Care	0	$0.00	2,937	$642,694.41	$642,694.41	4.55 %
	459,871	$11,546,753.54	67,947	$2,586,445.55	$14,133,199.09	

Cost Per Client (Percentiles are Approximations)

25th	Median	75th	Max
$223.64	$554.02	$1,416.62	$52,633.26

Client Participation in the Cost of Care

	Clients	Percent
Client Pays All	92	0.96 %
Client Pays Some Portion	1670	17.43 %
Client Pays Zero	7817	81.61 %

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ATTACHMENT 6 (Page 1 of 1)

TRUMBULL COUNTY
Mental Health and Recovery Board
PREVIOUSLY TRUMBULL LIFELINES

Riverbend Center FY2011
12 beds: crisis, diversion & step-down
Operated by Burdman Group, Inc.
Length of stay data for discharges

	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10
OPENING CENSUS	6	6	8	10	6	8
ADMISSIONS	49	42	56	44	50	
DISCHARGES (all)	49	40	54	48	48	
CSA (N)	31	18	29	21	25	
CSA (%)	63.3	45.0	53.7	43.8	52.1	
TOTAL LOS	221.5	250.0	253.0	222.0	229.5	
MEAN LOS (all)	4.5	6.3	4.7	4.6	4.8	
CSA	4.4	5.8	4.8	5.7	4.8	
Non-CSA	4.8	6.6	4.5	4.4	4.7	
MEDIAN LOS (all)	4.0	5.0	4.0	5.0	3.0	
CSA	4.0	5.0	4.0	5.0	4.0	
Non-CSA	3.5	4.5	3.0	3.0	2.0	
DAYS THIS MONTH	232	260	254	186	257	
AVG DAILY RES POP	7.5	8.7	8.5	6.0	8.6	
CAPACITY (%)	62.4	72.2	70.6	50.0	71.4	

	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11
OPENING CENSUS						
ADMISSIONS						
DISCHARGES (all)						
CSA (N)						
CSA (%)						
TOTAL LOS						
MEAN LOS (all)						
CSA						
Non-CSA						
MEDIAN LOS (all)						
CSA						
Non-CSA						
DAYS THIS MONTH						
AVG DAILY RES POP						
CAPACITY (%)						

	FY2011	FY2010	FY2009	FY2008	FY2007	FY2006	FY2005	FY2004
ADMISSIONS	241	555	528	526	533	477	472	434
Monthly avg	48.2	46.3	44.0	43.8	44.4	39.8	39.3	36.2
DISCHARGES	239	561	522	527	534	476	478	430
Monthly avg	47.8	46.8	43.5	43.9	44.5	39.7	39.8	35.8
CSA (N)	124	295	320	327	348.0	n/a	n/a	n/a
CSA (%)	51.9	52.6	61.3	62.0	65.2	n/a	n/a	n/a
TOTAL LOS	1,176	3,034	2,884	3,042	3,039	3,012	2,859	2,768
MIN LOS	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5
MAX LOS	33	62	43	34	34	42	51	74
MEAN LOS (all)	4.9	5.4	5.5	5.8	5.7	6.3	6.0	6.4
CSA	5.0	5.8	5.3	n/a	n/a	n/a	n/a	n/a
Non-CSA	4.8	5.0	5.8	n/a	n/a	n/a	n/a	n/a
MEDIAN LOS	4.0	4.0	4.0	5.0	5.0	5.0	5.0	5.0
CSA	5.0	5.0	4.0	n/a	n/a	n/a	n/a	n/a
Non-CSA	3.0	4.0	4.0	n/a	n/a	n/a	n/a	n/a
DAYS THIS YEAR	1,189	2,987	2,895	3,017	3,029	2,960	2,885	2,838
Monthly avg	237.8	248.9	241.3	251.2	252.4	246.7	240.4	236.5
AVG DAILY RES POP	7.8	8.2	7.9	8.3	8.3	8.1	7.9	7.8
CAPACITY (%)	64.8	68.2	66.1	68.9	69.2	67.6	65.9	64.8

FY2009 Individual CPST Service for Medicaid-Eligible Children and Adolescents
Clients Served, Total and Per Capita Units, Total and Per Capita Costs: Five Largest Providers
(By Diagnostic Group, Sorted by number served)

