

Mental Health & Recovery Board of Ashland County

COMMUNITY PLAN FOR SFY 2012-2013

December 31, 2010

Revised 8/1/2011



Offering Rays of Hope

MISSION STATEMENT

The Mental Health and Recovery Board of Ashland County, through a network of providers, ensures the availability and accessibility of quality services that support recovery for individuals with mental illness and/or alcohol and drug addiction.

VISION STATEMENT

To create an environment that brings hope and improves the quality of life for persons affected by mental illness and substance abuse.

VALUE STATEMENTS

- *Everyone is entitled to live a quality life in the community*
- *Recovery is Possible; Stigma can be eliminated & Resources are available*
- *Person Centered*
- *Priority Directed*
- *Recovery Focused*
- *Comprehensive and Holistic*
- *High Quality/Research-Based*
- *Accountable*
- *Client Driven*

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.

Mental Health & Recovery Board of Ashland County

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

ADAMHS, ADAS or CMH Board Executive Director

Date

ADAMHS, ADAS or CMH 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.

Ashland County reflects the economic downturn that has been experienced throughout the state and nation. There are several local manufacturing industries that have either significantly reduced their workforce, have relocated, or have been completely dissolved. U.S. Department of Labor statistics indicate Ashland County's unemployment rate has changed from 7.8% in October of 2008 to **13%** in March of 2009 (an increase in 5.2% over just 5 months). Since March of 2009 the unemployment rate has dropped steadily to 10.4% in August of 2010. Ashland continues to experience a higher rate of unemployment as compared to the Statewide average.

The Board and its partners have noticed a downturn in the number of consumers of mental health and/or alcohol/drug services with insurance which may be related to the changes noted in

employment. This is expected to result in higher percentages of the cost of services being born by the Board. Insurance coverage for clients, when present, has been steadily declining in quality as well as coverage. Given current economic conditions the Board has noticed an increase in the number of Medicaid eligible individuals seeking behavioral health services.

The Board has been severely impacted by the recent presence of a “Medicaid Only” mental health agency. Despite numerous efforts by the Board to educate the agency of the potential negative effects to the county; they continue to operate. In just three years the Board’s Medicaid Match responsibility has increased *by over 100%* to an average of \$300,000 per fiscal year. The economic and programmatic impacts of this situation to the Board and the County are significant. The Board’s ability to fulfill its statutory obligations has been challenged by the presence of this agency. Solutions to this situation involve the reform of Medicaid at the State level, an issue widely discussed in years past. OACBHA, the professional organization representing all Boards in the State have proposed a plan to shift Board Community Medicaid responsibilities to ODJS’ 525 line item while maintaining non-Medicaid and Recovery Support Services funding to the Boards. By all accounts this proposal has garnered wide-spread support by state partners.

In the past five years, the Board has seen a *20 percent reduction in state funds, or \$473,000*. With this in mind, Board members chose to replace a 5-year 1-mill levy in November 2010. The replacement levy passed comfortably with over 57% of the vote. Local levy funding will help restore approximately \$200,000 thru utilization of current property valuations.

The following Measures and/or Efficiencies have been implemented to reduce program costs:

- Reduced Board Administrative Costs through benefit reductions/salary freezes (Board Staff have not received salary increases in 3 consecutive years);
- Taking advantage of the tools that are already built into the systems that we have such as Group Policy and various SQL Server tools for data management (saves money by utilizing less 3rd party commercial tools);
- Use free and low cost alternatives when available such as open source tools and other Services;
- Actively encouraging office-wide efficiencies to reduce costs related to supplies, travel and utilities.;
- Shared office space and office equipment with 3 other organizations;
- Continued work on automating as much as possible repetitive tasks such as extract management, enrollment processing, agency payment process, file processing, report processing, and utilization monitoring; and
- Aggressively monitoring expenses and trying to squeeze out any cost savings

The Budgetary Planning Efforts for SFY 12-13 are thought to be some of the most difficult in recent memory. The national and state economic future is uncertain, additionally the elections in November have radically changed the expectations/parameters that the Board will have to operate under. The Board is committed to preserving the highest quality services to the most vulnerable Ashland County residents during the upcoming biennium. The Board will forecast its revenue for the next biennium given all known variables at the time of the forecast. Agency Application Guidelines are then issued which take this forecast into consideration. Board staff and members will meet with contract agencies to review their proposal and ultimately the Board will vote on what services will be supported and at what level. This process does not typically culminate until the May 2011 Board meeting. As of the submission of this plan the forecast has been completed (although tentative) but the guidelines have not yet been issued to the contact agencies. Once received, the agencies will return their applications by April 15, 2011 and Board staff and Board members will begin review, discussion and meetings with each of the agencies submitting a proposal. The Board's planning efforts continue to evolve based on feedback received each year. The Board has tried to be sensitive and reduce the administrative burden to agencies in the application process while at the same time ensuring that Board members and staff have all the information necessary to make sound decisions regarding support and funding.

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.

With the obvious stipulations that there are unknown consequences if/when the balance of power in Congress shifts (i.e., Repeal and Replace), the Board anticipates the following implications of recently enacted health care reform legislation as it relates to behavioral health:

- More people will be eligible for Medicaid or get financial help purchasing private insurance. The law provides tax credits for some low-income Americans to help them meet the cost of purchasing insurance.
- Cheaper drugs will be made available for people on Medicaid and drugs that have traditionally been excluded from Medicaid coverage will now be eligible for a federal Medicaid match equivalent to what these medications cost the states.
- Prescription drugs for those covered by Medicare (the elderly and disabled) will become more affordable as the donut hole is closed. The donut hole is the gap between the initial drug coverage and catastrophic drug coverage provided by Medicare in which patients are required to pay for their own medications. The law also requires Medicare Part D prescription benefit plans to cover drugs in every category of medication, including mental health prescription drugs, such as antidepressants and antipsychotics.
- This legislation ends the common practice of not selling insurance policies to people with pre-existing conditions. This change will end any disincentive to seek treatment for fear you will be labeled with a diagnosis and denied insurance in the future and will help people get insurance who have already been diagnosed with a mental health condition.

- The legislation extends the **Wellstone Domenici Parity and Addiction Equity Act** to apply to any plan included in the health insurance exchanges, including all individual and group insurance policies. The Wellstone Domenici Act only applied to group employer insurance plans for employers with more than 50 workers. It did not apply to Medicare, but did apply to Medicare managed care plans. In addition, the Wellstone Domenici Act did not require plans to provide any mental health benefits. Rather it said if a plan provided mental health benefits they had offer the same benefits for mental health as for physical health.
- Insurance providers will be required to provide a minimum basic mental health benefit.
- Individuals with pre-existing conditions will have immediate access to insurance through high-risk pools.
- The new law eliminates annual and lifetime limits on mental health (and physical health) benefits.
- The range of Home and Community Based Services (HCBS) offered to people with disabilities who require long-term care, but do not wish to be institutionalized, will be expanded. States will also be allowed to target these services toward specific groups, such as people with serious mental illnesses.
- National Depression Centers of Excellence will be established and funded with 5 year grants. These institutions are intended to promote increased access to the best interdisciplinary, evidence-based care for people with depression, disseminate research and establish treatment guidelines.
- Sets minimum standards for health insurance policies that can be purchased by businesses and individuals through state level Exchanges,
- Makes significant improvements to Medicaid including expanding the number of people who can qualify for the extensive mental health services Medicaid covers,
- Authorizes demonstrations and tests of approaches that it is hoped will improve the quality of health care in this country,
- Creates several new options for long-term care of people with disabilities,
- Expands Medicaid eligibility, allowing childless adults who are not classified as having a disability to qualify for the program (although these newly eligible individuals will not receive full benefits),
- Improve coordination of primary care and mental health services for people using the public mental health system,
- Encourage medical homes that address a person's total health care needs, including mental health and substance abuse needs,
- Greatly improves a Medicaid state option for home and community based services for people with disabilities, including those with serious mental illnesses, and

- Expands Medicaid's focus on home and community based care in several ways.

In short, many individuals with mental illnesses will now have access to health insurance that covers mental health and substance abuse services on a par with the coverage of medical and surgical care. Those who cannot afford insurance will qualify for subsidies that will help them pay for it. Insurers will have to meet certain requirements, including covering people regardless of any pre-existing condition.

Several other provisions in this law will also help people with mental illnesses, such as prevention programs, improvements to Medicare's drug benefit, a new insurance plan for long-term community care, reauthorization of the children's state health insurance program (SCHIP) along with other changes.

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.

Ashland County is a rural county with a number of light industrial facilities. The U. S. Census Bureau estimates that the population in Ashland County in 2006 was 54,727 and has increased an estimated 4.2% from 2000 to 2006. It is in the outer reaches of the growth corridor from Akron/Cleveland and Columbus. This is influenced by its location on I-71. Much of the growth continues to be in the Northwest area of the county and also in a suburban-like ring around the county seat of Ashland.

The county and city government has recently built a new justice center, which holds the county jail, the Sheriff's Department, City Police and Municipal Court. This has allowed for the development of improved alcohol/drug services on-site at the jail.

In terms of prevention the aforementioned growth indicates that there will be a need for gradual growth in this area of service. Another aspect of this will be that schools are being expanded with the likelihood of increased demand for services. It may be the case that many of the youth coming into the county may be coming from more urbanized areas and may be somewhat more affluent. This may result in some change in the nature of the youth population and may have implications for how students are approached in prevention programming. Migration to the county may also result in a slightly higher level of racial diversity although the recent census still shows a lack of diversity in Ashland County.

The Boards only contract alcohol/drug provider is the **Ashland County Council on Alcoholism & Drug Abuse (ACCADA)**. ACCADA has been an extremely stable agency serving the needs of Ashland County for more than 25 years. ACCADA provides out-patient services, jail services

and is the Board's gatekeeper for residential and detox services. ACCADA provides services that are accessible, client-centered and cost-effective. **Appleseed Community Mental Health Center** is the primary mental health contract agency of the board. They provide the entire array of outpatient services including crisis intervention services and 24/7 Hotline services. The board also contracts with **Catholic Charities Community Services** for limited mental health and drug/alcohol prevention services. Finally the board contracts with **Lifeworx**, for consumer-operated services. Each of the agencies listed above, have made significant contributions to the development of this Community Plan

*Adults diagnosed with SMI or at-risk for SMI in Ashland County***

The most current demographic data available for this population of focus comes from State Fiscal Year 2009 (SFY 09) which encompasses persons receiving mental health services in Ashland county between the dates of July 1, 2008 and June 30, 2009. Adults with or at-risk for SMI receiving services in the county are typically Caucasian (92%), equally likely to be male or female, likely (72%) to have a completed high school, and living in the city of Ashland (60%). Additionally, it is somewhat likely that the individual drives a vehicle (54%) and has been receiving mental health service in the county for at least one year (37%). According to the statewide Ohio data base (*DataMart*) for Ashland County in SFY 09 a total of 479 residents of the county were classified as SMI and received services at least once during the fiscal year. This is the most reliable and accurate measure available pulling directly from the State billing database.

