Enter Board Name: <u>Mental Health & Recovery Board of Ashland County</u>

NOTE: OhioMHAS is particularly interested in areas identified as priorities for RecoveryOhio, including: (1) access and capacity changes for mental health and addiction services for both adults and children/youth; (2) health equity concerns for racial and ethnic minorities and people living in Appalachia or rural Ohio; (3) distinctive challenges for multisystem youth, families involved in child welfare, and for criminal justice-involved Ohioans; (4) prevention and/or decrease of opiate overdoses and/or deaths; and/or (5) suicide prevention.

Environmental Context of the Plan/Current Status

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1. Describe the economic, social, and demographic factors in the board area that influence service delivery.   Note: With regard to current environmental context, boards may describe the impact of Behavioral Health Redesign including Medicaid Managed Care carve-in.

Economic Factors:
*Ashland County is a rural county, designated as an Appalachian County, by the federal government. Approximately **20%** of Ashland County residents were below the poverty line, according to the 2012-2016 American Community Survey – 5-year estimates. Ashland County generally reflects the improved economy experienced throughout the state and nation. There has been an increase in businesses locating to the county's business park and several small startups have been experienced and are infusing new life to the downtown corridor. U.S. Department of Labor statistics indicate Ashland County's unemployment rate has changed from **5.9%** in March of 2016 to **3.2%** in April of 2019. This change reflects a 45.7% **decrease** in the local unemployment rate.*

Social & Demographic Factors:
*U.S. Census population estimates from 2018 indicate a population of **53,745**. 18.7% are 65 years are older, 22.5% are under 18 years or age, 50.8% are female, 96.7% are White and 1.5% report Hispanic or Latino heritage. 88.4% report high school graduation or higher with 20.2% reporting Bachelor's degree or higher. 9.2% of persons under age 65 report a disability. Median household income is $50,893 with 11.4% meeting the poverty thresholds (some variation from the American Community Survey above).*

BH Redesign & Medicaid Managed Care Carve-in:

All three of the Board's contract agencies reported significant challenges with both BH Redesign and the Carve-in of BH Medicaid to Managed Care. Below are summary bullets based on over two years of discussions with the agencies on these two issues:
  * *Speed of implementation. Years of having a stable and predictable system (services, rates, funders and reimbursement) was disrupted with a relatively short time to ramp up and adapt to a new model of community behavioral health;*

- *Cashflow. All three agencies struggled to properly bill and receive timely payments for services rendered. Cash reserves long thought sufficient were depleted.*
- *Electronic Health Record Implementation. All three agencies had to secure a vendor, purchase and implement an EHR at the same time of Redesign & Managed Care.*
- *BH Redesign significantly impacted critical services. The following services were listed as having been negatively impacted by redesign: Psychiatry, Diagnostic Assessment, Case Management, Nursing, Counseling and Crisis Intervention.*
- *Workforce shortages. All three agencies indicated a shortage of skilled applicants to fill newly created or vacant positions.*
- *MACSIS Replacement. When OhioMHAS made the decision to sunset MACSIS, they elected not to replace it with another state-wide billing system for non-MCD claims. This was likely an error. As a result, Boards were responsible in standing up a new claims adjudication system for the counties under their responsibility. Therefore, in addition to working with each of the managed care companies for billing/payment as well as MITS, they had to negotiate yet another system for non-MCD claims.*

Time will tell whether major or minor changes are needed in how the State moves forward with community behavioral health. ODM Director Corcoran said recently that, "all options are on the table."

Assessing Needs and Identifying Gaps

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2. Describe needs assessment findings (formal & informal), including a brief description of methodology. Please include access issues, gaps in services and disparities, if any.

   a. Needs Assessment Methodology: Describe how the board engaged local and regional planning and funding bodies, relevant ethnic organizations, providers and people living with or recovering from mental illness and addiction in assessing needs, evaluating strengths and challenges and setting priorities for treatment and prevention in SFY 2019. [ORC 340.03 (A)(1)(a)]. Describe the board's plan for on-going needs assessment in SFY 2020 if they differ from this current fiscal year.

