Ohio Department of Mental Health and Addiction Services (OhioMHAS)

Community Plan Guidelines SFY 2019 and 2020

Enter Board Name: Mental Health and Recovery Board serving Belmont, Harrison, and Monroe Counties (MHRB)

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

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.

Social and Demographic Factors

The Mental Health and Recovery Board serving Belmont, Harrison, and Monroe Counties (MHRB) in southeastern Ohio covers 1,408 square miles requiring over two hours to travel from the northwest corner of Harrison County to the southern portion of Monroe county. This entire area is connected by Interstate 70 making it a beltway for transportation that encourages tourism, industry, as well as drug trafficking. The US Census reports a total population estimate for 2017 of the three counties as 97,191 (Belmont 68,029; Harrison 15,216; Monroe 13, 946).

Diversity	BELMONT (Total: 68,029)	HARRISON (Total: 15,216)	MONROE (Total: 13,946)
White	93%	95.2%	98.9%
Black or African-American	4.14%	2.01%	0.06%
Asian	0.396%	0.53%	0.01%
American Indian & Alaska Native	0.25%	.001%	0.01%
Two or More Races	1.27%	1.23%	0.34%
Other Race Alone	0.09%	0%	0%
Hispanic	0.89%	0.90%	0.52%

Health Rankings

The Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute recently released the 2019 County Health Rankings. Reviewing the table below, the MHR Board's three county geographic area, when compared to the state of Ohio, appears to generally be in slightly poorer health, higher obesity, less physical activity, less people driving impaired, less children living in poverty, lower teen birth rate, less mental distress, and higher prevalence of diabetes. When comparing the three counties to each other Monroe county stands out with the highest obesity, the least physical activity, the lowest teen birth rate, the highest percentage of children living in poverty, and the longest life expectance.

	Belmont	Harrison	Monroe	Ohio
% Fair/Poor Health	17	17	19	17
Poor Physical Health Days	3.8	4.	4.	4.
Poor Mental Health Days	4.	4.1	4.2	4.3
% Low Birth Rate Babies	8	6	8	9
% Adult Smoking	22	21	21	23
Obesity	34	35	36	34
% Physically Inactive	30	28	32	25
% Excessive Drinking	18	18	17	19
% Impaired Driving	24	27	40	33
Teen Birth Rate	33	38	31	41
% of Children in Poverty	17	21	24	25
Life Expectancy (years)	76.6	76	78.7	77
% in Frequent Physical Distress	11	12	12	13
% in Frequent Mental Health Distress	12	13	13	14
Diabetes prevalence	13	13	15	12

Economic Factors

Household Income: In 2017, the Ohio Median household income was $54, 0212 and the United States Median household income was $60,336 – Belmont County ($46,484); Harrison County ($46,223); and Monroe County ($43,299).

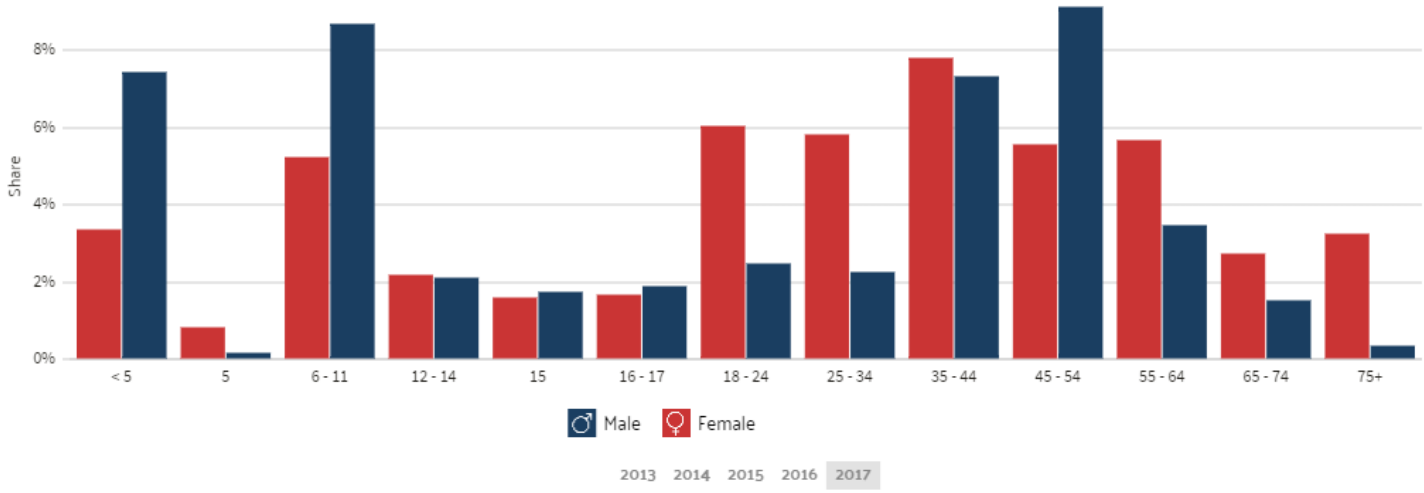
The economy of Belmont County employs just over twenty-nine thousand people. The largest industries in Belmont County are Health Care & Social Assistance (5,428 people), Retail Trade (4,045 people), and Manufacturing (2,408 people), and the highest paying industries are Mining, Quarrying, & Oil/Gas Extraction ($80,026).

Harrison County's economy employs over six thousand with the largest industries including Health Care & Social Assistance (1,175), Manufacturing (1,014) and Retail Trade (794 people); and the highest paying industries are Utilities ($62,386), Agriculture, Forestry, Fishing & Hunting ($52,000) and Professional, Scientific & Technical Services ($52,250).