*Youth diagnosed with SED or at-risk for SED in Ashland County***

Again, utilizing the MACSIS DataMart from SFY 09 417 youth were served who could meet the definition of SED. Similar to the adult population, most SED youth served are Caucasian (97%), slightly more likely to be male (56%) and live in the city of Ashland (60%).

The most recent service trend has been the increase in persons seeking/receiving services to opiate addictions. Utilizing interview data from the director of ACCADA there has been a steady increase (roughly 20% per year increase) over the last four years for this service. As indicated previously, this trend was a significant factor in the Board's decision to implement M.A.T. for this population.

**Please note that PCS Datamart data from SFY 2009 was utilized as the SFY 2010 data does not include the "SMD" filter.

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

Question 4: Describe major achievements.

-Achievements

- Continued Growth in Suboxone/Buprenorphine Treatment for persons addicted to

heroin/opiates. Please note that local levy funding is utilized in some cases to assist the individual early in the recovery process to secure needed medications; but a gradual transition to individual payment responsibility is effected.

- Continued growth in EBP's (Supported Employment, Integrated Dual Disorder Treatment, Early Childhood Mental Health, Incredible Years, Intensive Home Based Services, Motivational Interviewing, School-Based Behavioral Health Services, Consumer Operated Services, and NAMI).
- 3-year Culture of Quality Certification (thru OACBHA) in January 2009.
- 3rd Annual R.S.V.P. "Recovery" Conference held in September of 2010
- Planning will begin for Ashland to host the 4th Annual R.S.V.P. conference in September 2011.
- Ashland County has joined the emerging national "Medication Optimization" project where the latest research evidence around the use of psychiatric medications in the recovery process is utilized. National meetings will begin early in 2011 to develop protocols for this effort.
- The Board and its community partners involved in the Older Adult Behavioral Health Coalition have implemented four exciting initiatives in the last bi-ennium: a.) Vial of Life b.) Caregiver Notebook c.) Health & Wellness Awareness Initiative and d.) Healthy IDEAS

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

- The Board applied to the Department of Health & Human Services (SAMHSA) for a Mental Health Transformation Grant (MHTG). Based on the priority score provided by DHHS it is unlikely the Board will receive funding in the next biennium. This was the Board's first attempt at a grant of this type. The Board fully intends to reapply if the opportunity is available.
- The Board would like to implement another Crisis Intervention Team (CIT) training for local law enforcement personnel. Budgetary considerations have been cited by the various agencies as the reason they could not currently participate in the weeklong training (e.g., cost to cover officers shifts who are in training).
- The Board is desirous to work with the local Consumer Operated Program and Adult Care Facility to develop Peer Run Crisis/Respite services as a way to further reduce the need for private and state hospitalizations.

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.

-Board Process (Mental Health and Drug/Alcohol Prevention):

The Board recognizes the importance of preventative services. When determining prevention needs the Board employs a similar process to that used when determining treatment needs. The Board considers historical and emerging need trends. Additionally, the Board considers the mission of the Board and the Board's strategic plan. Determining need can only occur thru ongoing and continuous collaboration with the Boards partners (Stakeholders). Partners most often include: A.C.C.A.D.A. (AoD Agency), Appleseed (MH Agency), Lifeworx (Consumer Operated Program) & Catholic Charities (MH Agency) community partners (General Public, Juvenile Court, FCFC, DJFS, Schools, etc.) The Board is keenly aware that without this process of including key stakeholder groups in its considerations and discussions, determining prevention needs would be incomplete. In short, the Board "Listens, Talks and Tracks."

- **Data Sources Utilized:**

Contract Agency Assurances and Required Reporting; MACSIS Billings; FCFC Monthly Reporting; School-Community Liaison Program Reporting; Board's AoD Committee; Board's Planning and Finance Committee Meetings;

- **Data Source Types:**

Quantitative and Qualitative data was collected.

- **Methodology:**

Interview and discussion (large and small meetings), phone conferencing and email as well as feedback from prevention facilitators.

- **Time Frames:**

SFY 2010 thru first third of SFY 2011.

- **Stakeholders Involved:**

Family and Children First Council; Juvenile Justice (Court, Detention & Probation); Criminal Justice (Courts; Police & Jail); General Public; Contract Providers (Mental Health & Drug/Alcohol); Board members; County Commissioners

Board Process (Mental Health and Drug/Alcohol Treatment):

- The Board recognizes the importance of treatment services. When determining treatment needs the Board employs a similar process to that used when determining prevention needs (Listen, Talk and Track). The Board considers historical and emerging need trends. Additionally, the Board considers the mission of the Board and the Board's strategic plan. Determining need can only occur thru ongoing and continuous collaboration with the Boards partners (Stakeholders). Partners most often include: A.C.C.A.D.A. (AoD Agency), Appleseed (MH Agency), Lifeworx (Consumer Operated Program) & Catholic Charities (MH Agency) community partners (General Public, Juvenile Court, FCFC, DJFS, Schools, etc.) The Board is keenly aware that without this process of including key stakeholder groups in its considerations and discussions, determining treatment needs would be incomplete.

- Data Sources
MACSIS; Board Provider Network; Board Community Partners

- Data Types
Quantitative Data (i.e., MACSIS Costing/Volume Data) and Qualitative (i.e., Provider and Community Partner Feedback and Formalized Satisfaction Survey's).

- Methodology
Volume of Service by population groupings, gender, diagnostic criteria analysis;
Cost of Service by population groupings, gender, diagnostic criteria and analysis ; and
Aggregate analysis of satisfaction survey data based on highest/lowest rated.

- Time Frames
SFY 2010 thru first third of SFY 2011.

- Stakeholders Involved
Board Provider Network; Board Community Partners (Schools, Juvenile Court, DJFS/Children Services, Family and Children First Council, Local University, Local Hospital, Police/Sheriff, Board Planning and Finance Committees;

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**);
- b. Adults with severe mental disability (SMD) and children and Youths with serious

- emotional disturbances (SED) living in the community (**ADAMHS/CMH only**);
- c. Individuals receiving general outpatient community mental health services (**ADAMHS/CMH only**);
- d. Availability of crisis services to persons without Medicaid and/or other insurance. (**ADAMH/CMH only**)
- e. Adults, children and adolescents who abuse or are addicted to alcohol or other drugs (**ADAMHS/ADAS only**)
- f. Children and Families receiving services through a Family and Children First Council;
- g. Persons with substance abuse and mental illness (SA/MI); and
- h. Individuals involved in the criminal justice system (both adults and children)
- i. Veterans, including the National Guard, from the Iraq and Afghanistan conflicts

Access to Services

Question 8:

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

AoD Prevention

There continue to be no major issues or concerns with regard to accessing prevention services in the county at this time. This is due in large part to the local levy funded “School-Community Liaison Program.” This prevention program is active in every school district in the county and has consistently shown very strong outcomes in improving attendance, behavioral issues and academic issues. If the State decides that local levy funding must be prioritized to pay for Medicaid match and that match exceeds anticipated 408 funding this program and several other local levy funded programs would be reduced or eliminated. The Board is hopeful that local levy funding will continue to be used for local needs based on the decision of the 18-member statutorily established Board.

AoD Treatment

With respect to access issues related to treatment services, the primary challenge remains accessing detox/residential services. The regional Medical Detox and Hospital Residential treatment program closed its doors in FY 04. This closing has made Detox/Residential services more difficult to access. A.C.C.A.D.A. continues to act as the Boards designee/gatekeeper in placing consumers in need of Detox/Residential services. While A.C.C.A.D.A. has developed a contract with Glenbeigh and other State Detox/Residential providers the logistics of arranging services at a much further distance are significant. With this in mind, the Board had increased funding for Detox/Residential in fiscal years 08/09 and was able to maintain those levels in 10/11. The Board anticipates less funding (10%?) being available for these services in SFY 12/13. It is hoped that the generic version of Buprenorphine will be available during the 12-13 cycle. If this occurs, the reduced cost of the medication will allow the county’s Medication Assisted Treatment (M.A.T.) program to serve additional consumers. While Ashland County does not offer Intensive Outpatient services, A.C.C.A.D.A. intensifies existing individual and group treatment to meet the needs of persons

served.

MH Prevention

Neither the Board, its contract agencies nor community partners have identified any access issues/concerns for mental health prevention services; however the Board has prioritized Mental Health Prevention as a “low priority” service, meaning, in times of significant funding restrictions this programming could be reduced or eliminated to free up funding for higher prioritized services/programs.

MH Treatment

The biggest challenge in accessing Medicaid Mental Health Treatment and Recovery Support services is the service of youth/adult Pharmacological Management (Psychiatric Services). Waiting lists can range from 4-6 weeks for routine appointments with crisis situations getting appointments within 2 weeks. Non-Medicaid Mental Health Treatment/Recovery Support services are potentially in jeopardy if significant changes to Medicaid are not made. The Departments are aware of the Board Associations (OACBHA) position to try and elevate Behavioral Health Medicaid to the ODJFS 525 line item while preserving 408/505 funding for Recovery Support Services. The success of this position will determine, to a large degree, the availability of viable services to persons not on Medicaid and for services not funded by Medicaid.

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);

At present the Board does not feel that it has gaps in Crisis Care Services. Over the past 7 years the County has been able to improve Crisis Care Services to such a degree that State Hospital Bed Day Reservations have dropped from 1350 days to 300 days! This has helped by re-directing funding to the community to re-invest in non-Medicaid services, mitigating against state reductions over the last four years and continue to grow evidence based services prioritized by the Board and our contract agencies and partners (i.e., Consumer Operated Services, Integrated Dual Disorder Treatment, Supported Employment, Early Childhood Mental Health, etc.). If gaps do appear, the Board will work swiftly and collaboratively with our Crisis Agency (Appleseed Community Mental Health Center) to fill those gaps with qualified personnel.