	All diagnoses			Non-Psychotic			Adjustment Prob			Childhood Disorder		
	Clients	Units	Per Cap	Clients	Units	Per Cap	Clients	Units	Per Cap	Clients	Units	Per Cap
Agency 34	535	19,531	36.5	219	6,950	31.7	114	2,441	21.4	50	2,305	46.1
Agency 19	292	28,377	97.2	107	9,374	87.6	79	3,758	47.6	76	5,798	76.3
Agency 18	116	5,777	49.8	29	2,249	77.6	28	1,965	70.2	15	566	37.7
Agency 27	32	1,263	39.5	19	820	43.2	5	185	37.0	1	113	113.0
Agency 15	29	252	8.7	11	58	5.3	0	0	--	13	140	10.8
	Clients	Bd Cost	Per Cap	Clients	Bd Cost	Per Cap	Clients	Bd Cost	Per Cap	Clients	Bd Cost	Per Cap
Agency 34	535	$416,596	$779	219	$148,244	$677	114	$52,067	$457	50	$49,166	$983
Agency 19	292	$605,281	$2,073	107	$199,947	$1,869	79	$80,158	$1,015	76	$123,671	$1,627
Agency 18	116	$122,720	$1,058	29	$47,854	$1,650	28	$41,855	$1,495	15	$11,933	$796
Agency 27	32	$26,649	$833	19	$17,302	$911	5	$3,904	$781	1	$2,384	$2,384
Agency 15	29	$5,375	$185	11	$1,237	$112	0	$0	--	13	$2,986	$230
Total	1004			385			226			155		

	Major Affective			Conduct Disorder			Other Psychoses			Other		
	Clients	Units	Per Cap	Clients	Units	Per Cap	Clients	Units	Per Cap	Clients	Units	Per Cap
Agency 34	79	3,339	42.3	21	391	18.6	47	3,140	66.8	31	951	30.7
Agency 19	37	2,012	54.4	35	3,227	92.2	35	3,526	100.7	12	672	56.0
Agency 18	4	213	53.3	36	398	11.1	3	382	127.3	1	4	4.0
Agency 27	2	39	19.5	1	12	12.0	2	36	18.0	2	58	29.0
Agency 15	1	8	8.0	0	0	--	2	41	20.5	2	5	2.5
	Clients	Bd Cost	Per Cap	Clients	Bd Cost	Per Cap	Clients	Bd Cost	Per Cap	Clients	Bd Cost	Per Cap
Agency 34	79	$71,221	$902	21	$8,340	$397	47	$66,976	$1,425	31	$20,285	$654
Agency 19	37	$42,916	$1,160	35	$68,832	$1,967	35	$75,210	$2,149	12	$14,334	$1,195
Agency 18	4	$4,473	$1,118	36	$8,372	$233	3	$8,148	$2,716	1	$85	$85
Agency 27	2	$823	$412	1	$253	$253	2	$760	$380	2	$1,224	$612
Agency 15	1	$171	$171	0	$0	--	2	$875	$438	2	$107	$54
Total	123			93			89			48		

Data Source: MACSIS Data Warehouse
www.dwcubes.mh.state.oh.us

Trumbull County Mental Health and Recovery Board

FY2009 MACSIS Data
01/02/2010 extract

FY2009 Data
Individual CPST service only
Medicaid clients only
Ages 0-17 only
All diagnoses