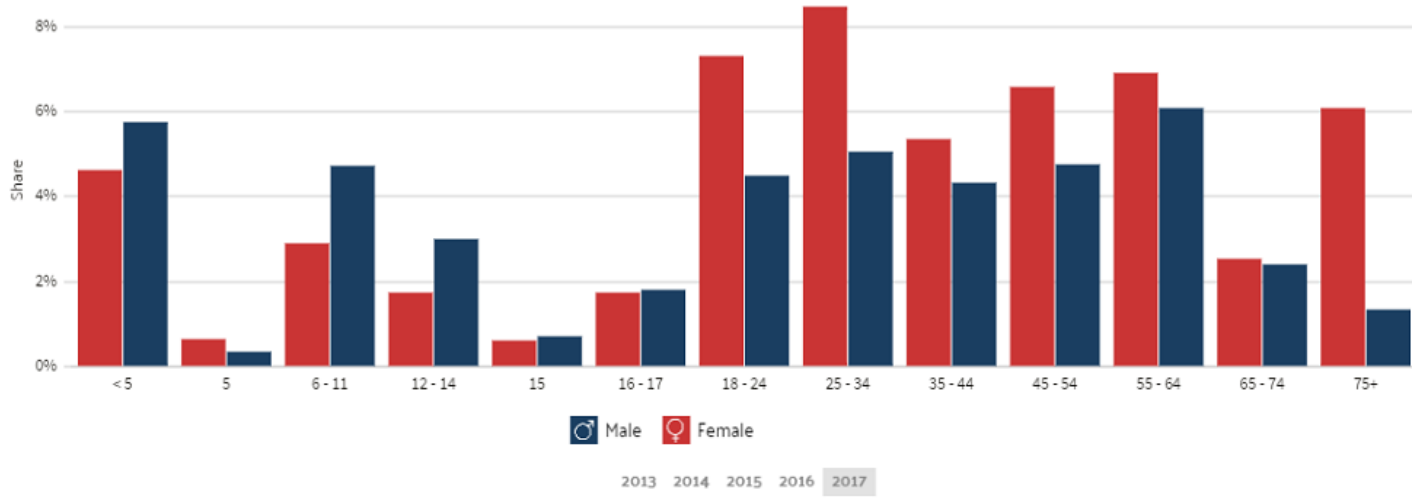
The economy of Monroe County employs approximately five thousand individuals with the largest industries involving Health Care & Social Assistance (846 people), Retail Trade (687 people), and Construction (519 people). The highest paying industries are Mining, Quarrying, & Oil/Gas Extraction ($71,883), Agriculture, Forestry, Fishing & Hunting ($60,526), and Wholesale Trade ($47,639).

Percentage of Poverty: (Ohio Poverty Report, 2017)

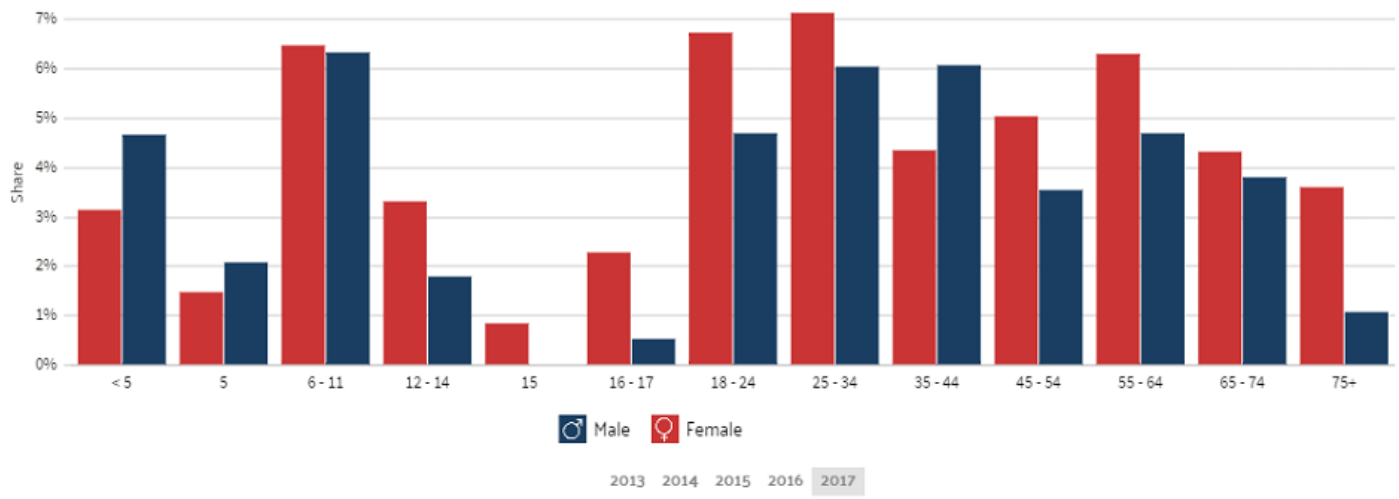
Monroe County table (19.7% - 2,772)



Belmont County table (14.1% - 9,153)



Harrison County table (15.7% - 2,371)



Behavioral Health Redesign including Medicaid Managed Care carve-in

The rural three county area continues to benefit from Medicaid expansion even as it enjoys an economic boost from the natural gas and oil fracking industry. Recent enrollment data reports that approximately 8.7% of all adults ages 19-64 in Belmont County are enrolled in Group VIII, with Monroe represented at 10.2% and Harrison at 10.4%. The numbers for all three counties reflect a slight increase from the prior year (2016). Harrison County showed an increase despite being tagged as the "fastest growing local economy" according to the financial news service Wall St. 24/7.

In both Belmont and Monroe over 25% of the residents are receiving Medicaid benefits while in Harrison the percentage is 29%. Those numbers are still much lower than other portions of the state including counties considered Appalachia, Cuyahoga County, and the counties bordering Pennsylvania.