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);

Since the Board only has one contract agency that provides Crisis Intervention Services, that agency’s crisis staff are prioritized for ongoing training. The Board’s contract with the agency (Appleseed) is supportive of appropriate training to ensure the staff are qualified to effectively provide the service. The Board is involved in the review of all training activities and ultimate approval of Mental Health Officers (Prescreeners) for the County. This is done officially thru a Board resolution. Currently there are a sufficient number of trained staff to meet current needs; however the Board meets regularly with the agency to determine if any emerging staffing needs exist and will continue to do so in SFY 2012-13.

Question 9: Workforce Development and Cultural Competence*:

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

The Board is very involved in supporting local providers in attracting, retaining and developing qualified direct service staff for the provision of behavioral health services. Some of the activities the Board has done in this regard include: Offering college internships/practicum opportunities for Social Work/Counseling Students, Funding the costs of "Head Hunter" firms to secure a Child Psychiatrist, understanding the ever increasing costs for providers to offer healthcare coverage to their employees, developing appropriate interview and screening processes for providers to use, participating in the interviewing process for new provider employees, and recognizing provider staff for their exceptional work (including financial reorganization in the form of higher service rates for Prescreeners). The Board does not have a current relationship with the Departments for this purpose but is open to the idea. Fortunately the local behavioral healthcare system is currently in a good position with regard to qualified, licensed and/or credentialed staff. The one notable exception is in the area of adult psychiatry. Only recently announced, a long-time and much respected adult psychiatrist announced his intention to take another position out of state. This has presented a challenge to the local system. The Board is working collaboratively with Appleseed to help fill this position as quickly as possible.

Cultural Competence is a set of attitudes, skills, behaviors, and policies that enable organizations (e.g., Boards and Providers) and staff to work effectively in cross-cultural situations (*see Appendix D for State of Ohio definition).

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.

- Current Activities
 - a.) Ashland County embraces the principles of equal access and non-discriminatory practices in planning, funding and service delivery;
 - b.) Ashland County believes cultural competence might be achieved by identifying and understanding the needs and help-seeking behaviors of individuals and families;
 - c.) Ashland County believes that culturally competent organizations design and implement services that are tailored or matched to the unique needs of individuals, children, families, organizations and the community at large; and
 - d.) Ashland County recognizes behavioral health as an integral and inseparable aspect of primary health care.
- Strategies
 1. Model a culturally competent system of care at the Board level and seek to instill that system

of care first through the Board's contract agencies, secondly thru the Board's partner agencies and lastly to the community at large.

2. Adopt Board Mission, Vision and Values consistent with a culturally competent system of care.
3. Embed these principles in agency funding application guidelines and contract assurances
4. Embed principles of cultural competency in community events (e.g., public relations activities (print, radio and television), training events and the Board's Annual Dinner.

- **Successes**

In July of 2010, the Board completed administration of the MHSIP and YSS-F instruments to persons receiving services from provider agencies. Representative Results were as follows:

With regards to Cultural Sensitivity, respondents on the YSS-F were particularly favorable. 100% Agreed or Strongly Agreed that staff at the agencies spoke with them in a way that they understood. 96.9% Agreed or Strongly Agreed that agency staff respected their families' religious/spiritual beliefs and 96.8% said staff were sensitive to their cultural/ethnic background. On the MHSIP 82% Agreed or Strongly Agreed that staff were sensitive to their cultural background (race, religion, language, etc.).

- **Challenges**

Building and sustaining a local system of care that is culturally competent requires ongoing effort. Staff Turnover at the various provider and partner agencies, Stigma, lack of education or misinformation remain. The Board is committed to continuing its effort to build and sustain the most culturally competent system possible.

Capital Improvements

Question 10: Capital Improvements:

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

At present, the Board does not have, nor does it anticipate construction and/or renovation needs during the 12-13 biennium. As the country and state recover from the recession the Board may be in the position to pursue capital improvements in a collaborative relationship between a Board funded Consumer Operated Agency and Adult Care Facility, Shelter + Care Vouchers and additional Permanent Supportive Housing options. The Board is beginning preliminary discussions and planning for these potential ventures.

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 and Treatment and Recovery Services

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

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

The Board process to determine its capacity, prevention, treatment and recovery services priorities for SFY 2010-2013 included discussion and analysis of: The amount of need (# of persons in need of a particular service), the ramifications of not meeting the needs of a person(s), available funding, capacity of contract agencies to meet prioritized need, community acceptance of need and service(s), all applicable statutory requirements of the Board, State defined needs/priorities and the Board's Strategic Plan, including Board Mission, Vision and Values.

After meeting with all relevant stakeholder groups the Board developed and formally approved a prioritization continuum for all prevention and treatment & recovery services funded by the Board. This process was last completed by the Board during the SFY 2011 budgeting process (January thru June of 2010) and will occur again beginning in January 2011 for SFY 2012 and SFY 2013. It is anticipated the process will operate similarly to previous years. Board funded services are categorized as "Low," "Medium" or "High" Priority.

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.

Behavioral Health Capacity Priorities:

1. Maintain access to crisis services for persons with SPMI, SMD, and SED regardless of ability

to pay.

2. Maintain access to services to all age, ethnic, racial, and gender categories as well geographic areas of the county.
3. Increase the use of data to make informed decisions about planning and investment.
4. Promote and sustain the use of “evidence-based” policies, practices, strategies, supportive housing, peer support, and other programs.
5. Adult and Family of Youth consumers report that they are satisfied with the quality of their care.

Goals:

1. Continue to prioritize crisis services during the contracting process and continue to make those services available regardless of ability to pay.
2. Continue to maintain access through the Board-Agency contracting process (Assurances).
3. Continue to utilize data from MACSIS, consumer satisfaction and outcomes data (MHSIP and YSS-F) and Matrix reporting when making decisions about planning and investment.
4. Continue to support EBP’s like Intensive Home Based Services (I-FAST), IDDT, SE and Peer Support.
5. Utilize the MHSIP and YSS-F to measure level of satisfaction.

Objectives:

1. Confirm via MACSIS, Board-Agency Meetings and Consumer Feedback
2. Confirm via MACSIS, Board-Agency Meetings and Consumer Feedback
3. Confirm via MACSIS reporting, Matrix Reporting and MHSIP and YSS-F reporting
4. Confirm via Board contract and Board-Agency Meetings
5. Confirm via MHSIP and YSS-F reporting

Behavioral Health Prevention Priorities

Mental Health Prevention Priorities

1. Suicide Prevention
2. Depression Screenings
3. Early Intervention Programs

Goals:

1. Maintain youth depression/suicide screening programs like Red Flags and Teen Screen.
2. Maintain youth anti-bullying efforts using the Olweus method.
3. Maintain older adult and other at-risk population screening and education for suicide and depression.
4. Maintain Early Intervention programs like Early Childhood Mental Health and Incredible Years.

Objectives:

1. Number of youth/classrooms screened for depression/suicide within +/- 5% of SFY 2010.
2. Number of youth/classrooms trained in Olweus antibullying within +/- 5% of SFY 2010.
3. Number of older adult screening and education for suicide and depression increase over SFY 2010 by 5%.

4. Number of youth/classrooms effected by ECMH and IY within +/- 5% of SFY 2010.

Alcohol and Other Drug Prevention Priorities:

1. Childhood/underage drinking
2. Youth-Led Prevention

Goals:

1. Maintain focus on increasing the number of young adults & teens that perceive alcohol, tobacco and other drug use as harmful;
2. Maintain focus on increasing the number of young adults & teens who avoid use and perceive non-use as the norm.

Objectives:

1. and 2. Continue with the array of Board funded AoD Prevention Program to see an increase of 5% over SFY 2010 outcomes.

Behavioral Health Treatment and Recovery Support Services Priorities

Alcohol and Other Drug Treatment and Recovery Support Services Priorities

The Board will continue to prioritize services to the same groups of recipients outlined by ODADAS and SAPT Block Grant: pregnant women, women, injecting drug users, client and staff at risk of tuberculosis, and early intervention for individuals with or at risk for HIV disease.

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.
5. Increase the number of customers who participate in self-help and social support groups at the completion of the program.

Objectives:

1. Increase by 5% over SFY 11 results.
2. Increase by 5% over SFY 11 results.
3. Increase by 10% over SFY 11 results.
4. Increase by 5% over SFY 11 results.
5. Increase by 10% over SFY 11 results.

Mental Health Treatment and Recovery Support Services Priorities

The Board will prioritize services to SMD, SPMI and SED consumers but is hopeful that funding will still be available to serve others not meeting these definitions as developed by

ODMH.

Goals:

1. Increase the number of customers reporting positively about social connectedness and functioning and client perception of care.
2. Decrease re-hospitalization at Regional Psychiatric Hospitals in 30 and 180 days.
3. Decrease school suspensions & expulsions
4. Increase school academic performance & attendance

Objectives:

1. Increase by 5% over baseline data collected in SFY 2011.
2. Decrease by 10% over SFY 2011 data.
3. Decrease by 3% over SFY 2011 data.
4. Increase by 4% over SFY 2011 data.

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?

Concerning Access, it will be the goal of the Board to 1.) Maintain access to crisis services for persons with SPMI, SMD, and SED regardless of ability to pay and 2.) Maintain access to services to all age, ethnic, racial, and gender categories as well as geographic areas of the county.

Objectives:

- 1.) It has been the policy of the Board not to deny access of crisis services for persons with SPMI, SMD, and SED regardless of ability to pay. This is an important position of the Board to maintain and it will continue to work with the agency providing Crisis Services to ensure this continues.
- 2.) The Board regularly reviews service utilization data and will continue to expect to see that all age, ethnic, racial and gender categories as well as geographic areas of the county are being served.

Strategies:

- 1.) and 2.) The Board will utilize the MHSIP and YSS-F instruments which both have a domain measure of "ACCESS" to determine the level of agreement persons receiving services have of the access of those 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.)

-Consumer Satisfaction with Services & Staff

Plan to Identify: It is the goal of the Board to utilize the MHSIP and YSS-F Measures which both have a domain to measure consumer satisfaction with services and staff.

Plan to Increase: Based on the results of the MHSIP and YSS-F, Board staff will work with contract agencies and utilize comments from consumer responses to, as best as possible, address concerns and increase satisfaction with services and staff. It is the Board's objective to see at least 80% of respondents Agreeing or Strongly Agreeing that they are satisfied with staff and services. If responses fall below that objective a plan of increase will be developed. This may be as simple as considering the hours in which services are made available to as involved as having a series of "Strategy Café" sessions with consumers to formally enlist their help in making system changes.