   The Ashland Board continues to feel strongly that they are in best position to know the needs of the local community. The primary methodology utilized consisted of both formal assessment/outcomes results as well as participant/consumer feedback and various community collaborations (partner meetings.) Board staff are involved with multiple community/regional collaboratives in an effort to continually assess the behavioral needs of the county. Additionally, the Board's "Outcomes-Satisfaction Survey" process is one mechanism the Board uses to collect needs information directly from those participating in behavioral health services. The Board has regular meetings (monthly) with its provider partners and both use the opportunity to discuss current/emerging needs as well as solutions to those needs. The Board, in partnership with the County-City Health Department and Hospital participated in a community-wide needs assessment. The Board, along with its partners contracted with the Hospital Council of Northwest Ohio (HCNO) to conduct the survey and guide the CHIP process. Survey data is being used to inform this community plan process as well as MHRB planning for the next 1-4 fiscal years (SFY 20-23).

b. Describe how the board collaborated with local health departments and their 2019 State Health Improvement Process. In your response, please include, if applicable, the following: 1) collaborative efforts specific to assessing needs and gaps and setting priorities. 2) barriers or challenges the board believes will have to be overcome moving forward that will result in complimentary public health and behavioral health plans, 3) advantages, if any, realized to date with collaborative planning efforts, 4) next steps your board plans on undertaking to further alignment of public health and behavioral health community planning.

SFY 2019 saw the Board partner with the local health department and hospital to be part of a community-wide health assessment (CHA) and community health improvement plan (CHIP) process.

1) *– Our contracted consultant, Hospital Council of Northwest Ohio (HCNO), utilized the Mobilizing Action for Planning and Partnerships (MAPP) framework to take the findings from the community health assessment (needs) and develop prioritized strategies to fill identified gaps. A summary document of the process utilized, including the six phases, can be found HERE.*

2) *– Barriers or challenges primarily have to do with mutual education. The Board and community behavioral health system educating public health on our vision, mission, goals and public health, including the local hospital system, doing the same with the Board and community behavior health system. Another challenge identified was getting sufficient buy-in from local school districts for the youth survey. There was considerable effort expended in agreeing on an approved survey with questions acceptable to all parties.*

3) *– An advantage Ashland County has that other counties may not, is the Board's adoption and embrace of the Adverse Childhood Experiences study. The findings of the study provide a "common-ground" that all systems can use in conceptualizing primary/behavioral health. There is no more powerful "cross-cutting" measures than those identified by the ACEs research, namely, trauma. The Board has been able to make the point to the Health Department, Hospital and other CHIP partners about the critical importance of ACEs. In fact, ACEs training to this group has already started!*

4) *– The next steps involve finalizing the CHIP for data based on the adult CHA and going through the same process with the youth CHA data to arrive at a CHIP that includes both adults and youth. We will outline action steps related to putting the CHIP into action and follow-up meetings to gauge progress made towards identified strategy implementation and key metrics. Additionally, the Board, Health Department and UH-Samaritan Hospital will meet to review HCNO's performance and whether to use them going forward for future CHA/CHIP activities.*

c. Child service needs resulting from finalized dispute resolution with Family and Children First Council [340.03(A)(1)(c)].

The Board has a good working relationship with our local FCFC. We recently partnered with the FCFC, JFS/CS and local provider agencies to apply for the "Strong Families-Safe Communities" regional funding opportunity. The Coordinator is still relatively new (and part-time) but is working hard to fulfill both state and local expectations. The Board works with FCFC and any behavioral health child service needs resulting from finalized dispute resolution with the Council. This is not something that happens with any regularity (low need).

d. Outpatient service needs of persons currently receiving treatment in State Regional Psychiatric Hospitals [340.03(A)(1)(c)].

The Board and its primary contract agency (Appleseed) have a good working relationship with our Regional Psychiatric Hospital (HBH). Staff at the Board and Appleseed regularly participate in monthly conference calls with HBH regarding admission and discharge concerns. The only articulated outpatient need expressed by HBH is the availability of 24/7 staffed group homes. This need is met utilizing existing housing resources with intensive off-site services and supports and very limited 24/7 Adult Care Facility placements. New since our last community plan was the Board's addition of a Hospital-Community Liaison. The Liaison works closely with Ashland admissions at HBH and private hospitals, hospital staff, family, and community services to ensure continuity of care and reduced chance of re-hospitalization. The Liaison is able to advocate for persons at HBH via individual/team meetings. Hospital Bed Day utilization has remained stable as well as re-hospitalizations in spite of significant capacity issues at HBH due to a psychiatric shortage (closed civil unit).

e. Service and support needs determined by Board Recovery Oriented System of Care (ROSC) assessments.