Impact of Medicaid expansion:

The availability of Medicaid to cover treatment services has shifted the dynamics locally between the Board and area contract providers. With 90% of individuals and their treatment billed to Medicaid, some providers are so confident in the amount of Medicaid resources they can garner that they want no non-Medicaid support from the Board. With a pool of potential treatment seeking individuals with Medicaid, some providers could afford to not panel staff with private insurance, in effect redirecting them to private providers or enrolling them on a fee-for-service basis with the Board. The largest impact was felt by addiction providers who experienced a significant increase in Medicaid earnings from individuals who now met the means test for Medicaid.

Impact of BH Redesign and Medicaid Managed Care Carve-in:

In implementing Medicaid BH redesign, including managed care integration, providers quickly became consumed with payment issues, claims, correcting errors, and understanding new requirements. They were unable or unwilling to adopt a new business model of commercial managed care. With the contract relationship between MCPs and providers, the board was left largely on the sidelines with no role to play. This reduces the likelihood and effectiveness of any care

coordination between the commercial managed care plans and community services that the board may bring to the table.

Impact on access, effectiveness and efficiency of system services is hard to determine with limited data sharing. From information that is available, it appears that there has been a 15% reduction in the number of individuals serviced from the same time frame in FY 2018 to FY 2019 and a 30% reduction of Medicaid units paid and a 10% reduction in non-Medicaid (Board reimbursed) units paid. Along with the real reduction in individuals served and claims paid, trying to figure out how to accurately process claims from correct coding to correcting errors has "sucked" all the creative energy out of the local provider system. There seems no time or energy to on-board new or creative systems.

It "feels" that access to services have been diminished to certain groups of peoples. Serving non-Medicaid individuals has been reduced in favor of serving those with Medicaid. Groups of professionals are no longer providing certain services since it is not now within their scope (nurses unable to provide assessments). Incarcerated individuals continue to be underserved as providers shift resources to guarantee Medicaid billings.

Suicide Prevention: According to data found in The Ohio Alliance for Innovation in Population Health (The Alliance), suicide rates are rising across Appalachian Ohio (home to nine of Ohio's 10 counties with the highest suicide rates per 100,000 population over the past 10 years). From 2008 through 2017, suicide rates for Belmont County – 3,322 lives; Harrison County – 748 lives; Monroe County – 551 lives were lost. The impact of declining manufacturing jobs has been felt keenly in the area. In recent years Monroe County experienced a spike in suicides due to the closing of a major plant (2012). Since that year the county continues to average three a year in a county of slightly over 15,000 in population. In 2017, Belmont County's lost sixteen residents to suicide. An affirmative link between overdose deaths and suicides has been established which reveals overdose related suicide deaths for Belmont County are at 10.0%; 4.8% in Harrison County; 13.6% in Monroe County.

Based on this information there are several initiatives taking place in MHRB service area and with our community partners including:

- The implementation of the Man Therapy awareness campaign in an attempt to engage this high risk, middle-age male population
- The promotion of Crisis Text Line and funding of school-based prevention programs for youth that increases the protective factor and resiliency of our youth.
- Gatekeeper Trainings for Faith Based Community Leaders
- Finally, the Suicide Prevention Coalitions, which was established in 2010 for Monroe County and 2017 for Belmont County, in an effort to coordinate local resources, increase awareness of suicide as a public health problem, and educate our community to better recognize when someone they know may be suicidal, is still active. The Coalition offers free training and consultation for community groups to raise awareness of suicide as a public health issue and to educate the public about how to recognize and respond to someone who needs help.

Assessing Needs and Identifying Gaps

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.

MHRB utilizes its collaborative partnerships with community partners, stakeholders, coalitions, providers, and those on the ROSC continuum to assess needs, and identify gaps and disparities. This is evidenced by its participation with all three county CHIP Workgroups, all three county Community Corrections Planning Board, the local Ohio Valley Trauma Informed Services Initiative, all three counties Family and Children First Councils, Suicide Prevention Coalitions within Belmont and Monroe Counties, Substance Abuse Prevention Coalitions within all three counties. Regional and state efforts include Recovery Summit Planning, OACBHA Recovery is Beautiful Blueprint, Kids Committee, Executive Council, Managed Care Committee, Resource Modernization Committee, Committee to Address Suicide, and Hospital Committee.

A summary of identified needs for which a gap still exists in within our communities include:

- Consumers, family members, referral sources & agency staff are often unaware of available services and don't know how to access them
- More community education about mental illness & addictions is needed (along with consistent strategies to decrease stigma)
- Interim services and more assertive linkages (especially during transitions from jail, hospitals, and after crisis services) using peer-based recovery support staff or case managers are needed
- Need for additional PSH transitional housing (for persons with mental illnesses and for those with addictions)
- Lack of peer specialists/recovery coaches and/or consumer-operated services
- Need for more proactive and integrated community response to emerging issues
- Access is impaired by workforce shortages both in numbers and by licenses
- Individuals with private insurance may experience longer access times

Data has been utilized from the following sources to determine current behavioral healthcare trends and needs:

- MHRB Strategic Plan 2016-2019
- OACBHA Ohio's Crisis Continuum
- Ohio 2017 Permanent Housing Capacity & Funding
- The Joint Legislative Committee on Multi-System Youth Recommendations, 2016
- Harrison County CHIP, 2017
- Belmont County CHIP, 2017
- Monroe County CHIP, 2018-2020
- 2019 Ohio HIPO Values
- Provider Service Plans from contracted providers
- ROSC Survey
- Administration of the *Pride Risk and Protective Factor Survey* (5,000 students in grades 6-12 in all Belmont County public school districts)

- Belmont County Family and Children First Shared Plan
- Monroe County Family and Children First Shared Plan
- Harrison County Family and Children First Shared Plan
- Service and fiscal utilization data from PartnerSolutions; client demographics & other population characteristics

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.