Report Name: JEM16a

	Board	Provider	Client Count	Units	Units per Capita	Net Amount	Cost per Capita
1	Board A	9	334	55,486.0	166.1	$ 1,183,462.33	$ 3,543.30
2	Board B	9	21	2,468.0	117.5	$ 52,642.44	$ 2,506.78
3	Board A	2	81	8,439.0	104.2	$ 180,003.87	$ 2,222.27
4	Board D	6	752	78,073.0	103.8	$ 1,663,825.17	$ 2,212.53
5	Board F	12	177	18,006.0	101.7	$ 383,696.34	$ 2,167.78
6	***Board E***	***19***	***292***	***28,368.0***	***97.2***	***$ 605,089.44***	***$ 2,072.22***
7	Board C	2	37	3,573.0	96.6	$ 76,212.09	$ 2,059.79
8	Board B	12	499	44,254.0	88.7	$ 943,937.82	$ 1,891.66
9	Board B	27	56	4,689.0	83.7	$ 98,937.90	$ 1,766.75
10	Board D	10	44	3,617.0	82.2	$ 77,150.61	$ 1,753.42
11	Board D	25	26	2,157.0	83.0	$ 44,907.01	$ 1,727.19
12	Board F	7	32	2,507.0	78.3	$ 53,474.31	$ 1,671.07
13	Board A	33	10	732.0	73.2	$ 15,613.56	$ 1,561.36
14	Board F	37	7	481.0	68.7	$ 10,259.73	$ 1,465.68
15	Board F	1	8	509.0	63.6	$ 10,856.97	$ 1,357.12
16	Board D	24	37	2,011.0	54.4	$ 42,894.63	$ 1,159.31
17	Board A	29	332	17,954.0	54.1	$ 382,958.82	$ 1,153.49
18	Board C	4	440	22,984.0	52.2	$ 490,248.72	$ 1,114.20
19	Board C	8	146	7,270.0	49.8	$ 155,069.10	$ 1,062.12
20	***Board E***	***18***	***117***	***5,771.0***	***49.3***	***$ 122,592.52***	***$ 1,047.80***
21	Board B	2	81	3,919.0	48.4	$ 83,592.27	$ 1,032.00
22	Board C	34	28	1,295.0	46.3	$ 27,622.35	$ 986.51
23	***Board E***	***27***	***33***	***1,271.0***	***38.5***	***$ 26,818.10***	***$ 812.67***
24	Board D	13	126	4,625.0	36.7	$ 98,651.25	$ 782.95
25	***Board E***	***34***	***535***	***19,480.0***	***36.4***	***$ 415,508.40***	***$ 776.65***
26	Board C	16	39	1,403.0	36.0	$ 29,925.99	$ 767.33
27	Board A	31	14	400.0	28.6	$ 8,532.00	$ 609.43
28	Board B	11	35	794.0	22.7	$ 16,936.02	$ 483.89
29	***Board E***	***15***	***29***	***252.0***	***8.7***	***$ 5,375.16***	***$ 185.35***
30	Board F	35	15	122.0	8.1	$ 2,602.26	$ 173.48

FY2009 Data
Individual CPST service only
Medicaid clients only
Ages 0-17 only
Attn Deficit w Hyperact

Report Name:JEM16b

	Board	Provider	Client Count	Units	Units per Capita	Net Amount	Cost per Capita
1	Board A	9	126.0	22,197.0	176.2	$ 473,462.01	$ 3,757.64
2	Board B	19	9.0	1,076.0	119.6	$ 22,951.08	$ 2,550.12
3	Board B	12	142.0	12,368.0	87.1	$ 263,809.44	$ 1,857.81
4	Board D	6	153.0	13,267.0	86.7	$ 282,791.33	$ 1,848.31
5	Board F	12	46.0	3,917.0	85.2	$ 83,467.26	$ 1,814.51
6	Board D	10	11.0	909.0	82.6	$ 19,388.97	$ 1,762.63
7	***Board E***	***18***	***25.0***	***1,894.0***	***75.8***	***$ 40,282.32***	***$ 1,611.29***
8	Board A	29	36.0	2,445.0	67.9	$ 52,151.85	$ 1,448.66
9	Board B	27	20.0	1,371.0	68.6	$ 28,928.10	$ 1,446.41
10	***Board E***	***19***	***86.0***	***5,667.0***	***65.9***	***$ 120,877.11***	***$ 1,405.55***
11	Board C	4	80.0	4,736.0	59.2	$ 101,018.88	$ 1,262.74
12	Board C	12	7.0	411.0	58.7	$ 8,766.63	$ 1,252.38
13	Board C	34	18.0	1,007.0	55.9	$ 21,479.31	$ 1,193.30
14	Board A	2	10.0	529.0	52.9	$ 11,283.57	$ 1,128.36
15	Board C	8	34.0	1,573.0	46.3	$ 33,552.09	$ 986.83
16	***Board E***	***27***	***15.0***	***639.0***	***42.6***	***$ 13,482.90***	***$ 898.86***
17	Board F	7	4.0	166.0	41.5	$ 3,540.78	$ 885.20
18	***Board E***	***34***	***165.0***	***6,051.0***	***36.7***	***$ 129,067.83***	***$ 782.23***
19	Board A	3	1.0	36.0	36.0	$ 767.88	$ 767.88
20	Board B	2	3.0	107.0	35.7	$ 2,282.31	$ 760.77
21	Board D	21	5.0	178.0	35.6	$ 3,796.74	$ 759.35
22	Board D	13	6.0	201.0	33.5	$ 4,287.33	$ 714.56
23	Board B	11	17.0	421.0	24.8	$ 8,979.93	$ 528.23
24	Board F	35	2.0	47.0	23.5	$ 1,002.51	$ 501.26
25	Board C	16	7.0	148.0	21.1	$ 3,156.84	$ 450.98
26	Board F	1	5.0	90.0	18.0	$ 1,919.70	$ 383.94
27	Board D	2	3.0	34.0	11.3	$ 725.22	$ 241.74
28	Board F	32	1.0	4.0	4.0	$ 85.32	$ 85.32
29	***Board E***	***15***	***9.0***	***34.0***	***3.8***	***$ 725.22***	***$ 80.58***
30	Board A	31	4.0	9.0	2.3	$ 191.97	$ 47.99