The Ashland Board adopted a guiding document in 2014 entitled, "The Three Legs of the Stool." This document was recently revised and expanded and released as, "Our Human Community." While the Board is largely supportive of the ROSC initiative, the Three Legs approach is, in our view, far more robust than ROSC. For example, while ROSC stresses the importance of recovery within a community the Three Legs approach goes beyond this to challenge the prevailing view of "mental illnesses" as biologically based and best addressed using a "medical model." Additionally, the Three Legs approach is very concerned with the impacts of Trauma in childhood and throughout the lifespan and the effects of trauma to behavioral and primary health so clearly shown through the ACE Study research. Utilizing the Three Legs approach service and support needs are as follows:

- *Increased Hospital Diversion Options in/close to Ashland County. Options that are consistent with the Three Legs (e.g., Living Room Model) would be ideal in reducing the need for state and private hospitalizations. Additionally, the re-traumatization that often occurs because of hospitalization can be avoided. The "acid-test" for any community/organization*

claiming to be "Trauma-Informed" is in the way in which they treat people experiencing a crisis event;

- *Increased access to physician's familiar and comfortable working with persons to reduce their psychiatric medications in a medically appropriate way. As we continue to learn more about the devastating developmental and iatrogenic effects of psychotropic drugs, options must exist to assist those individuals who want to responsibly [taper off](#) their prescribed medications; and*
- *Increased support to Peer Support and Peer-Operated Services. The Ashland Board has funded a Peer-Operated/Peer-Directed organization for over ten years. The amount of funding/administrative/developmental support from the state has been minimal in that time. We would like to seed a recommitment to these services with OhioMHAS leadership and support helping to facilitate: quality training of those wanting to be a Peer Supporter, ongoing training to those who will be supervising Peer Supporters, and a framework that draws from both Shery Mead's [Intentional Peer Support](#) and Mental Health America's [Center for Peer Support](#).*

f. Needs and gaps in facilities, services and supports given the Continuum of Care definitions found in the Ohio Revised Code [ORC 340.03(A)(1)].

As discussed previously, locally identified needs, priorities, and resources do not always align with continuum of care and other state requirements, and priorities. Our Board, like many others, has resource concerns (staffing and funding) that further complicate compliance with the Continuum mandate. Specific gaps vis-à-vis the Continuum of Care are as follows:

- *Ambulatory Detox (OAC 3793:2-1-08(X)) – The Board and its partners, including persons served, have not identified this service as a need. **We are requesting a waiver** from providing this service within the Board area. We ask that those persons who may have need of this service be referred to the service in the closest accessible Board area.*
- *Intensive Outpatient Service (OAC 3793:2-1-08(Q)) – The Board, in discussions with the county's only certified addictions agency, has determined that there is not a "critical mass" of service participants (clients) that are both eligible and available for this service. Bear in mind that Ashland County does not currently have any specialty dockets (Drug Court, etc.) that would naturally be a source of referrals for IOP. This may change in SFY 2020 however. The Board is **requesting a waiver** from providing this service within the Board area. We would like the flexibility of referring those few eligible & available service participants to the closest Board area where the service is accessible.*

g. Needs and gaps associated with priorities of the Executive Budget for 2020-2021 including crisis services, criminal justice-involved populations, families involved with child welfare, and prevention/early intervention across the lifespan.

General speaking, the Governor's Executive Budget showed significant support for Boards and their roles and responsibilities to plan, fund, manage and evaluate the local behavioral health system. Regional Mental Health Crisis Stabilization and Substance Abuse Stabilization funding is appreciated. A potential need will be for those funds to be flexible with regards to drug specificity ("addiction" versus "opioid addiction") and moving between the two categories. For example, Medicaid reimbursement has helped to meet the needs for detox. Boards in the region

having the flexibility to move funds from Substance Abuse Stabilization to Mental Health Crisis Stabilization as needed would be appreciated and assure the entire line is expended.
Of particular interest to Ashland County is the funding in ALI 336643 to expand crisis service infrastructure and provide flexible resources for local crisis stabilization and crisis prevention efforts. As mentioned, the Board would like to partner with local and possible regional entities to pilot a non-hospital-based crisis respite center using a model like "the Living Room model." We are hopeful that these funds could help meet a local need for crisis services.

Our local jail has been over capacity for several months with no end in sight. It's not uncommon for inmates to be struggling with behavioral issues and given the capacity issues, more inmates are being to the State hospital rather than managed at the jail. The Behavioral Health-Criminal Justice Linkage funding combined with federal SOR and local levy has allowed the Board to invest in robust behavioral services at our local jail. This is a high need and we are hopeful these funds continue to be part of the Governor's Executive Budget.

Getting "upstream" is important to the Board in Ashland County. As a result, funding for K-12 prevention (ALI 336623) and behavioral health treatment (ALI 200625) are high needs.

Finally, due in part to the opioid epidemic, Ashland County has one of the highest rates of youth in the custody of children services in Ohio. 176 youth were in custody as of June, 2019.