MHRB participates in the County Health Improvement Planning process in all three counties serving on various task forces, committees and workgroups on topics that intersect with behavioral health. The Health Departments from each county review a variety of administrative and epidemiological data sources in setting priorities and selecting activities from implementation. In both Monroe and Belmont County MHR Board staff participated in a community wide strategic planning effort that identified needs but also developed goals, objectives, and outcome measures for the county health improvement plans. One example of MHRB-sponsored partnership with public health is increasing behavioral health literacy and connection to the local system through Gatekeeper trainings and stigma reduction around behavioral health and treatment. The success of our coalitions and collaborative partnerships such as with the Health Districts in their Health Improvement Planning efforts is driving the demand for data-driven, prevention interventions that have visible results and promote the overall health and safety of communities. The better connected and educated our community organizations and residents become, the awareness of behavioral health has increased. While there is greater awareness of the scope and severity of the MH/AOD problem among healthcare providers, there are well intended but uncoordinated and often inexperienced responses (i.e. stigma, lack of competency in treating SPMI, comorbid MH/AOD, and severe AOD issues) across these healthcare systems. As a result, services within these systems of care are likely to become more fragmented at the expense of vulnerable consumers and their loved ones without close collaboration and communication. The MHRB promotes and supports evidence-based comprehensive school-based frameworks including trauma-informed care and Positive Behavioral Intervention and Supports in all three counties.

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

Currently, there are no cases engaged with the Family and Children First Council that have advanced to dispute resolution in Belmont, Harrison, or Monroe counties.

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

For the most part, the needs of this population MHRB continues to work with our providers to ensure a seamless transition from one level of care to another. The majority of our State Hospital admissions are forensic, and we do monitor these consumers and help with linkages when needed. Data and feedback gathered both through our monthly multi-disciplinary team meetings as they relate to individuals served thorough the RPH has been helpful in the sense that it reaffirms what we know about this target population. The Board maintains close communication with our local pre-screening agency (Southeast, Inc.) regarding local individuals that are placed in the RPH. MHRB utilizes Southeast, Inc. to provide OMHAS certified outpatient services to all individuals hospitalized upon referral from the State Hospitals.

Care Coordination through Southeast, Inc. not only make the connection with the individual in the hospital but also support the plan for return to the community and provide follow-up contact after discharge. To assure adequate linkage back to the community, the MHR Board reimburses the provider for case management services for any individual that is not a client but is need of services to assure a health and safe transition back to the community.

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

The MHRB in fiscal year 2016 completed its first ROSC assessment. Three hundred eighty-five surveys were sent out with 160 returned for a rate of 42%. In general, the ROSC in fiscal year 2016 indicated a high percentage of "Do Not Know" responses in most categories. In addition to using the ROSC results, the Board utilized available information received from community needs assessments, environmental scans, demographics, and community stakeholder groups. Over the last two years the MHRB has worked collaboratively with our contract agencies on many initiatives to impact the "Do Not Know" ratings in the 5 domains. Our accomplishments include the following:

1. **Focus on Clients and Families**

- Implemented a client satisfaction tool across all providers for FY18.
- Yearly funding of regional and state recovery conference.
- Media releases promoting behavioral health awareness.
- Family Education/Support Group (SUD/OUD related)

2. **Timely Access to Care**

- Access Reports for services across providers are monitored monthly and reviewed by the Board's Quality Management Workgroup.
- Quick Response Team implemented in for area hospitals
- Additional services and hours of availability were added in all three counties.
- Enhanced 24-hour Crisis Helpline Services for all three counties.

3. **Healthy, Safe & Drug Free Communities**

- Participation, leadership and leveraging of funding to support the development of all three counties Suicide Prevention Coalitions.
- Collaborated in the development of the SHIP, CHIP and CHAW plans in all three counties.
- Training for Pax Good Behavior Games now available to local school districts in Belmont County through a collaboration with local providers and the educational services center.
- Assisted in making available Naloxone to first responders in all three counties.
- Mental Health/Crisis Intervention Training (GateKeeper training)provided to local Faith Leaders
- Partnered with Barnesville Hospital to bring speaker David Sheff to the area

4. **Accountable Financing**

- Acquired additional grant funding to implement new services and recovery supports.
- Improved funding disparities between the three counties.
- Developed Quality Management Reports and additional funding opportunities based on positive outcomes from treatment.
- Joined Partner Solutions Group which has provided us with individual county and integrated fiscal and service information.
- Performance based contracting for vocational services

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)].

- Increase positive outcomes with peer services: We have NA, AA, Al-Anon, Recovery Summit and other 12 step-oriented programs in our communities. We have a Sober Living House that is managed by peer support specialist. We also have a small Quick Response Team formed by Peer Specialists; that is the extent of our formalized peer service.
- Jail services-While we have offered behavioral health services in the jail; they have not been utilized effectively and efficiently. We continue to collaborate with our commissioners and sheriff's department to try to design effective services specifically to reduce RPH admissions and care coordination upon release.
- Transportation continues to be an issue in our county. Belmont, Harrison, and Monroe Counties is comprised of 1408 square miles. Our Board service area lacks reliable and accessible public transit needed to improve the quality of life for its residents. Public transit that strengthens the economy and improves options for our rural/Appalachian area. Limited public transit services in all three counties impact access to services, making engagement with and participation in services particularly difficult for clients with limited resources ..
- Consumer/Family member involvement in determining gaps, needs etc.

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.

Our Board service area is not without its challenges and many of these challenges are probably seen throughout the state. One of the greatest challenges has been in the area of communication to the general public. Despite a fairly rich array of services, we still hear daily that essential services do not exist in Belmont, Harrison and Monroe Counties as the community at large remains unaware of the services available. MHRB makes significant investments in printed materials that are circulated

throughout the year, as do most of the contract agencies. But through town hall meetings and community forums, it has become increasingly obvious that the information is not making into the hands of individuals-in-need at the time when they need it.