Plan to Assess Cultural Competence: The Board is best positioned to assess cultural competence in relation to satisfaction with services and staff by once again utilizing the MHSIP and YSS-F domain data developed for just this purpose. The Goal will be utilizing the MHSIP and YSS-F instruments and the objective would be to see at least 85% of respondents Agreeing or Strongly Agreeing that their culture, traditions, religion, beliefs, etc. are respected by agency staff. Failing that percentage, the Board will take a similar approach as that identified above to solicit solutions directly from persons served.

-Staff Recruitment

Plan to Identify: The Board plans to continue its working relationship with provider agencies to stay abreast of any staff recruitment, retention or training issues. The Board has regular meetings with each of its contract agencies and has assisted agencies in the past with the cost of recruitment for difficult issues, interviewing strategies, etc.

Plan to Increase: Given current staffing patterns and the upcoming budget cycle it is the Board's objective not to increase staffing but, rather, to maintain as much of the current quality staffing in the local system of care as possible.

Plan to Assess Cultural Competence: The Board will continue to be attentive to contract agency staffing needs and requests around cultural competence as it relates to staff recruitment. Current staffing patterns at the contract agencies are more than reflective of the Ashland County community at large. Again, working collaboratively with our contract agencies, in the event a particular staffing need exists (i.e., Hispanic counselor), the Board will work with the agency to secure a qualified individual to meet the need.

-Staff Training

Plan to Identify: Similar to the Boards plan for recruitment discussed above. Working with our contract agencies, the Board will identify staff training needs. Current agency allocations already include an allotment for ongoing staff training. Additionally, the Board sponsor's at least one training per year (RSVP) that seeks to provide low cost/no cost training to contract staff that is both an identified need and consistent with the Board's long term strategic plan.

Plan to Increase: It is not the Plan of the Board to increase staff training for the next biennium. In fact a reduction in staff training of approximately 10% is anticipated. The Board will work

with its contract agencies in deciding which trainings to keep, for whom, and at what level.

Plan to Assess Cultural Competence: Given the fact that the budget for staff training is anticipated to be reduced, it is imperative that the Board work with its agencies to identify and prioritize any/all trainings that will be responsive to cultural competence needs.

-Addressing Disparities in Access and Treatment Outcomes

Plan to Identify: It is the goal of Board staff in the SFY 12/13 biennium to exam the MHSIP and YSS-F outcomes data by race, age, gender, or any other identified factor that might bely the existence of a “Disparity” in access and treatment outcomes. A know “disparity” is built into the current system of care with regards to access in that agencies typically triage service calls based on the perceived severity of need. The Board does not see a need to change that practice given the current shortage of funding and future funding reductions.

Plan to Increase: To the extent disparities are discovered, it will be the Board’s plan to increase equity in the local system of care and decrease disparity. The objective would be to end any disparities by the fiscal year of when they are discovered.

Plan to Assess Cultural Competence: To the extent disparities exist, it will be important to determine to what extent those disparities are due in whole or in part to cultural competence issues. If identified, the Board would then work with the agencies around systems changes and/or staff training/recruitment to end the practice(s).

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.

Board’s Goal:

To increase the number of children and families who have accessed AOD services utilizing 484 funding.

Board’s Objective:

The Board would like to fully expend these funds annually.

Board’s Plan:

Working with the Family & Children First Council, County Commissioners and local children services to identify more families and children eligible for these funds.

The Commissioners and Board work collaboratively and fund services jointly in the following manner. When residential/out of home placement is necessary the County Commissioners, via Child Welfare, fund room and board costs while the Board funds the Medicaid eligible treatment services needed. This collaboration is seen most clearly during regular Family & Children First Council meetings where the needs of local residents involving both systems are discussed.

Additionally the Board and County Commissioners have determined that existing 484 funds will be used primarily for outpatient services and in some cases for higher levels of care including detox and

residential treatment. ACCADA regularly hosts consultation meetings with the Children Service supervisor to assure that there continues to be a good working relationship between the two systems.

Board's Plan to Verify Results:

The Board will utilize the MACSIS system to verify any increases. Quarterly reports are already submitted to the ODADAS.

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 for the Ashland Board.

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?

Boards Plan to Address Needs of Civilly and Forensically Hospitalized Adults:

- Conditional Release Parameters –

The Board's primary MH contract agency (Appleseed) will work within the Continuity of Care Agreement to plan, as appropriate, for those persons qualifying for conditional release. In general, the Board prefers an individual forensically committed to be released on a conditional release status rather than "maxing out" their sentence at the hospital. Conditional release allows for increased treatment options (e.g., Hospitalization) in the event there are challenges trying to assist the person in flourishing in a community environment. Please note that Ashland County has not had someone on a Conditional Release status in over two years.

- Discharge Planning Procedure –

As indicated in the Continuity of Care Agreement (between the Board and Heartland Behavioral Healthcare); discharge of forensic and civilly committed persons is a joint process between the person served, involved family/friends, hospital treatment team and the Board's primary mental health agency. It is the Board's position that State Hospitalizations, outside of forensic commitments, should be of the least duration necessary that allows for the person to return to their home environment successfully. Discharge begins at admission. The Board strives to see 80% of their civil discharges with lengths of stay equal to or less than 7 days. This goal was achieved in SFY 2010 and is on track to be met in SFY 2011.

- Non-Violent Misdemeanants-

The Ashland Board has not noticed this increase, but to the extent it exists the Board will work collaboratively with local law enforcement, as appropriate, to address any unique needs/challenges posed by the state hospital discharged non-violent misdemeanant.

*It should be noted that the Ashland Board appreciates the professionalism and courtesy shown by

the staff at Heartland Behavioral Healthcare. Mr. Carpenter and his staff go the extra mile to ensure that our county residents admitted receive high quality care and receive for no longer than is necessary. We do not think any other campus is on par with the HBH campus.

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?

Possible implications include service gaps resulting in unmet needs. The Board is hopeful that any potential gaps are identified as early as possible and changes made to eliminate those gaps through increased/targeted services. Changes of this type would be reflected in the Community Plan Update.

Where needs go unaddressed and/or under-addressed it is possible that other systems including juvenile justice, schools, primary health, JFS, faith-based organizations and other social service organizations will have to play an increased role.

Unfortunately, need is always in excess of resources necessitating a community response to mental health and substance use disorders that is prioritized. Using the process approved by Board members which takes into account the Board's mission, vision, values, strategic plan, state/federal mandates, community needs, etc. the Board does its best to fulfill its obligations.

There is the potential for an increase in state psychiatric hospitalizations (bed day utilization) due to potential reductions in recovery support services. Boards have recently been informed by ODMH that the SCUD will go away beginning in SFY 12. The ramifications to this decision are unknown but potentially significant. Further ODMH/ODADAS submitted budgets that clearly were not carefully thought out in terms of the Mental Health Act of 1988 or existing client need (Both Medicaid and Non-Medicaid). In short, so much of the budget is still unknown, particular the Board Associations plan to move the Board's Medicaid Match responsibilities to the ODJFS 525 line while maintaining 100% of existing 408, 505 and 401 funding for recovery support services.

If the Board retains responsibility for Medicaid Match, the trend towards more and more of the Board's funding being needed for "Medicaid Only" services means vital Non-Medicaid services will go unfunded or underfunded. This creates a significant challenge for the Board to fulfill its goal of assisting persons with behavioral health disorders thrive in their communities. The very services that assist persons to thrive may be eliminated or significantly reduced due to a combination of state policy and funding decisions. The question of whether the Mental Health Act of 1988 is being funded adequately or appropriately will be discussed throughout the next two years and, possibly, beyond.

If Behavioral Health Medicaid Match responsibilities are shifted to ODJFS (525 Plan) and 408, 505 and 401 line items are adequately funded, Boards will be in position to reform existing behavioral health services to focus on services that work for those in recovery regardless of whether the services are Medicaid eligible or the individual is Medicaid eligible. Emphasis will be on effectiveness.

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.

A 10% reduction in State funding would equate to approximately \$215,000 reduction in funding. That coupled with the elimination of Enhanced FMAP and possible Federal funding reductions will of course have a major impact on our system.

Over the years we have had to reduce and eliminate most non-core treatment and prevention services in response to decreasing funding. Currently state funding only covers core treatment services (Medicaid match and Non-Medicaid services) and prevention services. Since we are required to match Medicaid expenditures, the reduction in funding will greatly affect services available to indigent individuals needing mental health and/or alcohol and drug services that are not covered by Medicaid or other insurance. As you are aware, there are many high risk indigent individuals that, for various reasons, do not qualify for Medicaid but need services to keep them functioning in the community. The reduction in state funding coupled with increases in Medicaid expenditures will bring us one step closer to having to use all available state funding for Medicaid eligible claims. While it is hard to predict the exact volume reduction in persons served and services, that is the anticipated result of a funding reduction of 10%.

The projected reduction in state funding will also have an impact on monitoring and evaluation as it will likely have a negative impact on key administrative staffing at both the provider and board level. Theoretically, Board defined “high-risk” groups would be least effected since the Board will try to, as much as is possible, preserve funding/services to that identified group(s); of course this will have to come at the expense of groups prioritized lower.

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

Community Plan Guidelines for SFY 2012-2013 September 29, 2010

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.

- Private Hospitals

The Board via Appleseed has a good relationship with Private Hospitals. Each year the Board allocates funding to be used at the discretion of the contract agency responsible for Crisis Intervention Services (Appleseed) in minimizing State Hospitalizations. The primary intent of these funds is to utilize Private Hospitals, where appropriate, to avoid state hospitalization placements. Med-Central Mansfield, Summa St. Thomas/Barberton and Akron Children's Hospital are the three private hospitals most often used by Ashland County. If the Board were not as satisfied with the professionalism of Heartland Behavioral Healthcare (HBH) as they are, increased discussions with private hospitals would be necessary.

- Local School Systems

The Board's largest levy funded program is the School-Community Liaison Program. Employees of the program are housed within each of the four school districts served. Without excellent collaboration and coordination with the local school system this program would not enjoy the success it does. Nine year outcomes show consistently high levels of improvement in academic performance, behavioral issues and attendance. Satisfaction surveys of school personnel consistently rate the program as superior and feel collaboration is good.