	# in Custody	**Child Population**	**Rate per 1,000**
Ashland	176	12,554	14.0
Ohio	15,928	2,601,997	6.1

Consequently, the number of youth in kinship/foster care has grown dramatically. Our county has a tremendous need for funding that will support these kinship/foster families, assists in recruiting additional foster families, provides adequate funding to children services, and supports programs like Ohio START (Sobriety, Treatment, and Reducing Trauma).

3. Complete Table 1: Inventory of Facilities, Services and Supports Currently Available to Residents of the Board Area. (Table 1 is an Excel spreadsheet accompanying this document. Instructions are found on page 10 of the Guidelines).

   COMPLETED

4. Considering the board's understanding of local needs, the strengths and challenges of the local system, what has the board set as its priorities for service delivery including treatment and prevention? Please be specific about strategies for adults; children, youth, and families; and populations with health equity and diversity needs in your community.

   Below is a table that provides federal and state priorities. Please complete the requested information <u>only</u> for those federal and state priorities that are the same as the board's priorities and add the board's unique priorities in the section provided. For those federal and state priorities that are not selected by the board, please check one of the reasons provided or briefly describe the applicable reason in the last column.

   Please address goals and strategies for any gaps in the Ohio Revised Code required service array identified in the board's response to question 2.d. in the "Assessment of Need and Identification of Gaps and Disparities" section of the Community Plan [ORC 340.03(A)(11) and 340.033].

   Priorities undertaken in SFY 2019 that the board is continuing into 2020 as well as new priority areas identified for SFY 2020 may be included.

Priorities for (Mental Health & Recovery Board of Ashland County)				
Substance Abuse & Mental Health Block Grant Priorities				
Priorities	Goals	Strategies	Measurement	Reason for not selecting
SAPT-BG: Mandatory (for OhioMHAS): Persons who are intravenous/injection drug users (IDU)	Prioritized due to the rise in opiate addiction in the county (consists of rapid intake and referral to physician)	Education and Harm Reduction addressed as part of treatment	Track patient specific education at local hospital Use of flexible funding # of IV drug users	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):
SAPT-BG: Mandatory (for boards): Women who are pregnant and have a substance use disorder (NOTE:ORC 5119.17 required priority)	Prioritized for treatment when they present	To ensure that Women who are pregnant with substance use disorders are seen first	Track the number of women seeking services and the time from initial contact to treatment	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):
SAPT-BG: Mandatory (for boards): Parents with SUDs who have dependent children (NOTE: ORC 340.03 (A)(1)(b) & 340.15 required consultation with County Commissioners and required service priority for children at risk of parental neglect/abuse due to SUDs)	Prioritized for treatment when they present	Continue to work with the Commissioners (via JFS-Children Services) and the Family and Children First Council to ensure those parents with substance abuse disorders and dependent children are prioritized	Track the number of men/women seeking services and the time from initial contact to treatment Track the number of youth/families referred to ACCADA for treatment vs. how many present for treatment	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):
SAPT-BG: Mandatory (for OhioMHAS): Individuals with tuberculosis and other communicable diseases (e.g., AIDS.HIV, Hepatitis C, etc.)				**X** No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):
MH-BG: Mandatory (for OhioMHAS): Children with Serious Emotional Disturbances (SED)	The Board intends to continue to provide a full continuum of Behavioral Health Services for persons diagnosed as SED including: Diagnostic Assessment, Counseling, CPST, and Pharm Mgt services	Utilize existing/emerging contract agencies for the provision of services	Utilize the MHISP (Adult) and YSS-F (Youth) measures to gauge system level consumer outcomes and satisfaction Utilize SmartCare (Non-MCD)/Medicaid data to verify amount, duration type and frequency of services	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):
MH-BG: Mandatory (for OhioMHAS): Adults with Serious Mental Illness (SMI)	The Board intends to continue to provide a full continuum of Behavioral Health Services for persons diagnosed as SMD including: Diagnostic Assessment, Counseling, CPST, and Pharm Mgt services	Utilize existing/emerging contract agencies for the provision of services	Utilize the MHISP (Adult) and YSS-F (Youth) measures to gauge system level consumer outcomes and satisfaction Utilize SmartCare (Non-MCD)/Medicaid data to verify amount, duration type and frequency of services	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):

MH-Treatment: Homeless persons and persons with mental illness and/or addiction in need of supportive housing	Continue to support efforts to provide stable housing to at-risk or homeless persons with mental health or addiction concerns	Provide rental subsidy funding to assist Appleseed housing efforts. Active in Homeless Coalition. Providing Support to ACCESS Homelessness Program Consider whether establishment of a Housing Authority and/or Landbank would be useful.	# of Persons Assisted # of Persons maintaining residence	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):
MH-Treatment: Older Adults	The Board continues to prioritize this population to assist in reducing BH challenges as well as risk of suicide, abuse, neglect and exploitation	Long-standing "Older Adults Behavioral Health Coalition" is the primary mechanism to achieve the Board's goals.	# of Initiatives consistent with Goals; # of Older Adults impacted by Initiatives;	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe)

