| 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.**

Overarching concerns that influence service delivery in the catchment area of the Mental Health & Recovery Board of Clark, Greene & Madison Counties (MHRB) are complex. As our local communities respond to unprecedented levels of trauma and environmental challenges, MHRB is pressed to respond. Our Board area recognizes that these solutions require partnership with systems as well as deliberate involvement in local, state, and federal policy.

Health Policy Institute of Ohio's (HPIO) 2019 Health Value Dashboard ranks Ohio 46 out of 50 states and the District of Columbia on health value. This ranking indicates that while Ohioans spend more on health care compared to other state's residents, they remain less healthy.

One key indicator of health value is access to quality healthcare. People living in rural areas are disproportionately more likely to struggle with accessing care providers than those living in urban or suburban areas, and our Board's three counties average more than 70% rural farmland. Provider shortages and constrained financial resources accentuate this challenge for our region. Patient-to-provider ratios continue to trend better than state averages but remain inadequate for quality care.

According to a recent article in the *Dayton Daily News*, psychiatrists, especially child psychiatrists, are retiring faster than the next generation can be trained. Simultaneously, demand for mental health services in the area is increasing. The article reported that nearly 20 percent of Americans have some type of mental health issue, but only a third receive treatment. This trend is reflected throughout our entire Board area.

Access-related issues are critical, but they are only a piece of the puzzle. Research indicates that access to care constitutes only about 20% of overall health. The remaining 80% is shaped by social, economic, and physical environments as well as health behaviors. The importance of factors that are unrelated to access is palpable in HPIO's dashboard, which identified three reasons for Ohio's poor ranking: "not all Ohioans have the same opportunity to be healthy, resources are out of balance, and addiction is holding Ohioans back" (p. 9-11). These reasons align with environmental and social, economic, and demographic factors in Clark, Greene, and Madison Counties.

**Environmental and social factors in Clark, Greene & Madison Counties**
Drug overdose and overdose deaths continue to be a focus for our Board area. We know that while specific drug use trends change, the underlying issues that lead to and perpetuate addiction must continue to be addressed.

As opioid-related deaths in our area decrease, use of other drugs like methamphetamine increase. Fentanyl continues to drive overdose deaths, along with rising cocaine, methamphetamine, and combination drug use. Changes indicate that the prevention strategies for people who use substances may need to expand to more broadly address the use of non-opiate drugs.

While all our counties have been touched by the opiate epidemic, Clark County remains the most heavily impacted. Data trends from the most recent Clark County Drug Death Report suggest that the highest rates of unintentional overdose occur in different age groups each year, illustrating that no age group has been left untouched. A recent report from the Ohio Department of Health indicated that unintentional overdose also touches several races and ethnicities. In 2017, black non-Hispanic males had the highest overdose rates for the first time since 2008. In addition, nonintentional overdose rates have been rapidly increasing for white non-Hispanic females, black non-Hispanic females, Hispanic males, white non-Hispanic males, and Hispanic females.

Ripple effects of the opioid epidemic are widespread. The economic, emotional, and social burdens are felt by our health departments, hospitals, children's services, criminal justice systems, providers, first responders, and other systems-level partners alike. Just as no age group has been left unaffected, no system is untouched.

For instance, our Clark County care provider United Senior Services identified an increased need for grief, caregiving, and financial support for grandparents who are raising their grandchildren due to parental addiction or overdose. Similarly, Rocking Horse Community Health Center recently began a support group for children whose parents or guardians are or were in active addiction.

First responders are another population that is heavily impacted by high overdose rates. Repeated exposure to overdose, death, and trauma takes an emotional toll on first responders, and it can contribute to the development of mental health issues like depression or Post-Traumatic Stress Disorder (PTSD). Cultural norms and disincentives to seek help within police and fire departments can exacerbate these negative effects. Locally, we hear seasoned first responders talk about how the constant overdose runs are severely impacting their mental health—and some are even quitting or are tempted to quit after years of service. In some instances, mental health issues among first responders have led to increased suicide rates. Ruderman Family Foundation's 2018 white paper *Mental Health and Suicide of First Responders* indicated that police officers and firefighters now are more likely to die by suicide than in the line of duty.