- Family and Children First Council

The Board has had a historically collaborative relationship with the local Family and Children First Council. Ashland's FCFC is actually housed within the MHRB and the Board functions as the Administrative Agent for Council. With funding changes in the SFY 12-13 budget the Council Coordinator has had to reduce her time to a part-time status. The community is collectively concerned that the Council will be less impactful due to reduced funding levels. Families that are involved in multiple systems in the community have benefited most by the collaboration between Council and the Board. Because of regular service coordination meetings involving Board contract agencies and the families involved, solutions have been generated to the satisfaction of the families in most situations.

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)?

Currently, customers are involved in the planning process primarily thru collaboration with the local consumer operated program. Current/past customers involved with the consumer operated program (Lifeworx!) are asked for their feedback regarding all aspects of the planning process including needs assessment, prioritization, planning, evaluation and implementation. Additionally, both customers and the general public are involved in the planning process through four major avenues:

1. Contract Agency Customer/Community Satisfaction Surveys;
2. Board Customer/Community Satisfaction Surveys;
3. Board initiated community focus groups, and

4. Board involvement with the Family & Children First Council

Feedback from each of these avenues is incorporated into the ongoing planning process for Mental Health and Alcohol/Drug services.

The Mental Health and Recovery Board of Ashland County regularly collaborates with the following local systems:

- Juvenile Court
- Jail
- Education/School Superintendents
- Family and Children's First Council
- Department of Jobs and Family Services
- Directors of contract agencies
- Homeless Coalition
- School Liaison Coordinator
- Domestic Violence Shelter
- Rape Crisis Program
- Prosecutor's Office
- Faith Based Organizations
- District V Area Agency on Aging
- Council on Aging
- Municipal Court
- Law Enforcement
- Hospital (Samaritan Regional Health System)
- Salvation Army (Kroc Center)
- Service Organizations (Rotary, Lions, etc.)

The benefits of intersystem collaboration are enumerable. The Mental Health and Recovery Board of Ashland County values its collaborative efforts. They are critical in determining community needs/gaps in services as well as a source of satisfaction for services currently being offered. Innovative programs like our Jail program would not have been possible if not for the intersystem collaboration that exists. The Board's initiatives around Crisis Intervention Teams (CIT), Supported Employment and Intensive Home Based Services would not be successful without strong collaboration.

The Board is in the planning stages to begin a "Consumer Advisory Council" for Ashland County. The Board is serious about soliciting the input of current/past consumers in all aspects of Board operations. The Board believes that current/past consumers have a critical role to play in any local system of care. The Board envisions the Council meeting 3-4 times yearly to discuss any/all concerns they may have with the local behavioral health system of care and their solutions for improving the system. Council members will have direct input into the Community Planning Process.

Regional Psychiatric Hospital Continuity of Care Agreements

Community Plan Guidelines for SFY 2012-2013 September 29, 2010

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.*

Eight prescreening staff (100%) were trained during fiscal year 2010 on the Continuity of Care Agreement between the Board, Appleseed Community Mental Health Center and Heartland Behavioral Healthcare. The Training was conducted by Hattie Tracy, the Director of Emergency Services at Appleseed. Hattie was integral in the original development of the Agreement and is knowledgeable about the prescreening process.

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

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

The Commissioners and Board work collaboratively and fund services jointly in the following manner. When residential/out of home placement is necessary the County Commissioners, via Child Welfare, fund room and board costs while the Board funds the Medicaid eligible treatment services needed. This collaboration is seen most clearly during regular Family & Children First Council meetings where the needs of local residents involving both systems are discussed. Additionally the Board and County Commissioners have determined that existing 484 funds will be used primarily for outpatient services and in some cases for higher levels of care including detox and residential treatment. A.C.C.A.D.A. recently hosted a consultation meeting with the Children Service supervisor to assure that there continues to be a good working relationship between the two systems and alcohol/drug provider agency. The Board, along with its contract agencies and the FCFC, are trying to enhance/improve communication/collaboration with the Child Welfare System, particularly for those youth/families at risk for either out of home/county placement or for those parents who may feel as if custody relinquishment is the only way that their child/children can get the help he/she/they might need.

The Board has been allocated \$16,820 in HB 484 funding for SFY 2011.

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.

Boards Current Evaluation Focus in Relation to ORC 340.03 (A)(4) and ORC 5119.61 (G)

ORC 340.03 (A)(4) reads as follows:

(4) In accordance with criteria established under division (G) of section 5119.61 of the Revised Code, review and evaluate the quality, effectiveness, and efficiency of services provided through its community mental health plan and submit its findings and recommendations to the department of mental health;

ORC 5119.61 (G) reads as follows:

(G) Establish criteria by which a board of alcohol, drug addiction, and mental health services reviews and evaluates the quality, effectiveness, and efficiency of services provided through its community mental health plan. The criteria shall include requirements ensuring appropriate service utilization. The department shall assess a board's evaluation of services and the compliance of each board with this section, Chapter 340. or section 5119.62 of the Revised Code, and other state or federal law and regulations. The department, in cooperation with the board, periodically shall review and evaluate the quality, effectiveness, and efficiency of services provided through each board. The department shall collect information that is necessary to perform these functions.

- **In Terms of a Success:**

At the time of the SFY 10-11 Community Plan submission, the Board was still uncertain as to the Departments plans/policy around consumer's outcomes. Since that time ODMH, at least, has indicated a preference for the MHSIP and YSS-F measures. Taking that lead, the Ashland Board has formally adopted the use of MHSIP and YSS-F to collect, in part, consumer outcome information. This is a major step Board in allowing the Board to make funding/prioritization decisions based on program/agency effectiveness and efficiency. As of December 2010, the Board has administered the MHSIP and YSS-F once to clients at each contract agency. The Board will do a second administration in January 2011 and based on the combined results will, for the first time in some years, have the ability to begin to analyze consumer outcomes in terms of agency funding levels. Further use of MACSIS Affiliation Codes and Roster Reporting will allow the Board to get specific effectiveness and efficiency measures for specialized programming like IDDT and SE. This might be possible statewide if the Departments see value in the concept.

- **In Terms of a Challenge:**

The biggest challenge facing the Board involves assuring a representative sample of clients is obtained while at the same time, minimizing administrative burden to the agencies and clients completing the instruments. The Board has initially elected to have two administration times six months apart. The Board is open to utilizing other mechanisms, like mailing the surveys with a postage paid return envelope, if current collection and sampling strategies prove unsuccessful.

Boards Current Evaluation Focus in Relation to ORC 340.033 (H)

ORC 340.033 (H) reads as follows:

(H) 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

ORC 340.15 reads as follows:

(A) 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*** [emphasis added] 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

- **In Terms of a Success:**
In SFY 2010 the Board was successful in expending 74% of the funding allocated for ORC 340.033 (H) and ORC 340.15 services. The Board is on pace to better that percentage in SFY 2011.
- **In Terms of a Challenge:**
One of the biggest challenges in ensuring success of this Board goal is the frequent staff turnover that occurs at Children Services. In addition to line staff it is not uncommon for middle & upper managers to turn over every one to two years. Just within the past few months, the Executive Director retired and the Associate Director was fired. ACCADA, has tried to meet at least yearly with middle managers and line staff to help coordinate our treatment efforts related to ORC 340.033 (H) and 340.15.

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.

Goal Type	Objectives	Indictors/Measures	Progress Definition
BH-Capacity			
1. Continue to prioritize crisis services during the contracting process and continue to make those services available regardless of ability to pay.	1. Ensure services are prioritized	1. Board-Agency contracting process; MACSIS reporting	1. The extent to which Crisis Services are available
2. Continue to maintain access to services through Board-Agency contracting process (Assurances).	2. Ensure there is access to prioritized BH services	2. Board-Agency Assurances	2. The extent to which waiting lists for services are necessary
3. Continue to utilize data	3. Produce reports using	3. MACSIS, Board-	3. Board reports utilizing

<p>from MACSIS, Consumer Satisfaction and Outcomes data and Reporting Matrices when making decisions about planning and investment</p> <p>4. Continue to support EBP's like Intensive Home Based Services (I-FAST), IDDT, SE and Peer Support.</p>	<p>MACSIS, Matrices, MHSIP and YSS-F</p> <p>4. Fund EMP's in SFY 12-13 contract</p>	<p>Agency Matrices, MHSIP and YSS-F</p> <p>4. Line item(s) funding I-FAST, IDDT, SE and Peer Support</p>	<p>the identified data sources</p> <p>4. The number of persons served by the identified EBP's.</p>
<p><u>MH-Prevention</u></p> <p>1. Maintain youth depression/suicide screening programs like Red Flags and Teen Screen.</p> <p>2. Maintain youth anti-bullying efforts using the Olweus method.</p> <p>3. Maintain older adult and other at risk population screening and education for suicide and depression.</p> <p>4. Maintain Early Intervention programs like ECMH and IY.</p>	<p>1. Number of youth/classrooms screened for depression/suicide within +/-5% of SFY 2011.</p> <p>2. Number of youth/classrooms trained in Olweus within +/- 5% of SFY 2011.</p> <p>3. Number of older adult screening & ed for suicide/depression > than SFY 2011 by 5%.</p> <p>4. Number of youth/classrooms affected by ECMH and IY within +/- 5% of SFY 2011.</p>	<p>1. Program Reports</p> <p>2. Program Reports</p> <p>3. Program Reports</p> <p>4. Program Reports</p>	<p>1. Actual screens within identified range of projections.</p> <p>2. Actual bullying efforts within identified range of projections.</p> <p>3. Actual screening/education within identified range of projections.</p> <p>4. Actual ECMH and IY services within projected range.</p>
Goal Type	Objectives	Indicators/Measures	Progress Definition
<p><u>AoD Prevention</u></p> <p>1. Maintain focus on increasing the number of young adults & teens that perceive ATOD use as harmful.</p> <p>2. Maintain focus on increasing the number of youth adults & teens who avoid ATOD use and perceive non-use as the norm.</p>	<p>1. Continue with the array of Board funded AoD Prevention Programs to see an increase of 5% over SFY 2011 outcomes.</p> <p>2. Continue with the array of Board funded AoD Prevention Programs to see an increase of 5% over SFY 2011 outcomes.</p>	<p>1. PIPAR system</p> <p>2. PIPAR system</p>	<p>1. Youth/Classrooms indicating on objective measure the anticipated changes.</p> <p>2. Youth/Classrooms indicating on objective measure the anticipated changes.</p>
<p><u>MH Treatment & Recovery Support Services</u></p> <p>1. Increase the number of customers reporting positively about social connectedness & functioning and client</p>	<p>1. Increase by 5% over baseline data collected in SFY 2011.</p>	<p>1. MHSIP and YSS-F</p>	<p>1. Scores will increase in the desired direction.</p>