Penetration of those with Mental Illnesses into the Criminal Justice System: Even with all of the collaboration and our community investment in jail treatment services, they have not been utilized effectively and efficiently. We continue to collaborate with our commissioners and sheriff's department to try to design effective services specifically to reduce RPH admissions and care coordination upon release. One such avenue of exploration may involve Sequential Intercept Mapping (SIM) process which "…outlines sequential points at which a person with mental illness can be 'intercepted' and kept from going further into the criminal justice system. Over time, as systems mature, it is expected that people will be intercepted earlier in the process, leading to fewer people entering the criminal justice system.

Crisis Services: The MHRB funds a wide range of emergency/crisis intervention services to assure residents have access to in office, face-to-face crisis intervention appointments. The MHRB has also funds countywide 24/7 crisis hotline through Southeast, Inc. The hotline includes access for individuals with a substance use disorder. The hotline provides access to a behavioral health professional who is able to assess an individual's needs and determine the appropriate disposition. Dispositions can include: information and connection to resources in the community; referral to treatment resources; scheduling of a crisis intervention appointment at one of the MHRB's contract providers; risk assessment and safety planning; assistance with hospitalization; and dispatch of the mobile crisis team for immediate on site crisis services. This includes direct admission capacity to RPHs.

As mentioned, a gap in our emergency services/crisis intervention services is the lack of a crisis stabilization/step-down unit in our Board service area. Access to such a unit would assist with diverting hospitalizations and could decrease the length of stay for those who need hospitalization. Another gap in our crisis intervention system of care is a "drop off" facility where first responders can take individuals who do not need hospitalization but need connection with support for stabilization of symptoms. Law Enforcement officers continue to inform the MHRB that community alternatives to the hospital are needed. In December 2018, our local hospital psychiatric acute/ inpatient closed for our Board service area. The long distance to Muskingum County or Tuscarawas County to use their 8-bed Crisis unit is less than ideal.

From the FY 2018/2019 biennium budget the AppCare Boards (those that admit to Athens Behavioral Health) supported the development of crisis stabilization beds within Jefferson County. This Board hopes to utilize these beds for the three county area if the issue of transportation can be addressed.

Families Involved with Child Welfare: With the number of children in custody continuing to rise due to the opioid epidemic and the inherent complexity when addressing families involved with child welfare which not only include SED in children and youth including differences in the primary mission or purpose of the many systems that work together to serve the youth/family. Examples of key findings and identified needs of this population from interactions with various community partners include:

- Support specifically for adopted youth and their adoptive families when struggling with behavioral health issues (trauma informed care/principles);
- Cohesive communicative services that connect between systems of care;
- The creation of a wellness plan/crisis plan;
- Preventing abuse through in-home supports;

- More support for parents to prevent removal from the home such as parenting programming (education, training, mentoring, supportive services, etc.)
- Unified strategy for data collection and sharing across systems to improve outcomes and best practices

Ongoing care and service coordination will not only benefit the parents' health, it will decrease the amount of time the child is out of the home and continue to provide access and address needs of the family.

Prevention/Early Intervention Across the Lifespan: MHRB is responsible for providing oversight and support of prevention, treatment and recovery supports for residents living with mental illness and/or substance use disorders within Belmont, Harrison, and Monroe counties. As discussed previously, identified needs associated with the priorities of the Executive Budget for 2020-2021 correlates to the substantial funding in upstream prevention efforts which include: empowering families and our communities through stigma reduction (healthy prevention and intervention approaches). We have begun laying the foundation through collaborative community partnerships (Health Depts; FCFC; Community Coalitions; etc.); however, continued efforts are needed. Other gaps include crisis stabilization to provide real time crisis stabilization resources for those who are most in need at all ages. Also, MHRB to support and promote the use of standardized screening tools for early identification and intervention. This has been an area where local providers have shown little interest on addressing adult prevention and the system could be enhanced if board such as this one was able to deliver prevention and education services.

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).

Priorities

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.

Below is a table that provides federal and state priorities. Please complete the requested information only 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 and Recovery Board serving Belmont, Harrison, and Monroe Counties (MHRB)				
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)	To provide a continuum of care for persons who are intravenous/injections drug users (ISU)	• Improve access through provider contracts • Expand and maintain Medication Assisted Treatment (MAT) • Maintain provision of MAT availability for incarcerated individuals • Development/Partnership with Vivitrol services • Partnering with local Health Depts. to emphasize harm reduction and stigma awareness through community trainings around overdose management – family, first responders, local service employers, etc.	• Increased access as evidenced by availability and decreased wait time • Medication Assisted Treatment (MAT) availability and transportation in all three counties across the board region	__ 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)	Continue to evaluate and strengthen the referral and treatment of women who are pregnant & have a substance use disorder which enhance treatment programs which enhance system awareness of treatment resources for women who are pregnant.	• All contract providers will continue to give priority status to all identified pregnant women who have substance use disorder. • Strengthen collaboration with Health Depts., FCFC, Help Me Grow, healthcare professionals through cross system outreach to promote public awareness	• Percentage of women receiving timely access to treatment (both physical and behavioral) • Board staff and contract providers will attend 80% of Board service area substance abuse prevention and harm reduction coalition meetings	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):

		regarding treatment services and programs. • Monitor and strengthen previously funded CURES Nurse Care Coordinator program that identify/engage/refer/treat of identified pregnant women who have substance use disorders for all three counties within the Board area.	• Decrease in the number of substance exposed newborns	
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)	To ensure that parents with substance abuse disorders who have dependent children receive timely assessments.	• Continue working with contract providers, Child Protective Services, Family Dependency Court, Juvenile Detention, to assure assessments are produced no later than 10 days after the date of request. • Maintain Family Dependency Treatment Court in Belmont County • Support certification of the FDTC in Harrison County in cooperation with DJFS, Juvenile Probation and contract provider	• Family and Children First Council (FCFCs) Service numbers and FCFCs Quarterly Meetings • Increase the number of SUD/OUD involved parents participating in the Harrison County FDTC. • Dependency, neglect, and abuse filings have increased by 53% in over the last year in Belmont County (from 2017).	__ 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.)	To decrease the number of individuals diagnosed with tuberculosis and other communicable disease	• If suspected, referral to appropriate healthcare providers or Health Home Program is made. Link persons with area support groups identified in the community	• Release of Information is gathered for the healthcare provider and follow up to the healthcare provider is documented	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):