Suicide also is rising among the general population. A recent longitudinal analysis conducted by The Ohio Alliance for Innovation in Population Health indicated a 24% increase in Ohio's suicide rate between 2008 and 2017. Although the highest suicide rates occurred in the Appalachian region, rural and suburban areas which mirror the makeup of Clark, Greene, and Madison counties experienced the greatest increase over the ten-year period. Clark County data

demonstrates this trend; the suicide rate increased from 15.9 per 100,000 people in 2014 to 18.4 in 2017. Comparatively, the 2017 state average was 14.8, and the national average was 14.

A 2016 report from the Centers for Disease Control and Prevention indicated that farmers have high suicide rates compared to that of other occupations due to stress, financial risk, the isolating nature of the job, and lack of access to health services. Farmers also are at risk for experiencing depression, anxiety, and substance use concerns. Given that Clark, Greene, and Madison Counties all have high percentages of agricultural land—67%, 63%, and 88%—respectively, this is particularly relevant to our Board area. Recent agricultural challenges, including unprecedented levels of rainfall, increase our concern and apprehension about the mental health of this specific population.

In May 2019, tornadoes caused widespread damage in Greene County. More than 700 structures sustained damage; 292 of those structures were destroyed. The storm also caused substantial damage to area businesses, and the emotional and psychological effects continue to affect the community at large. Even individuals who were not directly impacted by the storms may be adversely impacted. Given the erratic nature of the tornadoes—which left some homes demolished, while sparing houses next door or across the street—it can be hard for people of all ages to understand and reconcile the events. In our communities, people are having difficulty coping, and are experiencing a wide range of emotions including guilt, anxiety, sadness, and anger. They may be at risk for developing PTSD. Longer-term effects also are common, especially for children who are exposed to natural disasters. Although effects vary based on the individual child's experience and developmental stage when the event occurs, in some instances, this exposure might constitute an adverse childhood experience (ACE), which can lead to health issues later in life. As HPIO suggests in its 2019 Dashboard, ACEs contribute to Ohioans being left behind, threatening their opportunity to grow into healthier adults. Further, childhood trauma can contribute to a range of health issues later in life, including risk for addiction, mental illness, and unhealthy substance use habits.

We know access to safe and affordable housing is a challenge in our communities. Treatment works, but we know it cannot exist in a vacuum. That's why our Board area has invested heavily in housing and other supportive services that can help people stay healthy. Despite our housing investments—21% of our funding supports housing—it remains a challenge in our communities.

**Economic factors in Clark, Greene & Madison Counties**
Research indicates that social and economic factors account for about 40% of overall health. These factors are highly intertwined. For example, social changes that arise from the opioid epidemic are resulting in economic consequences for our senior population in Clark County. The senior population already is disproportionately impoverished—for households of people over the age of 60, the average income is just $20,780. As the household ages to 80-84, the poverty rate is 28.5%. Yet as fathers, mothers, and caregivers are impacted by addiction, our seniors are left to take care of their children. This not only creates an emotional toll, but also an economic one.

Poverty rates are not limited to Clark County's senior population. The 2018 Census estimates the median household income in Clark County is $46,275, which is 13.3% below Ohio's median household income. 15.4% of Clark County residents are living in poverty, which is 3.10% above the national average.

The 2018 Census estimates the median household income in Madison County is $62,897, with 9.6% of Madison County residents living in poverty.

The 2018 Census estimates the median household income in Greene County is $65,032, meaning 9.8% of Greene County residents are living in poverty. Although the overall poverty rates in Greene County do not seem high, both Fairborn (pop. 33,344) and Xenia (pop. 26,193) have poverty levels above 20%, which is more than 8.5% over the national poverty level percentage.