Additional Priorities Consistent with SAMHSA Strategic Plan and Reported in Block Grant				
Priorities	Goals	Strategies	Measurement	Reason for not selecting
MH/SUD Treatment in Criminal Justice system –in jails, prisons, courts, assisted outpatient treatment	Engage persons in AoD education, prevention and treatment while at the Jail and prepare for ongoing services at discharge	Fully utilize Board plus State Grant funding to provide BH Treatment and Education services both at the Jail and linkage services when persons are released	-Reduction in recidivism; -Reduction in Re-hospitalizations; -Increase in Stable Housing, Employment and/or Education; and -Increase in BH follow-up services	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe
Integration of behavioral health and primary care services	Begin to integrate primary and behavioral health within the county by partnering with local hospital and physician offices	Imbed BH workers in primary care settings for screening/assessment referral and treatment.	-Number of offices where imbedded workers are; and -Number of referrals received from PCP	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):
Recovery support services for individuals with mental illness or substance use disorders; (e.g. housing, employment, peer support, transportation)	Continue to encourage more local persons to be certified as Peer Recovery Supporters as well as targeted investments in Recovery Supports	-Continue to develop Consumer Operated Services to increase number of Certified Peer Recovery Supporters -Continue to work with providers around programming to address housing, employment and transportation challenges	-Number of Certified Peer Supporters in the county; -Number of CPS' employed by agencies/working in the county; -Number of homeless BH population; -Number of persons in IPS/SE program	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):
Promote health equity and reduce disparities across populations (e.g. racial, ethnic & linguistic minorities, LGBT)				__ No assessed local need __ Lack of funds __ Workforce shortage **X** Other (describe): current need is too small to be considered a priority

Prevention and/or decrease of opiate overdoses and/or deaths	Increase opiate prevention and positively impact the number of persons overdosing/dying from opioids.	Utilize community task force and certified prevention agency to achieve goals.	-Increased number of prevention activities around opioid overdose/death; -Increase number of educational opportunities on the issue; -Increased availability of NARCAN in the community	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe
Promote Trauma Informed Care approach	High priority of the Board to cultivate a trauma-informed philosophy and approach to programs and services	-Establish a TIC steering committee to guide relevant activities; -Provide education and awareness to agencies and community at large; -Provide professional development training	-Training Participant Evaluations -TIC Reflected in agency plans -TIC Services offered -TIC reflected in client records	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe
Ambulatory Detox (OAC 3793:2-1-08(X)) **Continuum of Care Mandate**	Work with ODMHAS, OACBHA and Legislature to allow for Boards to utilize "waiver" process where indicated	-After consulting with the provider and other community partners it was determined that this service type is not currently needed	-The waiver would allow a county resident to receive the service in another Board area where it's accessible (i.e., removing the mandate that the service must occur within the Board area")	
Intensive Outpatient Bundled/Unbundled (OAC 3793:2-1-08(Q)) **Continuum of Care Mandate**	Work with ODMHAS, OACBHA and Legislature to allow for Boards to utilize "waiver" process where indicated	-After consulting with the provider and other community partners it was determined that there was an insufficient number of eligible and available persons to start this service	-The waiver would allow a county resident to receive the service in another Board area where it's accessible (i.e., removing the mandate that the service must occur within the Board area")	
Prevention Priorities				
Priorities	Goals	Strategies	Measurement	Reason for not selecting
Prevention: Ensure prevention services are available across the lifespan	Continue Prevention Services for MH and ATOD for school-based youth. Increase Community-Based MH and ATOD Prevention in the county	-Continue to provide Classroom-Based MH and ATOD Prevention; -Increase Community-Based MH and ATOD Prevention efforts	-Number of classrooms where MH and ATOD Prevention are occurring; -Number of students involved in MH and ATOD Prevention programming; -Number of Community-Based MH and ATOD Prevention programs and persons attending	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):
Prevention: Increase access to evidence-based prevention	Continue to prioritize funding to those prevention programs supported by scientific evidence	Utilize registry's like NREPP to verify evidence of programs	-Number of prevention programs offered that are included in NREPP	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):