MH-BG: Mandatory (for OhioMHAS): Children with Serious Emotional Disturbances (SED)	To provide an array of services for children with SED and supports for their families	• Prioritize and increase services accessibility • Continue to partner with the local FCFC in its efforts to coordinate services and supports that are youth and family driven • Service delivery for children and families through projects that include: Early Childhood Mental Health/Child; Youth in Crisis (intensive home-based wraparound program); Respite and Mentoring; BCAP (therapeutic alternative school placement); EBPs school-based prevention programs in 2 counties; PAX training • Contributing to service coordination and funding for families involved in multiple systems and agencies with streamlining "wraparound" and increasing practice excellence • Contributing to funding of wraparound services, respite care, parent education and other education for reducing risk of out-of-home placement	• Contracts with community providers and outcome measures as defined by Board and its providers • Number of family's accessing treatment and support services through contracted providers and/or FCFCs Service Coordination Referrals • Standardized outcome reporting regularly on funding programs for trend comparison	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):
MH-BG: Mandatory (for OhioMHAS): Adults with Serious Mental Illness (SMI)	Provide an array of services for adults with SMI, to help them live independently in the local community.	Board continues to invest in the following specialized and evidence based programs to address these goals: • Vocational Programming • Residential Programming	• Number of attendees participating in Board supported (best practices) prevention and treatment training events.	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):

		• 24/7 Psychiatric Emergency Services (Crisis Hotline/Crisis Services) • Special Docket Courts • Trauma Informed Care • EBPs • Recovery Celebrations/Picnics • In-house counseling services within Belmont County Jail • Mental Health First Aid trainings • Crisis Intervention Team Trainings • Start-up of Re-entry Alliance • Nurse Care Coordinator Partnered with local health departments in all three counties as each developed their individual CHIP where MH/SUD was prioritized. Promote and offer trainings to support best practices in diagnosis and treatment planning for those with SMI		
MH-Treatment: Homeless persons and persons with mental illness and/or addiction in need of supportive housing	Increase access to permanent supportive housing for persons with mental illness or SUD	• Work with providers that homeless individuals with integrated care in identifying individuals in need of permanent housing. • Continue MHR Board Community Housing Assistance Program. • Continue MHR Board support for RCF placements.	• 100% of eligible individuals discharged from ABH will be offered MHR Board housing assistance. • Fund a minimum of 35 housing slots in residential care facilities.	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):

MH-Treatment: Older Adults	Improve opportunities for Older Adults through collaboration between agencies	• Provide for referral systems that engage both mental health providers and Community Partnerships (APS, I-Teams, Belmont Senior Services, Home Health Agencies, etc. • Educate Seniors on locally available mental health and substance abuse services	• Number of people served	__ 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	Ensure effective and appropriate behavioral health services are available to meet the needs of individuals and reduce State hospital admissions Improve follow-up with treatment upon release to reduce recidivism	• Coordinate and monitor Board funded projects within the juvenile and adult court continuum to ensure the behavioral health needs of adults and youth are efficiently and effectively managed • Continue to maintain key partnerships and programs with the adult and juvenile justice system • Strengthen Re-entry Alliance to reduce recidivism and meet the needs of the consumers	• Standardized outcome reporting regularly on funding programs for trend comparison • Board staff will attend 80% of meetings related to MH/SUD Treatment criminal justice system planning in Board service area • Number of re-entering residents served by re-entry funds and number of re-entry meetings held	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe
Integration of behavioral health and primary care services	Expand access to care for uninsured people through integrated models of primary care to help achieve identified outcomes and recovery to ensure service access for individuals with cooccurring needs	• Continue partnering with Barnesville Hospital, Barnesville Professional Association, and Crossroads in delivering MAT (vivitrol). • Continue looking for opportunities to partner with area FQHCs.	• Documented new and continued individual/client participation.	__ 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)	Improve outcomes for individuals with mental or substance use disorders through improved access to recovery support services.	• Provide funding and support local training towards certification of peer support recovery specialist • Increase access to support services through contract agency agreements • Strengthen Recovery Support Services through the development of a local peer-led education group and/or Consumer Operated Services	• Maintain running spreadsheet of training participants and certification recipients • Standardized outcome reporting regularly on funding programs for trend comparison	__ 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)	Encourage access to services to racial and ethnic minorities and LGBTQ populations	• Collaborate with identified organizations identified as experts • Collaborate with contract provider network to advance trainings and development activities to support a system of care that is culturally and linguistically appropriate, efficient, and of high quality	• Documentation will exist of trainings offered, held, and number of network participants.	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):
Prevention and/or decrease of opiate overdoses and/or deaths	Decrease the number of overdoses and/or deaths through the number of program options available to Board service area residents, for opiate treatment and prevention	• Solicit involvement from school districts, hospitals and the Faith-Based community through county substance abuse prevention coalitions and community resource events • Meet with 1 area hospital to explore feasibility of implementing AoD Sub-Acute detox for persons with opiate/alcohol addiction	• Number of consumers utilizing MAT services • Number of attendees participating in Board supported prevention and treatment training events. • Number of residential treatment facility beds utilized by Board service area residents.	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe

		• Maintain the use of MAT, specifically Vivitrol and oral Naloxone, and increase opportunities for this intervention as possible		
Promote Trauma Informed Care approach	Increase contract providers and agencies' knowledge about TIC and its use in ongoing patient care. Strengthen the implementation of the OVTSI - plan to introduce trauma-informed care across systems and faith-based communities.	• Assess additional or ongoing needs of providers who have received extensive training on trauma treatment over the past 3 years and provide trainings and funding to support trauma informed care and best practice treatment approaches • Implement a public awareness campaign with collaborative partners	• Number of healthcare professionals trained in TIC approaches in a year • Number of events, articles, and OVTSI/TIC programs held during the year.	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe
Prevention Priorities				
Priorities	Goals	Strategies	Measurement	Reason for not selecting
Prevention: Ensure prevention services are available across the lifespan	Promote a healthier community through work with our local health departments and other partner service agencies to decrease risk factors and increase protective factors identified within our community.	• Use of CHIP findings from Belmont, Harrison and Monroe Health Depts. • Use of ROSC for funding decisions • Issue an RFI for adult prevention/education for both mental health and addictions	• Standardized outcome reporting regularly on funding programs for trend comparison • Increase in adult prevention and education activities from MHR Board funding.	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):
Prevention: Increase access to evidence-based prevention	Maintain certified prevention programming and staff within our system.	• Contract for EBPs prevention services for children and youth, including school-based	• Standardized outcome reporting regularly on funding programs for trend comparison	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):

	Decrease risk and increase protective factor identified within our community	prevention of SUD and mental illness • Implementation of PAX Good Behavior Game		
Prevention: Suicide prevention	Continue to strengthen community knowledge of how to intervene with suicidal individuals. Increase the ability of local healthcare professionals to assess and intervene with suicidal individuals and to create protective factors in the community.	• Provide funding and staffing for public education and information regarding suicide prevention and myths & stigma of mental health symptoms • Continue to invest in Gatekeeper trainings to community groups and key stakeholders (i.e. first responders, faith-based, etc.) • Board staff and contract providers will attend 80% of Board service area suicide prevention coalition meetings	• Number of events, articles, and suicide prevention programs held during the year. • Number of healthcare professionals trained Gatekeeper trainings in a year	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):
Prevention: Integrate Problem Gambling Prevention & Screening Strategies in Community and Healthcare Organizations	All persons seeking or being referred to substance abuse treatment should be screened for problem gambling. Maintain a workforce that can discuss, assess and treat problem gambling.	• Ensure behavioral health providers have access to brief screening tools related to problem gambling. • Board will ensure providers are aware of training opportunities related to problem gambling treatment. • Ensure school-based prevention specialists discuss characteristics of problem gambling and referral options as a part of their curriculum	• Provider will have access to screening tools. • Providers will receive notification of at least one training related to problem gambling. • Prevention specialists receiving Board funding will be able to identify the topic of problem gambling in their curriculum. • Documentation exists of gambling screening at intake.	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):

		• Add screening tool to MHR Board website. • Continue screening all BH intakes for gambling		

Board Local System Priorities (add as many rows as needed)			
Priorities	Goals	Strategies	Measurement
Prevention: Mental Health and Addiction prevention and education efforts targeting adults and older adults in all three counties.	Increase all levels of prevention activities (universal, selective, and indicated) for adults and older adults	• Issue an RFI for prevention and education activities • Use the MHR Board website to disperse prevention information • Consider use of print media and PSAs to distribute information	• RFI issues • Documented increase in prevention services/activities targeting adults • MHR Board increased expenditures for education
Individuals involved in the Criminal Justice System:	Divert individuals from being incarcerated in the Belmont County Jail	• Collaborate with the Belmont County Court Judges to identify situations where diversion may be acceptable • Identify resources to fund court navigators that provide options in lieu of incarceration • Collaborate with Common Pleas Court and provider in implementing a mental health court like program.	• Documented decrease in the number of individuals admitted to Athens Behavioral Health • Court navigators in place within the county court system in Belmont County • Common Pleas Court has a functioning Mental Health Court like service.

Collaboration

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?)

As part of the effort to develop and ensure an efficient and comprehensive recovery-oriented system of care for the residents of Belmont, Harrison, and Monroe counties, the MHRB staff regularly interacts, coordinates and collaborates with provider agencies and other community partners and stakeholders. This occurs in a variety of ways, both informal and formal, via a variety of mechanisms (i.e. phone calls; board-hosted, structured meetings around a given purpose; involvement on task forces, committees). Ongoing, timely and current feedback is obtained as a result of this routine but essential interaction and coordination with key stakeholders, service and referral agencies and other community partners. Information gained about all aspects of the prevention and treatment service system through these interactions is regularly incorporated into the needs assessment and prioritization process via mechanisms such as required program reports to the Board, utilization reports, systems meetings with contract agencies and issue-focused or follow-up meetings around various needs.

General benefits derived from our collaborative efforts include: ⎪ Information sharing ⎪ Joint funding of particular programs or initiatives ⎪ Increased understanding of the roles, barriers and opportunities relative to various systems ⎪ Enhanced communication ⎪ Consensus around community needs and priorities ⎪ Identification of gaps in the service continuum. Below are descriptions of collaborative efforts that have taken place.