ATTACHMENT 8 (page 3 of 6)

	FY2009 Data						
	Individual CPST service only						
	Medicaid clients only						
	Ages 0-17 only						
	Oppositional Disorder						
	Report Name:JEM16b						
	Board	**Provider**	**Client Count**	**Units**	**Units per Capita**	**Net Amount**	**Cost per Capita**
1	Board A	9	37.0	5,527.0	149.4	$ 117,853.51	$ 3,185.23
2	Board F	12	32.0	4,134.0	129.2	$ 88,084.20	$ 2,752.63
3	Board F	7	4.0	471.0	117.8	$ 10,046.43	$ 2,511.61
4	Board D	10	5.0	559.0	111.8	$ 11,923.47	$ 2,384.69
5	Board D	6	216.0	22,928.0	106.1	$ 488,050.22	$ 2,259.49
6	Board C	2	9.0	814.0	90.4	$ 17,362.62	$ 1,929.18
7	Board B	12	55.0	4,382.0	79.7	$ 93,468.06	$ 1,699.42
8	Board B	27	3.0	231.0	77.0	$ 4,874.10	$ 1,624.70
9	Board A	2	29.0	2,115.0	72.9	$ 45,112.95	$ 1,555.62
10	***Board E***	***19***	***72.0***	***5,251.0***	***72.9***	***$ 112,003.83***	***$ 1,555.61***
11	Board C	4	64.0	4,475.0	69.9	$ 95,451.75	$ 1,491.43
12	Board B	2	53.0	2,616.0	49.4	$ 55,799.28	$ 1,052.82
13	Board A	29	39.0	1,753.0	44.9	$ 37,391.49	$ 958.76
14	Board D	13	101.0	4,168.0	41.3	$ 88,903.44	$ 880.23
15	***Board E***	***18***	***15.0***	***566.0***	***37.7***	***$ 11,932.74***	***$ 795.52***
16	Board C	8	7.0	258.0	36.9	$ 5,503.14	$ 786.16
17	Board B	22	4.0	126.0	31.5	$ 2,687.58	$ 671.90
18	***Board E***	***34***	***45.0***	***1,412.0***	***31.4***	***$ 30,117.96***	***$ 669.29***
19	Board D	28	7.0	202.0	28.9	$ 4,304.11	$ 614.87
20	Board C	16	11.0	295.0	26.8	$ 6,292.35	$ 572.03
21	Board C	18	4.0	96.0	24.0	$ 2,047.68	$ 511.92
22	Board B	36	4.0	87.0	21.8	$ 1,855.71	$ 463.93
23	Board F	2	3.0	64.0	21.3	$ 1,365.12	$ 455.04
24	Board A	31	5.0	81.0	16.2	$ 1,727.73	$ 345.55
25	Board A	14	3.0	37.0	12.3	$ 789.21	$ 263.07
26	***Board E***	***15***	***13.0***	***140.0***	***10.8***	***$ 2,986.20***	***$ 229.71***
27	Board F	35	2.0	16.0	8.0	$ 341.28	$ 170.64
28	Board F	17	1.0	8.0	8.0	$ 170.64	$ 170.64
29	Board D	2	7.0	55.0	7.9	$ 1,173.15	$ 167.59
30	***Board E***	***2***	***3.0***	***6.0***	***2.0***	***$ 127.98***	***$ 42.66***