Prevention: Suicide prevention	Ongoing priority to increase community awareness and prevention of persons who may be considering suicide	Continue county-wide Suicide Prevention rollout using the Question Persuade Refer (QPR) model as well as Postvention support group for those affected by suicide	-Number of QPR presentations and number attending -Number of Postvention groups held and number attending -Rate of Suicides in the County as recorded by the county's coroner	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):
Prevention: Integrate Problem Gambling Prevention & Screening Strategies in Community and Healthcare Organizations				_X_ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):

Board Local System Priorities (add as many rows as needed)			
Priorities	Goals	Strategies	Measurement
Jail Based AoD Programming	Engage persons in AoD education, prevention and treatment while at the Jail and prepare for ongoing services at discharge.	• Effective screening for opioids and other substance use disorders of all inmates • Regular education groups about drugs and alcohol offered at the jail • Incorporate goals of CURES/SOR programs	-Number of screens -Number of groups and persons attending -Success in drawing down CURES/SOR funding
School-Community Liaison Programming	Engage youth/families/school staff to reduce/prevent behavioral, emotional & academic challenges.	• Continue the School-Community Liaison Program in the county in partnership with the schools and Appleseed	-Number of referrals made & follow thru rate; -Percent Improvement in Academic Performance, Behavioral & Attendance
Multi-Generational Mentoring Programming	Bring together at-risk youth and seniors in a program that benefits the mental & emotional health of both.	• Continue the MGM Program at the Golden Center thru partnership with Catholic Charities	-Number of youth/mentors involved in the program and completing
Supported Employment	Assist persons diagnosed with severe emotional distress with competitive employment and/or meaningful activity.	• Continue/enhance IPS/S.E. Programming at Appleseed Community Mental Health Center	-Number of participants employed pt/ft or involved in school/volunteer activities
Housing for Homeless	Assist persons diagnosed with severe emotional distress in securing and maintaining housing as part of an overall recovery plan.	• Utilize local Homeless Coalition to maximize all available housing options	-Time between homelessness and secured housing -Number of successful Metro Vouchers utilized
Suicide Prevention	Increase community awareness and prevention of persons who may be considering suicide utilizing the local Suicide Prevention Coalition (QPR Trainings; Awareness Walk; Griever's Group; Resource Packets, etc.)	• Continue to offer Question Persuade Refer (QPR) gatekeeper training to the community • Promote Suicide Prevention and Awareness county-wide	-Number of QPR trainings and persons trained -Number of persons at Suicide Prevention & Awareness Walk

			-Number attending bi-annual Suicide Prevention Coalition Meetings -Number of Suicide Resource Packs distributed -Number of persons attending Suicide Grievers Support Group
Alternatives to Medication-Based "ADHD" Programming	Work with parents/youth with behavioral challenges find alternatives to medication-based approaches.	• Continue to fund/evaluate ADHD Alternative programming	-Number of youth/adults in showing improving grades, attendance and behavior at school
Intensive Home-Based Treatment	Work with emotionally distressed youth and families to improve socio-emotional health and functioning using evidenced based approached like I-FAST.	• Continue to utilize I-FAST with at-risk multi-system youth	-Number of referrals from CS/JFS to IFAST -Number of youth/involved families with successful CS outcomes (reunification; non-removal, etc.)
Peer Led & Peer Directed Services	Support programming that assists adults in recovery from Mental Health/Alcohol/Other Drugs achieve their goals through Peer Services/Supports.	• Support and fund peer directed services	-Number of participants attending peer-directed program activities (groups, etc.)
Integrated Healthcare Coordinator Activities	Assist persons with/without severe emotional distress who need assistance in connecting with local supports/helps.	• Continue contract with CCS to fund this program • Imbed BH workers in primary care or primary care workers in BH settings for screening/assessment, referral and treatment	-Number of persons diverted from higher levels of care and/or formal systems not needed if natural supports accessed -Number of offices where imbedded workers exist; -Number of referrals by imbedded workers
Trauma-Informed Care (TIC)	Cultivate a trauma-informed philosophy and approach to programs and services.	• Continue to provide TIC and ACE trainings throughout the county	-Number of TIC trainings and persons attending -Number of ACE/Resilience trainings and persons attending
Recovery Housing	Continue to strengthen and support local Recovery Housing consistent with HB 483.	• First Recovery House established in SFY 16 • Identify sufficiency of having one house or need for additional.	-Census (how full?) -Consumer outcomes of those in House
Increase Hospital Diversion Options	Develop additional State Hospital Diversion Options for Ashland County Residents in Crisis.	• Utilize Hospital Liaison position to expand available options	-Number of additional options -Plus/Minus 5% of projected State Hospital Bed Day utilization
Medication Optimization	Increase awareness and practice of the principles of Medication Optimization.	• Provide training opportunities to contract agencies (particularly nurses and psychiatrists around Medication Optimization. • Provider education and awareness trainings to the local hospital and physicians in the community.	-Number of trainings and participants -Number of training participants indicating increased awareness/understanding of Medication Optimization principles