While unsubsidized families who receive insurance through the Affordable Care Act saw their insurance premiums decline slightly in 2019, out-of-pocket costs are still rising. Limited median household incomes in Clark County and pockets throughout our other counties—such as Xenia and Fairborn in Greene County—make it hard for citizens to cover cost of treatment.

Unemployment also is an indicator of economic hardship. Although the Ohio Department of Job & Family Services showed that Clark County's labor force increased to 64,300 people from 63,200 in May, the unemployment rate continues to stay constant. Meanwhile, the wages for the jobs added continue to fall short of the state and national median income levels.

Greene County continues to rebuild after devastating unemployment rates following the recession. The unemployment rate decreased from 10.6% in 2009 to 4.1% in 2019. Wright Patterson Air Force Base has been a stabilizing factor not just for the county but for the entire region over the past several years.

Madison County's unemployment rate continues to trend .06% below the state average and .09% below the national average, however, many Madison County residents work in the agricultural industry, which has experienced hardship due to erratic weather conditions this year. Thus, we anticipate that farmers in Madison County will experience financial hardship in the coming year.

**Demographic information by county**
**Clark County**
Clark County is 397.47 square miles with approximately 339 persons per square mile and an estimated total population of 134,585. The 2018 Census estimates show a continued population decline of 2.7% between the 2010 Census and the 2018 adjusted estimates. According to 2018 US Census estimates, 86.9% of Clark County residents are Caucasian, 9.0% are African American, 3.5% are Hispanic, and .07% are Asian.

In HPIO's 2019 Health Ranking Report, Clark County ranked 69 out of 88 counties for health factors which is the same ranking Clark County received in 2018; however, there was a significant drop in ranking for health outcomes, which dropped 10 rankings. Health outcomes in Clark County ranked 80 out of 88 counties in Ohio.

**Greene County**
Greene County is 413.73 square miles with approximately 406 persons per square mile and an estimated total population of 167,995. The 2018 Census estimates shows an 4.0% increase in population between the 2010 Census and the 2018 adjusted estimates. According to 2018 US Census estimates, 86.1% of Greene County residents are Caucasian, 7.3% are African American, 2.9% are Hispanic, and 3.2% are Asian.

In the 2019 Health Ranking Report, Greene County ranked 11 out of 88 counties for health factors which is three higher than last year. The county's health outcome ranking remained the same.

While development in the western portion of Greene County continues to bring commercial and residential growth, the eastern portion of the county has maintained its agricultural roots. The county consists of nearly 244,000 acres, of which 177,000 remain agricultural. This provides Greene County with diversity that cannot be seen in many counties in Ohio.

**Madison County**
Madison County is 465.88 square miles with approximately 95 persons per square mile and an estimated total population of 44,413. The 2018 Census estimates shows an 2.0% increase in population between the 2010 Census and the 2018 adjusted estimates. According to 2018 US Census estimates, 90.1% of Madison County residents are Caucasian, 6.3% are African American, 2.1% are Hispanic, and 1.40% are Asian.

In the 2019 Health Ranking Report, Madison County ranked 36 out of 88 counties for health factors, a seven-county rise in rankings compared to 2018; however, there was a significant drop in ranking for health outcomes (11 spaces), landing at 41 out of 88 counties in Ohio.

| 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.**

With the unfortunate realities of limited and unsustainable funding, growing mental health and substance use concerns, the opioid crisis, rising suicide rates, and workforce trends like the psychiatrist shortage, MHRB is focused on building access and capacity in our communities. We know that this is the only way to address growing mental health and addiction-related needs in our community. Given the breadth of our work, these foci are malleable—but they consistently apply to our priorities and strategic plan.