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	FY2009 Data						
	Individual CPST service only						
	Medicaid clients only						
	Ages 0-17 only						
	Prolong Posttraum Stress						
	Report Name:JEM16b						
					Units		**Cost**
	Board	**Provider**	**Client Count**	**Units**	**per Capita**	**Net Amount**	**per Capita**
1	Board F	3	1.0	168.0	168.0	$ 3,583.44	$ 3,583.44
2	Board A	9	10.0	1,296.0	129.6	$ 27,643.68	$ 2,764.37
3	***Board E***	***18***	***2.0***	***254.0***	***127.0***	***$ 5,359.47***	***$ 2,679.74***
4	Board D	25	3.0	371.0	123.7	$ 7,790.79	$ 2,596.93
5	Board D	24	5.0	529.0	105.8	$ 11,283.57	$ 2,256.71
6	Board D	6	49.0	4,986.0	101.8	$ 106,351.38	$ 2,170.44
7	Board C	23	2.0	201.0	100.5	$ 4,287.33	$ 2,143.67
8	Board D	10	14.0	1,362.0	97.3	$ 29,051.46	$ 2,075.10
9	Board C	26	6.0	1,029.0	171.5	$ 12,436.14	$ 2,072.69
10	Board D	7	3.0	290.0	96.7	$ 6,185.70	$ 2,061.90
11	Board A	29	10.0	887.0	88.7	$ 18,919.71	$ 1,891.97
12	Board F	12	8.0	629.0	78.6	$ 13,402.98	$ 1,675.37
13	Board A	3	3.0	219.0	73.0	$ 4,671.27	$ 1,557.09
14	Board F	7	7.0	491.0	70.1	$ 10,473.03	$ 1,496.15
15	Board B	12	16.0	1,004.0	62.8	$ 21,415.32	$ 1,338.46
16	***Board E***	***19***	***41.0***	***2,261.0***	***55.1***	***$ 48,227.13***	***$ 1,176.27***
17	Board A	2	20.0	1,068.0	53.4	$ 22,780.44	$ 1,139.02
18	Board C	16	3.0	154.0	51.3	$ 3,284.82	$ 1,094.94
19	Board C	4	27.0	983.0	36.4	$ 20,967.39	$ 776.57
20	***Board E***	***34***	***30.0***	***1,069.0***	***35.6***	***$ 22,801.77***	***$ 760.06***
21	***Board E***	***27***	***5.0***	***180.0***	***36.0***	***$ 3,798.00***	***$ 759.60***
22	Board B	2	4.0	106.0	26.5	$ 2,260.98	$ 565.25
23	Board A	4	1.0	26.0	26.0	$ 554.58	$ 554.58
24	Board B	19	3.0	47.0	15.7	$ 1,002.51	$ 334.17
25	Board B	27	1.0	12.0	12.0	$ 253.20	$ 253.20
26	Board F	24	1.0	8.0	8.0	$ 170.64	$ 170.64
27	Board C	2	3.0	17.0	5.7	$ 362.61	$ 120.87
28	Board F	35	3.0	13.0	4.3	$ 277.29	$ 92.43
29	Board B	30	1.0	1.0	1.0	$ 21.33	$ 21.33
30	***Board E***	***4***	***1.0***	***1.0***	***1.0***	***$ 21.33***	***$ 21.33***

	FY2009 Data						
	Individual CPST service only						
	Medicaid clients only						
	Ages 0-17 only						
	Child Psychos NEC-Active						
	Report Name:JEM16b						
					Units		**Cost**
	Board	**Provider**	**Client Count**	**Units**	**per Capita**	**Net Amount**	**per Capita**
1	Board A	9	6.0	1,163.0	193.8	$ 24,806.79	$ 4,134.47
2	***Board E***	***18***	***2.0***	***345.0***	***172.5***	***$ 7,358.85***	***$ 3,679.43***
3	***Board E***	***19***	***27.0***	***3,321.0***	***123.0***	***$ 70,836.93***	***$ 2,623.59***
4	Board F	12	9.0	964.0	107.1	$ 20,541.42	$ 2,282.38
5	Board D	6	44.0	4,387.0	99.7	$ 93,556.18	$ 2,126.28
6	Board D	24	1.0	65.0	65.0	$ 1,386.45	$ 1,386.45
7	***Board E***	***34***	***42.0***	***2,719.0***	***64.7***	***$ 57,996.27***	***$ 1,380.86***
8	Board B	12	30.0	1,790.0	59.7	$ 38,180.70	$ 1,272.69
9	Board B	2	1.0	59.0	59.0	$ 1,258.47	$ 1,258.47
10	Board C	4	4.0	211.0	52.8	$ 4,500.63	$ 1,125.16
11	Board D	10	1.0	45.0	45.0	$ 959.85	$ 959.85
12	Board B	19	1.0	39.0	39.0	$ 831.87	$ 831.87
13	Board C	8	5.0	192.0	38.4	$ 4,095.36	$ 819.07
14	Board A	2	5.0	154.0	30.8	$ 3,284.82	$ 656.96
15	Board C	2	4.0	110.0	27.5	$ 2,346.30	$ 586.58
16	***Board E***	***27***	***1.0***	***16.0***	***16.0***	***$ 337.60***	***$ 337.60***
17	Board F	7	5.0	76.0	15.2	$ 1,621.08	$ 324.22
18	Board B	11	2.0	14.0	7.0	$ 298.62	$ 149.31
19	Board C	34	1.0	4.0	4.0	$ 85.32	$ 85.32
20	Board F	35	1.0	4.0	4.0	$ 85.32	$ 85.32
21	Board C	18	2.0	7.0	3.5	$ 149.31	$ 74.66
22	Board B	27	1.0	1.0	1.0	$ 21.10	$ 21.10
23	Board A	29	2.0	1.0	0.5	$ 21.33	$ 10.67