Jail-Community Linkage Services	Improve Behavioral Health Linkage for persons exiting the local jail. Reduce State Hospitalizations, recidivism and increase housing and employment.	• Maximize braiding funding (OhioMHAS, SOR, Local Levy) to fund behavioral heal services at the jail • Offer Trauma-Informed Care, ACEs, First-Responder Supportive trainings to local law enforcement via braided funds	-Reduction in recidivism; -Reduction in Re-hospitalizations; -Increase in Stable Housing, Employment and/or Education; and -Increase in BH follow-up services -Number of law enforcement attending trainings
Juvenile Court-Community Liaison	Improve BH Linkage for families/youth involved in the Juvenile Court, Children Services, FCFC and BH systems.	• Continue to develop Juvenile Court-Community Liaison position to offer support/resources to youth/families involved with the Juvenile Court • Provide support/resources/information to Juvenile Court staff	-Number of youth/families following up with recommended Behavioral Health services -Increase in number of youth "staying local" as opposed to being sent to detention center
Behavioral Health Services to Older Adults	Increase awareness of and access to, integrated behavioral-primary health services to seniors.	• Continue to utilize the Older Adults Behavioral Health Coalition to promote health and wellness to seniors and caregivers in Ashland County.	-Number of Initiatives consistent with Goals; -Number of Older Adults impacted by Initiatives;
Youth & Families Involved with JFS/CS	Provide mental health support to children in the care of Child Protective Services as well as individuals and families providing kinship and/or foster care through CPS/JFS.	• Maximize use of "Clinical Team" to positively impact multi-system "at-risk" youth • Encourage regular meetings between line staff of BH agencies and CS staff • Partner with CS on Transitional-Aged Youth exiting the foster care system	-Number of youth/families involved with Clinical Team w/positive outcomes -Number of regular coordinator meetings between BH agencies and CS -Number of TAY youth exiting foster care participating in BRIDGES or other TAY specific services

5. Describe the board's accomplishments achieved through collaborative efforts with other systems, people living with mental illness or addiction, family members, providers, and/or the general public during the past two years.   (Note: Highlight collaborative undertakings that support a full continuum of care. Are there formal or informal arrangements regarding access to services, information sharing, and facilitating continuity of care at a systems level?)

Selective collaboration accomplishments include:
Collaborating with our local JFS we were successful in receiving a $100,000 Community Innovation Grant to plan for improved services to youth at-risk of out of home placement. The implementation of the recommendations continues in SFY 19 and beyond;

Collaborating with local/regional consumers, providers and boards we were able to host the 11th annual Respect Success Value and Purpose (RSVP) conference with over 125 attendees. The 12th Annual Conference is already planned;

Collaborating with our local sheriff and police we continue to participate in drug take back awareness activities and promote the county's two permanent 'drop boxes' to aid the collection efforts over the long term;

Collaborating with several community partners including area seniors, social services and law enforcement we were able to continue supporting monthly Seniors and Law enforcement Together (SALT) meetings in SFY 19;

Collaborating with our local jail, Drug/Alcohol agency probation/parole and judges we continue to see success with the Behavioral Health-Criminal Justice allocation (previously grant-based);

Collaborating with local schools, and local behavioral health agencies Suicide Prevention trainings (Question Persuade Refer (QPR)) was provided to 333 high-school and middle-school students. Ashland continues to lead the nation in QPR trainings to this population;

Prior to the establishment of the community hub language, Ashland had established a good working opioid advisory group to discuss all aspects of the opioid issue as well as solutions. This group continues to meet monthly;

Collaborating with the local area chamber of commerce, the Board was able to provide key trainings on the opioid issue as it relates to the workforce and businesses and spotlighted the Ohio Chamber of Commerce resource, "[Dose of Reality](#)" opioid toolkit;

Collaboration with our contract providers as well as private providers in ongoing training activities the MHRB has been able to foster a recovery-oriented culture and more integrated system of care in our community;

Collaboration with other Boards (particularly those in the Heartland Collaborative or members of Heartland East) in preparing for a MACSIS replacement system, various aspects of BH-Redesign, Hospital Capacity Issues, and Workforce Shortage solutions;

Collaboration with Seniors and Senior Serving agencies to form the Older Adult Behavioral Health Coalition. The Coalition, now in it's 14th year continues to host/promote educational and awareness events around senior behavioral health and wellness.