Internally, we are building capacity with board members and staff through training, education, and preparation to more effectively and consistently implement best practices. We continue to make strides in the areas of communication and evaluation and have hired positions to achieve desired outcomes. Through these investments, we aim to use data collection and analysis to assess current capacity, monitor outcomes, and prioritize investments to enhance the continuum of care. We also hope to help all residents understand what to do when mental health concerns or substance use issues surface and reduce stigma that sometimes is tied to seeking treatment. To help achieve this objective, we plan to relaunch our website in SFY2020 and are in the process of creating consistent messaging about who MHRB is and what we do. An important aspect of this consistent messaging is the development of a preferred language document. Currently underway, this list will be used to educate our staff, board, and the public about using person-first, non-stigmatizing language through comprehensive educational communication strategies. In addition, MHRB updated our contract parameters, which allows us to shift funding mid-year to re-appropriate unused funding to where it is most needed. This will allow us to better utilize funding and evaluate effectiveness of services on an ongoing basis and to pivot based on identified gaps and needs in our community.

MHRB also invests in evaluation by collaborating with other Boards to continually identify effective strategies. As a Culture of Quality Board, our finance/facilities and program directors are trained as peer review surveyors and conduct surveys for other Board areas on a regular basis. This process is mutually beneficial—our staff share their expertise with other Board staff and simultaneously learn about other Boards' best practices and policies. Together, these internal investments build capacity and internal infrastructure in order to better position us to evaluate services and increase access for residents.

Ultimately, all MHRB business is about transforming the system structure in order to integrate services for mental illness and substance use disorder. We need to find the people with problems and engage them with helpful services as quickly as possible to reduce the chance of crisis. We aim to encourage long-lasting wellness and successful recovery for all

populations. We do this by approaching mental illness and addiction as chronic illnesses and by standing ready to help people plug back into healthy recovery supports or care whenever a recurrence happens.

Recognizing that we cannot feasibly do this alone, our Board is focused on collaboration with systems partners. We intentionally interface with community stakeholders, including local health districts; local, regional, and state planning and funding bodies; contract care providers; and individuals from all racial, ethnic, faith, and age groups—especially those with lived experience. MHRB approaches this not as a single event, but as an ongoing process to establish and sustain relationships. We build capacity, partnerships, and lead change in our communities.

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.**
Since 2016, MHRB has strived to develop and to maintain even closer relationships with our public health entities in all three counties. Historically, the Board has worked most closely with the Clark County Combined Health District (CCCHD) because of longevity with the Clark County Health Commissioner, value placed on effective communication, and growing understanding about how public health is inclusive of behavioral health. While that relationship remains strong, new leadership at MHRB and at other public health districts has accelerated a more intentional collaboration with the health commissioners and districts in Greene and Madison Counties as well.

While some parts of our relationships with health commissioners and districts are public—such as advocating together with legislators on common issues or releasing joint press releases—much of the work we do together is less visible. For example, multiple MHRB staff serve on the Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) planning committees, which will be further discussed in the following section. MHRB staff and health district employees communicate and work regularly to advance priorities outlined in the CHA and CHIP. Clark County's 2016-2019 CHA identified high non-emergency utilization of 911 as a concern. In response, the CCCHD, MHRB, and community partners, including representatives from the Springfield City and county government, created a task force which is working to develop a Business Associate Agreement that will aid in data sharing. The group also is working on a public messaging campaign to promote the use of 211 for non-emergent needs.

MHRB partners closely with other funders, like United Way, in all three counties. As similar regional funding bodies who address complex community issues and who are concerned with achieving measurable outcomes, our two United Way chapters and

MHRB can identify gaps and address unmet needs within our communities on a broader scale. MHRB serves on United Way and local health foundation advisory boards that are empowered to make funding decisions and participate in the grant selection process. Utilizing a collective impact framework, MHRB often operates as a backbone organization and serves as a catalyst for funding collaborations with other entities involving a diverse group of stakeholders. MHRB board members and staff are in leadership roles for United Way funding campaigns and grant awards in mutually reinforcing ways.

Together with community partners and coalitions, the Board uses its position in the community and funding streams to encourage local funding groups to invest in evidence-based strategies. Whether the strategic investment is related to behavioral health or not, we encourage local, state, and federal funding to enhance what is already working, reduce duplication, improve transparency, and to adopt strategies that work.