<p>perception of care.</p> <p>2. Decrease re-hospitalization at Regional Psychiatric Hospitals in 30 and 180 days.</p> <p>3. Decrease school suspensions and expulsions.</p> <p>4. Increase school academic performance & attendance.</p>	<p>2. Decrease by 10% over SFY 2011 data.</p> <p>3. Decrease by 3% over SFY 2011 data.</p> <p>4. Increase by 4% over SFY 2011 data.</p>	<p>2. State PCS system</p> <p>3. School-Community Liaison Program Report</p> <p>4. School-Community Liaison Program Report</p>	<p>2. Data will show readmit rates in the desired direction.</p> <p>3. Report will show decreases in desired direction.</p> <p>4. Report will show increases in desired direction.</p>
<p><u>AoD Treatment & Recovery Support Services</u></p> <p>1. Increase the number of customers who are abstinent at the completion of the program.</p> <p>2. Increase the number of customers who are gainfully employed at the completion of the program.</p> <p>3. Increase the number of customers who incur no new arrests at the completion of the program.</p> <p>4. Increase the number of customers who live in safe, stable, permanent housing at the completion of the program.</p> <p>5. Increase the number of customers who participate in self-help and social support groups at the completion of the program.</p>	<p>1. Increase by 5% over SFY 2011 data.</p> <p>2. Increase by 5% over SFY 2011 data.</p> <p>3. Increase by 10% over SFY 2011 data.</p> <p>4. Increase by 5% over SFY 2011 data.</p> <p>5. Increase by 10% over SFY 2011 data.</p>	<p>1. ACCADA Program Reporting.</p> <p>2. ACCADA Program Reporting.</p> <p>3. ACCADA Program Reporting.</p> <p>4. ACCADA Program Reporting.</p> <p>5. ACCADA Program Reporting.</p>	<p>1. Report will show anticipated changes.</p> <p>2. Report will show anticipated changes</p> <p>3. Report will show anticipated changes.</p> <p>4. Report will show anticipated changes.</p> <p>5. Report will show anticipated changes.</p>

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

There is a high level of collaboration between the Board relevant community partners and its agencies around the evaluation of services. The Board has regular (monthly or every other month) meetings with its contract agencies and part of each meeting is a discussion around the evaluation of services. The Board, with agency input, has established a “Reporting Matrix”

whereby both the agencies and Board Staff are clear on what reports to the Boards are due by when and what goals/objectives are required.

Agencies are responsible, as indicated through the contracting process, to supply the Board with regular reports around all manner of ongoing contract compliance issues. The evaluation of services is thus a multifaceted discussion between the agencies and Board Staff and can include multiple reports. For example, when evaluating the contracted service of “Crisis Intervention” the agency and Board Staff evaluate the volume of services (actual versus projected), the outcome of those services, any consumer feedback that exists relevant to those services, the impact on State Hospitalizations targets and any staffing challenges that have impacted or might impact the delivery of the service and any additional information deemed relevant by the agency or Board Staff. This process is repeated for all contracted services.

For simplicity, contract agencies are primarily responsible for the collection of data needed to evaluate services, while Board Staff are primarily responsible to analyze the data for trends and patterns. The agencies and Board Staff collaboratively work to discuss the implications of the data gathered and analysis conducted. Relevant community stakeholders are brought into this process as needed and appropriate.

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

Please refer to the above chart for this response. The Chart lays out Goals, Objectives, Indicators/Measures and Progress definition that will enable the Board and its key stakeholders to track progress toward achieving identified goals.

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

Both written and verbal communication through individual, small and large group meetings will be utilized to communicate progress towards achievement of goals. The Board already has a robust schedule of meetings with contract agencies and community partners that will be utilized to good effect when communicating progress. Additionally, the Board regularly utilizes print media as a way to communicate progress towards goals/achievements.

Portfolio of Providers and Services Matrix

TABLE I: PORTFOLIO OF ALCOHOL AND DRUG SERVICES PROVIDERS

Prevention Strategy and Level of Care	a. Provider Name	b. Program Name (Provider Specific)	c. Population Served	d. Prevention Level (Prevention only)	e. Evidence-Based Practice (EBP)	f. Number of sites	g. Located outside of Board area	h. Funding Source (Check the box if yes)		i. MACSIS UPI
								ODADAS	Medicaid Only	
PREVENTION										
Information Dissemination	A.C.C.A.D.A.	SOS/TRAP	Elementary School	Universal	N/A	3	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	01010
Alternatives	A.C.C.A.D.A.	Teen Institute	Middle & High School	Universal	Teen Institute	5	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	01010
	Catholic Charities Services	Teen Mentoring Program	Middle & High School	Selected	N/A	1	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	12762
Education	A.C.C.A.D.A.	BABES/Wee Too Life Skills	Elementary School	Universal	N/A	2	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	01010
			Middle & High School	Universal	Life Skills	3	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Community-Based Process	A.C.C.A.D.A.	A.C.C.A.D.A.	Middle & High School	Universal	N/A	1	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	01010
Environmental							<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Problem Identification and Referral							<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
PRE-TREATMENT (Level 0.5)										
OUTPATIENT (Level 1)										
Outpatient	A.C.C.A.D.A.	Outpatient Assessment, Treatment Planning, Counseling & Case Management Services	Adults and Youth; Male and Female		-Motivational Interviewing; -M.A.T.(Bupreorphine); -Cognitive-Behavioral Therapy	1	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	01010
Intensive Outpatient							<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Day Treatment							<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
COMMUNITY RESIDENTIAL (Level 2)										
Non-Medical							<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Medical							<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
SUBACUTE (Level 3)										
Ambulatory Detoxification							<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
23 Hour Observation Bed							<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Sub-Acute Detoxification							<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
ACUTE HOSPITAL DETOXIFICATION (Level 4)										
Acute Detoxification							<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

TABLE 2: PORTFOLIO OF MENTAL HEALTH SERVICES PROVIDERS

Promising, Best, or Evidence-Based Practice	a. Provider(s) Name(s)	b. MACSIS UPI(s)	c. Number of Sites	d. Program Name	e. Funding Source (Check all that apply as funding source for practice)				f. Population Served	g. Estimated Number Served in SFY 2012	h. Estimated Number Planned for 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)	Appleseed CMHC	1882	1		Yes	Yes	Yes	No	Adult	25	30
Assertive Community Treatment (ACT)	Appleseed CMHC	1882	1		Yes	No	Yes	No	Adult	70	80
TF-CBT	Appleseed CMHC	1882	1		Yes	No	Yes	No	Adult & Youth	100	110
Multi-Systemic Therapy (MST)	Appleseed CMHC	1882	1		Yes	No	Yes	No	Youth	40	50
Functional Family Therapy (FFT)					Yes No	Yes No	Yes No	Yes No			
Supported Employment	Appleseed CMHC	1882	1		Yes	No	Yes	No	Adult	30	40
Supportive Housing	Appleseed CMHC	1882	3 sites/ 11 units		No	No	Yes	No	Adult	20	25
Wellness Management & Recovery (WMR)					Yes No	Yes No	Yes No	Yes No			
Red Flags	Appleseed CMHC	1882	3 classrooms		No	No	Yes	No	Youth	60-90	60-90
EMDR					Yes No	Yes No	Yes No	Yes No			
Crisis Intervention Training (CIT)	Board + Agencies + Community Partners		1 class trained		No	No	Yes	Yes	Adult	0	0
Therapeutic Foster Care					Yes No	Yes No	Yes No	Yes No			
Therapeutic Pre-School					Yes No	Yes No	Yes No	Yes No			
Transition Age Services					Yes No	Yes No	Yes No	Yes No			
Integrated Physical/Mental Health Svces					Yes No	Yes No	Yes No	Yes No			
Ohio's Expedited SSI Process					Yes No	Yes No	Yes No	Yes No			
Medicaid Buy-In for Workers with Disabilities					Yes No	Yes No	Yes No	Yes No			
Consumer Operated Service	Lifeworx!	N/A	1		No	No	Yes	No	Adult	25	35
Peer Support Services	Lifeworx!	N/A	1		No	No	Yes	No	Adult	25	35
MI/MR Specialized Services					Yes No	Yes No	Yes No	Yes No			
Consumer/Family Psycho-Education	NAMI	N/A	2 classes		No	No	Yes	Yes	Adult	25	25

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?
- 5) For SFY 2012 Number of Units & Beds for the Adults who are SPMI/SMI.

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

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

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

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

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

ODMH 2012 Community Plan Adult Housing Categories

Please answer each category for your SPMI/SMI population.

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.