Collaboration with multiple service and provider organizations to form the Trauma-Resiliency Collaborative. This group is focused on making Ashland a "Trauma-Informed Community"; and

Ongoing Collaboration with local school systems to continue the very successful 'School-Community Liaison Program.' School Systems have been adding funds to local levy funds to increase the hours of Liaison time in their districts.

Inpatient Hospital Management

6. Describe the interaction between the local system's utilization of the State Hospital(s), Private Hospital(s) and/or outpatient services and supports. Discuss any changes in current utilization that is expected or foreseen.

Ashland County has seen an increase in State Hospital Utilization over the last 3 years. This has reversed a 10-year trend of decreasing utilization. The primary gatekeeping agency for admissions has expressed the need for additional State Hospital Diversion options. Therefore, as part of the 507 regional initiatives, the Board participated in 4 initiatives designed to increase diversion from the State Hospital and/or reduce the length of stay for State Hospital admissions. Several of the 507 projects were found to be worthwhile and are being continued with State and/or Local funding. The Board has developed a "Hospital-Community Liaison" position with local levy funds. This position has improved continuity of care for discharges and increased quality of care while individuals are inpatient. Additionally, communication between primary and behavioral health systems has improved.

Ashland is part of the Heartland Behavioral Health (HBH) catchment area. The hospital is in the midst of capital improvements but this seems to have negligible impact on bed day availability. The larger driver seems to be an increase in forensic vs. civil beds needed. Waiting times in Emergency Rooms continue to be high as well as the time spent by Health Officers (Prescreeners) in trying to secure an appropriate hospital (private or state) admission. It is not unusual for Health Officers to make 14, 15 or more phone calls to find placement when HBH is full or the admission was denied. This has put a strain on the individual/family in crisis as well as our relationship with the local hospital ER. The Ashland Board is still interested in discussing with OhioMHAS a shared-funding opportunity to pilot a local/regional crisis diversion model along the lines of "[The Living Room](#)"

A. Waiver Request for Inpatient Hospital Rehabilitation Services

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

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

A. HOSPITAL	Identifier Number	ALLOCATION
N/A		

B. Request for Generic Services

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

B. AGENCY	Identifier Number	SERVICE	ALLOCATION
N/A			

Community Plan for the Provision of
Mental Health and Addiction Services
SFY 2019-2020

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 Mental Health and Addiction Services (OhioMHAS) department a community mental health and addiction services plan for its service area. The plan is prepared in accordance with guidelines established by OhioMHAS in consultation with Board representatives. A Community Plan approved in whole or in part by OhioMHAS is a necessary component in establishing Board eligibility to receive State and Federal funds, and is in effect until OhioMHAS approves a subsequent Community Plan.

The undersigned are duly authorized representatives of the ADAMHS/ADAS/CMHS Board.

Mental Health & Recovery Board of Ashland County

_____

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

See Separate Attachment for Signed Signature Page   7/25/2019
_____   _____

ADAMHS, ADAS or CMH Board Executive Director   Date

See Separate Attachment for Signed Signature Page   7/25/2019
_____   _____

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.)].

Attached is the SFY 19-20 Community Plan Essential Services Inventory. **Each Board's completed SFY 2018 form will be sent in separate email should the board want to use it to update information.**

The Essential Services Inventory form included with this Community Plan requires the listing of services for which the board may not contract. This element is necessary due to current Ohio Revised Code to detail the behavioral health (BH) continuum of care in each board area.

Some additional Continuum of Care (CoC) information resources have been provided below to assist in this process, but board knowledge is vitally important given the limitations of these included CoC resources. For example, the attached resources may not address BH services provided by Children Service Boards and other key providers within the local behavioral healthcare system.

Instructions for the Essential Services Inventory

The goal is to provide a complete listing of all BH providers in the board area. However, at a minimum, at least one entity must be identified for each essential service category identified in Column A of the form.

In addition to the identification of the Essential Service Category, the spreadsheet identifies the treatment focus (Column B) and Service Location (Column C) of the service as required in Ohio Revised Code. The fourth column (Column D) provides a list of the Medicaid and Non-Medicaid services associated with each of the Essential Service Categories.

In Column E, please identify the Names and Addresses of providers who deliver the Column D Medicaid/Non-Medicaid payable services associated with each Essential Service Category and in Column F indicate by "Y" or "N" whether the Board has a contract with this agency to provide the services.

Additional Sources of CoC Information

1. **Emerald Jenny Treatment Locator https://www.emeraldjennyfoundation.org/**

2. **SAMHSA Treatment Locator https://www.findtreatment.samhsa.gov/**