ATTACHMENT 8 (page 6 of 6)

	FY2009 Data						
	Individual CPST service only						
	Medicaid clients only						
	Ages 0-17 only						
	Adj React-Emotion Conduc						
	Report Name:JEM16b						
					Units		**Cost**
	Board	**Provider**	**Client Count**	**Units**	**per Capita**	**Net Amount**	**per Capita**
1	Board F	7	1.0	311.0	311.0	$ 6,633.63	$ 6,633.63
2	Board A	9	25.0	4,539.0	181.6	$ 96,816.87	$ 3,872.67
3	Board B	19	1.0	108.0	108.0	$ 2,303.64	$ 2,303.64
4	Board D	6	71.0	5,033.0	70.9	$ 107,208.99	$ 1,509.99
5	***Board E***	***18***	***10.0***	***603.0***	***60.3***	***$ 12,861.99***	***$ 1,286.20***
6	Board F	12	11.0	622.0	56.5	$ 13,258.62	$ 1,205.33
7	Board A	29	27.0	1,522.0	56.4	$ 32,464.26	$ 1,202.38
8	Board B	12	47.0	2,346.0	49.9	$ 50,040.18	$ 1,064.68
9	Board D	24	6.0	277.0	46.2	$ 5,908.41	$ 984.74
10	Board F	24	1.0	46.0	46.0	$ 981.18	$ 981.18
11	***Board E***	***19***	***20.0***	***880.0***	***44.0***	***$ 18,770.40***	***$ 938.52***
12	Board C	4	45.0	1,798.0	40.0	$ 38,351.34	$ 852.25
13	Board B	2	6.0	216.0	36.0	$ 4,607.28	$ 767.88
14	Board C	16	2.0	65.0	32.5	$ 1,386.45	$ 693.23
15	Board D	28	1.0	31.0	31.0	$ 660.71	$ 660.71
16	Board C	2	3.0	87.0	29.0	$ 1,855.71	$ 618.57
17	Board C	8	4.0	85.0	21.3	$ 1,813.05	$ 453.26
18	Board B	11	2.0	40.0	20.0	$ 853.20	$ 426.60
19	***Board E***	***34***	***29.0***	***560.0***	***19.3***	***$ 11,944.80***	***$ 411.89***
20	Board D	33	1.0	19.0	19.0	$ 405.27	$ 405.27
21	Board A	2	8.0	130.0	16.3	$ 2,772.90	$ 346.61
22	***Board E***	***11***	***1.0***	***15.0***	***15.0***	***$ 319.95***	***$ 319.95***
23	Board C	26	2.0	31.0	15.5	$ 620.73	$ 310.37
24	Board F	5	1.0	9.0	9.0	$ 191.97	$ 191.97
25	Board B	20	2.0	13.0	6.5	$ 277.29	$ 138.65
26	Board D	4	1.0	4.0	4.0	$ 85.32	$ 85.32
27	Board A	14	2.0	4.0	2.0	$ 85.32	$ 42.66
28	***Board E***	***4***	***1.0***	***2.0***	***2.0***	***$ 42.66***	***$ 42.66***
29	Board A	5	2.0	2.0	1.0	$ 42.66	$ 21.33