(QUESTION 5)

Housing Categories	Definition	Examples	#SPMI/ SMI	# Units	# Beds
Crisis Care	Provision of short-term care to stabilize person experiencing psychiatric emergency. Offered as an alternative to inpatient psychiatric unit. Staff 24 hours' day/7 days a week. Treatment services are billed separately.	<ul style="list-style-type: none"> • Crisis Bed • Crisis Residential • Crisis Stabilization Unit 	N/A	N/A	N/A
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. <u>Type 1</u> : Room & Board; Personal Care; Mental Health Services <u>Type 2</u> : Room & Board; Personal Care <u>Type 3</u> : Room and Board	<ul style="list-style-type: none"> • Licensed as Type I, II or III (Residential Facility Care) • Residential Support • Supervised Group Living • Next-Step Housing from psychiatric hospital and/or prison 	N/A	N/A	N/A
ODH Licensed Residential Care	Includes room and board, and personal care 24/7 if specified in license. Rules in program or service agreement attached to housing are applicable. Treatment services are billed separately. Usually operator owned and staffed; provides 24-hour supervision in structured environment.	<ul style="list-style-type: none"> • Adult Care Facilities • Adult Family Homes • Group Homes 	Census Varies: @30 SPMI @10 SMI	3	11

Respite Care	Short-term living environment, it may or may not be 24-hour care. Reasons for this type of care are more environmental in nature. May provide supervision, services and accommodations. Treatment services are billed separately	<ul style="list-style-type: none"> Placement during absence of another caretaker where client usually resides Respite Care 	@25 SPMI @10 SMI	3	11
Temporary Housing	Non-hospital, time limited residential program with an expected length of occupancy and goals to transition to permanent housing. Includes room and board, with referral and access to treatment services that are billed separately.	<ul style="list-style-type: none"> Commonly referred to and intended as time-limited, short term living Transitional Housing Programs Homeless county residence currently receiving services Persons waiting for housing Boarding Homes YMCA/YWCA (not part of a supportive housing program) 	N/A	N/A	N/A
Board/Agency Owned Community Residence	Person living in an apartment where they entered into an agreement that is NOT covered by Ohio tenant landlord law. Rules in program or service agreement attached to housing. Refers to financial sponsorship and/or provision of some degree of on-site supervision for residents living in an apartment dwelling. Treatment services are billed separately.	<ul style="list-style-type: none"> Service Enriched Housing Apartments with non-clinical staff attached Supervised Apartments No leases: NOT covered by Ohio tenant landlord law 	N/A	N/A	N/A
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	<ul style="list-style-type: none"> HAP Housing as Housing Supervised Apartments Supportive Housing Person with Section 8 or Shelter Plus Care Voucher Tenant has lease <p>Supportive Services staff primary offices are on-site and their</p>	N/A	N/A	N/A

	may be a housing agency that provides housing to mental health consumers.)	primary function are to deliver supportive services on-site; these staff many accompany residents in the community to access resources.			
Permanent Supportive Housing (Subsidized Supportive Housing) with Supportive Services Available	Person living in an apartment where they entered into a lease with accordance to Ohio tenant landlord law or a mortgage and, in instances where ODMH allocated funds have been used, an exit strategy for the subsidy has been developed. Treatment services are billed separately. (The landlord may be a housing agency that provides housing to mental health consumers.)	<ul style="list-style-type: none"> • HAP • Housing as Housing • Supervised Apartments • Supportive Housing • Person with Section 8 or Shelter Plus Care Voucher • Tenant has lease • Supportive Services staff <u>primary offices</u> are <u>not on-site</u>; supportive serve staff may come on-site to deliver supportive services or deliver them off-site. (In this model a primary mental health CPST worker may be delivering the supportive services related to housing in addition to treatment services. 	Census Varies: @30 SPMI @10 SMI	3	11
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.	<ul style="list-style-type: none"> • Own home • Person with Section 8 Voucher (not Shelter Plus Care) • Adult with roommate with shared household expenses • Apartment without any public assistance • Housing in this model is not connected to the mental health system in any way. Anyone can apply for and obtain this housing. 	@30	Unk	Unk

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

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

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)

Additional ODMH Requirements (Formerly Community Plan – Part B)

Recently the Ohio Association of Community Behavioral Health Authorities (OACBHA) sent a letter to the Departments with regards to the timing of Community Plan – Part B information. Below is an excerpt:

“The Department’s letter dated November 10th, sites timelines provided in ORC 340.03 for the justification of the December 30, 2010 submission date of the Community Plan. Contrary to the December 30th date, under ORC 5119.62 Boards are given to May 1st of each year to elect to accept distribution of 408 funds. The SFY ’12-13 Community Plan Guidelines are requesting Boards to elect distribution of 408 funds without having knowledge of the per diem, their budget or the details of how bed day planning will be addressed. And, the request is being made prior to the statutory deadline.”

ODMH Staff has also communicated that the Department will be eliminating the SCUD. As previously communicated with ODMH staff, the Association continues to have concerns regarding this decision. The SCUD arrangement was part of the original 408 Settlement Agreement, and it was intended that any changes to this Agreement would occur collaboratively.”

Due to the reasons cited above, Ashland will submit the Part B materials with ORC 5119.62 and the Settlement Agreement in view.

Notification of Election of Distribution – SFY 2012 (Due: December 30, 2010)

The ASHLAND Alcohol, Drug Addiction and Mental Health Services Board or Community Mental Health Board has decided the following:

X The Board plans to elect distribution of ~~408~~/505 funds.

_____ The Board plans not to elect distribution of ~~408~~/505 funds

Signed:

Executive Director
Alcohol, Drug Addiction and Mental Health Services Board or
Community Mental Health Board

Date:

State Hospital Inpatient Days (Due: March 30, 2011)

BOARD NAME <u>Mental Health & Recovery Board of Ashland County</u>	
2012 Planned Use of State Hospital Inpatient Days By Hospital/Campus	
1. Heartland Behavioral Healthcare	462
Total All State Regional Psychiatric Hospitals Inpatient Days	462

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

Signed _____
ADAMH/CMH Board Executive Director

CSN Services

I anticipate renewing contracts for CSN services.

___ Yes, pursuant to Board Resolution dated ___ / ___ / 2011

X No

Board Membership Catalog for ADAMHS/CMHS Boards

Board Name		Date Prepared
Mental Health & Recovery Board of Ashland County		4-5-2010
Board Member Sylvia Adrian		<u>Appointment</u> ODMH
Mailing Address (street, city, state, zip) 112 N. Spring Street Loudonville, Ohio 44842		<u>Sex</u> F
Telephone (include area code) 419-994-3548 (Home) (740) 398-3628 (Cell)		<u>Ethnic Group</u> Caucasian
County of Residence Ashland		<u>Officer</u> _____
Occupation None		<u>Hispanic or Latino (of any race)</u>
Term 07/01/09 - 06/30/13 (first term)		<u>Representation: select all that apply:</u>
Year Term Expires 06/30/13		<u>Mental Health</u>
		<input type="checkbox"/> Consumer
		<input checked="" type="checkbox"/> Family Member
		<input type="checkbox"/> MH Professional
		<input type="checkbox"/> Psychiatrist
		<input type="checkbox"/> Other Physician
		<u>Alcohol Other Drug Addiction</u>
		<input type="checkbox"/> Consumer
		<input type="checkbox"/> Family Member
		<input type="checkbox"/> Professional
		<input type="checkbox"/> Advocate
Board Member Eva Beard		<u>Appointment</u> County
Mailing Address (street, city, state, zip) 853 Avalon Drive Ashland, Ohio 44805		<u>Sex</u> F
Telephone (include area code) 419-281-2290		<u>Ethnic Group</u> Caucasian
County of Residence Ashland		<u>Officer</u> _____
Occupation Retired		<u>Hispanic or Latino (of any race)</u>
Term 07/01/2010/ - 06/30/14 (first term)		<u>Representation: select all that apply:</u>
Year Term Expires 06/30/14		<u>Mental Health</u>
		<input type="checkbox"/> Consumer
		<input type="checkbox"/> Family Member
		<input type="checkbox"/> MH Professional
		<input type="checkbox"/> Psychiatrist
		<input type="checkbox"/> Other Physician
		<u>Alcohol Other Drug Addiction</u>
		<input type="checkbox"/> Consumer
		<input type="checkbox"/> Family Member
		<input type="checkbox"/> Professional
		<input type="checkbox"/> Advocate
Board Member Ryan Emmons		<u>Appointment</u> County
Mailing Address (street, city, state, zip) 702 Keen Ave. Ashland, Ohio 44805		<u>Sex</u> M
Telephone (include area code) 419-651-1765		<u>Ethnic Group</u> Caucasian
County of Residence Ashland		<u>Officer</u> _____
Occupation Whitaker Myers		<u>Hispanic or Latino (of any race)</u>
Term 07/01/08 - 06/30/12 (first term)		<u>Representation: select all that apply:</u>
Year Term Expires 06/30/12		<u>Mental Health</u>
		<input type="checkbox"/> Consumer
		<input type="checkbox"/> Family Member
		<input type="checkbox"/> MH Professional
		<input type="checkbox"/> Psychiatrist
		<input type="checkbox"/> Other Physician
		<u>Alcohol Other Drug Addiction</u>
		<input type="checkbox"/> Consumer
		<input type="checkbox"/> Family Member
		<input type="checkbox"/> Professional
		<input type="checkbox"/> Advocate
Board Member Ed Fulton		<u>Appointment</u> ODADAS
Mailing Address (street, city, state, zip) 940 Avalon Drive Ashland, Ohio 44805		<u>Sex</u> M
Telephone (include area code) 419-289-0780		<u>Ethnic Group</u> Caucasian
County of Residence Ashland		<u>Officer</u> _____
Occupation Retired		<u>Hispanic or Latino (of any race)</u>
		<u>Representation: select all that apply:</u>
		<u>Mental Health</u>
		<input type="checkbox"/> Consumer
		<input type="checkbox"/> Family Member
		<u>Alcohol Other Drug Addiction</u>
		X Consumer
		<input type="checkbox"/> Family Member