- **Family Dependency Court:** In the fall of 2018, Harrison County Juvenile Court implemented a Family Dependency Court to protect the safety and welfare of children, while giving parents the tools they need to become sober, responsible caregivers. To accomplish this, the Court has drawn together a treatment team that works collaboratively to assess the family's situation and devise a case plan that addresses the needs of both the children and the parents. In this way, the court team offers parents a viable chance to achieve sobriety, provide a safe and nurturing home, and hold their families together in Harrison County.
- **Eastern Alliance COG** continues to meet the demand for intensive support and permanent housing for SMD individuals who would otherwise spend their lives in and out of the state hospital. This partnership with Boards from Belmont, Harrison and Monroe and Jefferson Counties has proved vital in maintaining these individuals.
- **Suicide Prevention Coalitions (Belmont and Monroe)** Using community members and key stakeholders to increase public awareness of suicide prevention strategies, educate the public at large and promote/support gatekeeper tannings.
- **Youth in Crisis** The MHR Board in conjunction with the BHN Alliance collaborated to provide intensive home based treatment services for youth at high-risk for out-of-home placement. The established relationship between our Board, Juvenile Court ODJFS and the Developmental Disabilities system was instrumental in this collaborative initiative. This collaboration involved key partner agencies that provided positive family communication skills which impacted family functioning.
- **CIT** The 2017 training provided the officers an opportunity to build upon their knowledge of mentally ill individuals; increased their skills in assessing situations quickly and de-escalate those situations. The training also resulted in strengthening the relationship between law enforcement and our community system. The training was a joint collaborative effort between our Board, Belmont County Sheriff's Department, Belmont College, key partner agencies, and NAMI Ohio.

- **Family Service Coordination/FCFC** Currently in all three counties, decisions around the needs of at-risk children are jointly made and funded. The funders include Departments of Job & Family Services, Juvenile Court systems, Developmental Disabilities Systems and the Board. The Board has had a historically collaborative relationship with the local Family and Children First Councils. Prevent out-of-home placements; collaborative plans, shared funding contracts, competitive grant applications; pooled funding for multiple purposes such as youth mentorships, respite, equine therapy, art classes, etc.
- **Appalachian Behavioral Healthcare** MHRB staff meet monthly with Appalachian Behavioral Healthcare (ABH) and Southeast, Inc. staff to oversee the management of hospital admissions, aftercare, and any associated problems for persons served and their families.
- **Substance Abuse Prevention Coalitions** These groups have been created in all three counties and include MHRB staff and members from various organizations that are pooling resources, skills and time to increase awareness and education within their respective their communities.
- **Recovery Summits** The MHRB has participated in an annual recovery conference for 19 years that has been co-sponsored by the Eastern Alliance Council of Governments and Collaborative to promote a greater understanding of recovery from mental illness. These conferences have required increased attention to assessing the recovery needs of those receiving treatment services through the Boards' contracts. Through planning and participating with this conference, the Board has been emphasizing a focus on providing recovery-oriented services such as consumer operated services and supported employment as a means of developing a local recovery system during and post treatment for persons with mental illnesses and addictions.
- **AppCare** became a more formal institution as a result of OhioMHAS collaborative funding initiatives. Members are the boards that admit to Appalachian Behavioral Healthcare (BHM, Jefferson, Muskingum Area, GJM, AVH, ASL, and Washington and ABH. While the member boards have a long history of working together, when OhioMHAS distributed funding to "regional collaboratives" the group became a tool to decide regional resource distribution. The group meets quarterly to share ideas, best practices, problem solve, consult and discuss issues of mutual concern.
- **Directors' Meeting** Our local "Core Providers" meet on a regular basis with the Board staff in order to discuss and problem solve various ongoing needs in our community. Working collaboratively on various projects has proven to effective for identifying strengths and needs within the system of care.
- **Ohio Valley Trauma Support Initiative** This group was formed to create a coordinated, intentional effort to bring trauma-informed care into every aspect of the community, i.e. public schools, law enforcement, courts, medical and other health professionals.
- **Local Speaking Engagement - David Sheff, Author of Beautiful Boy** This event was co-sponsored by Barnesville Hospital with funds through the Rural communities Opioid Response Planning grant and the MHRB. The event was attended by nearly 300 area residents. They were able to hear his story and ask questions. A Recovery Resource Fair of over 14 organizations and a panel discussion was also available during the event as an opportunity for area residents to learn about resources, not just available in Barnesville, but also in the surrounding region to support those who are seeking recovery, navigating the early stages of recovery, and maintaining long-term recovery, as well as supporting families in recovery.

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.

   The Board contracts with Southeast, Inc. for emergency services programming for the system of care. Services are available 24/7 include a crisis hotline, pre-screening, inpatient psychiatric hospitalization (for adults), and transportation service to the hospital/crisis care facility. The hotline service is the central focal point for the Crisis System across the MHRB service area. The program is run 24/7 and provides information and referral services. It also serves as an initial crisis screen and is able to alert local law enforcement and first responders to emergent situations with residents requiring intervention, and maintains routine contact with consumers that require additional support in the off hours. Southeast, Inc. also manages pre-screenings for admission into the State Hospital. As manager of our emergency services system, Southeast, Inc. responsible for coordination of discharge planning.

   If a person is committed to the Hospital by the Judicial System, that person takes precedent and will be admitted prior to any civil client who needs to be admitted. The Board has no control over that and is currently finding the increasing number of Forensic patients use up the beds left for civil clients. If bed capacity is reached, the result is the local residents needing a hospital stay will be sent to another State hospital that will be out of their families and /or support systems reach. There is also the chance that, with no beds available, the Board's clients will spend hours in an emergency room waiting for a hospital bed. Issues with civil/forensic bed capacity at the state hospital and long admission times continue to remain a challenge for our region which results in access and capacity issues for inpatient psychiatric care; this has been especially problematic relative to the jails and probate court. The state has no known contingency plan for when all state beds reach capacity.

Community Plan Appendix 1: Alcohol & Other Drugs Waivers

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

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

SIGNATURE PAGE

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.

_____

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.)].

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/**