Term 07/01/08 – 06/30/12 (first term)	Year Term Expires 06/30/12	<input type="checkbox"/> MH Professional <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Other Physician	<input type="checkbox"/> Professional <input type="checkbox"/> Advocate
Board Member Tom Gaus		<u>Appointment</u> County	<u>Sex</u> M
Mailing Address (street, city, state, zip) 753 Co. Rd. 1775 Ashland, Ohio 44805		<u>Ethnic Group</u> Caucasian	
Telephone (include area code) 419-281-6805		<u>Officer</u> _____ <u>Hispanic or Latino (of any race)</u>	
County of Residence Ashland		Planning Committee Chairperson	
Occupation Retired		<u>Representation: select all that apply:</u>	
Term 07/01/10 – 06/30/14 (second term)		<u>Mental Health</u> <input type="checkbox"/> Consumer <input type="checkbox"/> Family Member <input type="checkbox"/> MH Professional <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Other Physician	<u>Alcohol Other Drug Addiction</u> <input type="checkbox"/> Consumer <input type="checkbox"/> Family Member <input type="checkbox"/> Professional <input type="checkbox"/> Advocate
Board Member Kimberly Harrison		<u>Appointment</u> County	<u>Sex</u> F
Mailing Address (street, city, state, zip) 142 Belle Ave. Ashland, Ohio 44805		<u>Ethnic Group</u> Caucasian	
Telephone (include area code) 419-289-3452 (Home) 419-289-1876 (Work)		<u>Officer</u> _____ <u>Hispanic or Latino (of any race)</u>	
County of Residence Ashland		Planning Committee Chairperson	
Occupation Counselor		<u>Representation: select all that apply:</u>	
Term 07/01/08 – 06/30/12 (first term)		<u>Mental Health</u> <input type="checkbox"/> Consumer <input type="checkbox"/> Family Member <input type="checkbox"/> MH Professional <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Other Physician	<u>Alcohol Other Drug Addiction</u> <input type="checkbox"/> Consumer <input type="checkbox"/> Family Member <input type="checkbox"/> Professional <input type="checkbox"/> Advocate
Board Member Mary Jones		<u>Appointment</u> County	<u>Sex</u> F
Mailing Address (street, city, state, zip) 488 U. S. Route 42 Ashland, Ohio 44805		<u>Ethnic Group</u> Caucasian	
Telephone (include area code) 419-651-3361 (Cell) 419-281-2888 (Home)		<u>Officer</u> _____ <u>Hispanic or Latino (of any race)</u>	
County of Residence Ashland		Chairperson	
Occupation None		<u>Representation: select all that apply:</u>	
Term 07/01/08 – 06/30/12 (first term)		<u>Mental Health</u> <input type="checkbox"/> Consumer <input type="checkbox"/> Family Member <input type="checkbox"/> MH Professional <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Other Physician	<u>Alcohol Other Drug Addiction</u> <input type="checkbox"/> Consumer <input type="checkbox"/> Family Member <input type="checkbox"/> Professional <input type="checkbox"/> Advocate
Board Member Pam Mowry		<u>Appointment</u> County	<u>Sex</u> F
Mailing Address (street, city, state, zip) 1675 Southwood Dr. Ashland, Ohio 44805		<u>Ethnic Group</u> Caucasian	
Telephone (include area code) 419-289-0480 (Home) 419-606-6508 (Cell)		<u>Officer</u> _____ <u>Hispanic or Latino (of any race)</u>	
County of Residence Ashland		Planning Committee Chairperson	
Occupation None		<u>Representation: select all that apply:</u>	
Term 07/01/10– 06/30/14 (second term)		<u>Mental Health</u> <input type="checkbox"/> Consumer <input type="checkbox"/> Family Member <input type="checkbox"/> MH Professional <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Other Physician	<u>Alcohol Other Drug Addiction</u> <input type="checkbox"/> Consumer <input type="checkbox"/> Family Member <input type="checkbox"/> Professional <input type="checkbox"/> Advocate

Board Member Rebecca Owens		<u>Appointment</u> County	<u>Sex</u> F	<u>Ethnic Group</u> Caucasian
Mailing Address (street, city, state, zip) 1913 Co. Rd. 655 Ashland, Ohio 44805		<u>Officer</u> _____ <u>Hispanic or Latino (of any race)</u>		
Telephone (include area code) 419-368-3084 (Home) 419-524-0733 (Work)		<u>Representation: select all that apply:</u>		
County of Residence Ashland	<u>Mental Health</u>		<u>Alcohol Other Drug Addiction</u>	
Occupation Richland County Catholic Charities	<input type="checkbox"/> Consumer		<input type="checkbox"/> Consumer	
Term 07/01/10 – 06/30/14 (second term)	Year Term Expires 06/30/14	<input type="checkbox"/> Family Member		<input type="checkbox"/> Family Member
		<input type="checkbox"/> MH Professional		<input type="checkbox"/> Professional
		<input type="checkbox"/> Psychiatrist		<input type="checkbox"/> Advocate
		<input type="checkbox"/> Other Physician		
Board Member Shari Shafer		<u>Appointment</u> ODADAS	<u>Sex</u> F	<u>Ethnic Group</u> Caucasian
Mailing Address (street, city, state, zip) 711 Hillcrest Dr. Ashland, Ohio 44805		<u>Officer</u> _____ <u>Hispanic or Latino (of any race)</u>		
Telephone (include area code) 419-289-3571		<u>Representation: select all that apply:</u>		
County of Residence Ashland	<u>Mental Health</u>		<u>Alcohol Other Drug Addiction</u>	
Occupation Teacher	<input type="checkbox"/> Consumer		<input type="checkbox"/> Consumer	
Term 07/01/10 – 06/30/14 (second term)	Year Term Expires 06/30/14	<input type="checkbox"/> Family Member		X Family Member
		<input type="checkbox"/> MH Professional		<input type="checkbox"/> Professional
		<input type="checkbox"/> Psychiatrist		<input type="checkbox"/> Advocate
		<input type="checkbox"/> Other Physician		
Board Member Diana Spore		<u>Appointment</u> ODMH	<u>Sex</u> F	<u>Ethnic Group</u> Caucasian
Mailing Address (street, city, state, zip) 849 W. Main Street Ashland, Ohio 44805		<u>Officer</u> _____ <u>Hispanic or Latino (of any race)</u>		
Telephone (include area code) 419-289-1107		<u>Representation: select all that apply:</u>		
County of Residence Ashland	<u>Mental Health</u>		<u>Alcohol Other Drug Addiction</u>	
Occupation None	<input checked="" type="checkbox"/> Consumer		<input type="checkbox"/> Consumer	
Term 07/01/10– 06/30/14 (first term)	Year Term Expires 06/30/14	<input type="checkbox"/> Family Member		<input type="checkbox"/> Family Member
		<input type="checkbox"/> MH Professional		<input type="checkbox"/> Professional
		<input type="checkbox"/> Psychiatrist		X Advocate
		<input type="checkbox"/> Other Physician		
Board Member Gail Sweet		<u>Appointment</u> ODADAS	<u>Sex</u> F	<u>Ethnic Group</u> Caucasian
Mailing Address (street, city, state, zip) 177 Ronald Ave. Ashland, Ohio 44805		<u>Officer</u> _____ <u>Hispanic or Latino (of any race)</u>		
Telephone (include area code) 419-496-2274		<u>Representation: select all that apply:</u>		
County of Residence Ashland	<u>Mental Health</u>		<u>Alcohol Other Drug Addiction</u>	
Occupation Retired	<input type="checkbox"/> Consumer		<input type="checkbox"/> Consumer	
Term 07/01/09- 06/30/13 (second term)	Year Term Expires 06/30/13	<input type="checkbox"/> Family Member		<input type="checkbox"/> Family Member
		<input type="checkbox"/> MH Professional		<input type="checkbox"/> Professional
		<input type="checkbox"/> Psychiatrist		X Advocate
		<input type="checkbox"/> Other Physician		

Board Member Nancy Udolph		<u>Appointment</u> County	<u>Sex</u> F	<u>Ethnic Group</u> Caucasian
Mailing Address (street, city, state, zip) 1227 Eastbrook Dr. Ashland, Ohio 44805		<u>Officer</u> _____ <u>Hispanic or Latino (of any race)</u>		
Telephone (include area code) 419-289-2508		County of Residence Ashland		
Occupation Social Work Department at Ashland University		<u>Representation: select all that apply:</u>		
Term 07/01/09 -06/30/13 (first term)	Year Term Expires 06/30/13	<u>Mental Health</u> <input type="checkbox"/> Consumer <input type="checkbox"/> Family Member <input type="checkbox"/> MH Professional <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Other Physician	<u>Alcohol Other Drug Addiction</u> <input type="checkbox"/> Consumer <input type="checkbox"/> Family Member <input type="checkbox"/> Professional <input type="checkbox"/> Advocate	
Board Member Jenny Whitmore		<u>Appointment</u> County	<u>Sex</u> F	<u>Ethnic Group</u> Caucasian
Mailing Address (street, city, state, zip) 1227 Fairway Drive Ashland, Ohio 44805		<u>Officer</u> _____ <u>Hispanic or Latino (of any race)</u>		
Telephone (include area code) 419-281-1012 (Home) 419-281-3681 (Work)		County of Residence Ashland		
Occupation Property Manager		<u>Representation: select all that apply:</u>		
Term 07/01/10- 06/30/14 (first term)	Year Term Expires 06/30/14	<u>Mental Health</u> <input type="checkbox"/> Consumer <input type="checkbox"/> Family Member <input type="checkbox"/> MH Professional <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Other Physician	<u>Alcohol Other Drug Addiction</u> <input type="checkbox"/> Consumer <input type="checkbox"/> Family Member <input type="checkbox"/> Professional <input type="checkbox"/> Advocate	
Board Member Barbara Workman		<u>Appointment</u> ODADAS	<u>Sex</u> F	<u>Ethnic Group</u> Caucasian
Mailing Address (street, city, state, zip) 1022 Twp. Rd. 984 Ashland, Ohio 44805		<u>Officer</u> _____ <u>Hispanic or Latino (of any race)</u>		
Telephone (include area code) 419-289-3900 (Home)		County of Residence Ashland		
Occupation Samaritan Hospital Emergency Room		<u>Representation: select all that apply:</u>		
Term 07/25/07- 06/30/11 (first term)	Year Term Expires 06/30/11	<u>Mental Health</u> <input type="checkbox"/> Consumer <input type="checkbox"/> Family Member <input type="checkbox"/> MH Professional <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Other Physician	<u>Alcohol Other Drug Addiction</u> <input type="checkbox"/> Consumer <input type="checkbox"/> Family Member <input checked="" type="checkbox"/> Professional <input type="checkbox"/> Advocate	
Board Member Mike White		<u>Appointment</u> County	<u>Sex</u> M	<u>Ethnic Group</u> Caucasian
Mailing Address (street, city, state, zip) 1193 CR 620 Ashland, Ohio 44805		<u>Officer</u> _____ <u>Hispanic or Latino (of any race)</u>		
Telephone (include area code) 419-962-4959 (Home)		County of Residence Ashland		
Occupation Retired		<u>Representation: select all that apply:</u>		
Term 07/01/10- 06/30/14 (first term)	Year Term Expires 06/30/14	<u>Mental Health</u> <input type="checkbox"/> Consumer <input type="checkbox"/> Family Member <input type="checkbox"/> MH Professional <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Other Physician	<u>Alcohol Other Drug Addiction</u> <input type="checkbox"/> Consumer <input type="checkbox"/> Family Member <input type="checkbox"/> Professional <input type="checkbox"/> Advocate	

Board Forensic Monitor and Community Linkage Contacts

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

Name	Street Address	City	Zip	Phone Number	Email
Patty Abel	2233 Rocky Lane	Ashland	44805	419-281-3716	pattyabe@appleseedcmhc.org

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

Name	Street Address	City	Zip	Phone Number	Email
Patty Abel	2233 Rocky Lane	Ashland	44805	419-281-3716	pattyabe@appleseedcmhc.org

INSERT ADDITIONAL BOARD APPENDICES AS NEEDED