MHRB utilizes the Collective Impact (CI) approach to guide its work. CI helps systems to work better together by identifying a common agenda, tracking progress and continuous improvement, applying mutually-reinforcing strategies, practicing continuous communication, and by having backbone support that includes individuals or organizations who are highly committed to the goal. This approach also can be used to braid funding that is able to address the most critical needs in the community; funders pool dollars and used evidence-based techniques to create lasting, measurable change.

As evidenced by recruiting practices for our Board and staff, our representation across geographic and special populations, and our focus on elevating perspectives from individuals and families who experience mental illness and addiction, our Board values differing perspectives and seeks continuous feedback. We have a history of sponsoring clinical and frontline staff workforce development in cultural competency to better serve racial, ethnic, faith-based, and minority groups using evidence-based practices. For instance, the Board advocates for Feedback-informed-treatment (FIT) and participates regularly in events like The Addiction Crisis: A Catholic & Lutheran Response training session to equip ministers, parish nurses, and church committees who expressed interest in knowing more about addiction. In November 2018, the Board sponsored Eye-Movement Desensitization and Reprocessing (EMDR) training and ongoing supervision to better serve populations that are more likely to experience trauma. Since evidence suggests that trauma is common among specific populations—especially among minority, faith-based, and ethnic groups—our Board is focusing on infusing trauma-informed care throughout pathways to access our continuum of care.

As previously stated, we are heavily involved in the CHA & CHIP processes, which formally gather primary data and elicit feedback from community about how to better serve minority populations.

As a founder, funder, and leader in our suicide prevention and substance use coalitions, MHRB helped identify strategies to reach individuals and families with lived experience, faith communities, and underrepresented ethnic groups to increase help seeking and pathways to effective care. For example, Get Recovery Options Working (GROW), a coalition effort in Clark County, goes into areas that have more minority populations, who experience more poverty, have higher rates of crime, and consequently, those who experience more trauma to offer resources and pathways to treatment.

In July, our Board volunteered to host the first listening session for Governor DeWine's RecoveryOhio Minority Health Working Group. A former board member is co-chair of this working group. This connection provides us with direct access to learn from minority health leaders across the state and to relay our local needs to state leaders. We selected panelists who represented a range of ages; both male and female; several minority communities; and variety of socioeconomic backgrounds, including: LGBTQ, Hispanic and bilingual populations, diverse African American communities, individuals and family members with lived experience of mental health and substance use concerns, and a medical doctor with integrated physical-behavioral health experience. During the event, we made a public commitment to continue working with minority residents to learn more about their experience and to help increase their access to care.

To complement and to better inform our work locally around serving minority populations, looking forward we aim to strengthen our relationship with the National Association for the Advancement of Colored People.

Finally, in recent years, MHRB has made a concerted effort to increase the diversity of our board members to include more persons of color. We also strive to include individuals and families with lived experience. In fact, we exceed the minimum number of people and families with lived experience required to serve as board members.

MHRB wholeheartedly adopts the philosophy of including people with lived experience, and thread it throughout our work. We advocate for the inclusion of people with lived experience and their families and encourage them to serve on any committee we participate in—whether it is within our network or led by other planners or funders. Inclusion of individuals with lived experience is invaluable. It easily builds an immediate feedback loop to guide the work, destigmatizes seeking help, and allows others to understand underlying issues that might contribute to or exacerbate mental health or substance use issues. It also empowers those with lived experience and their family members to inform policy change and to share directly with audiences about their perception of unmet needs, barriers, and additional resources.

Our Board regularly holds formal and informal focus groups of people with lived experience around the topics of prevention, recovery supports, Recovery Oriented

Systems of Care (ROSC), gaps and needs, suicide prevention strategies, and overdose risk, among other relevant topics.

It should be noted that while MHRB tries to infuse and elevate individuals with lived experience, we are aware that there is a risk of the individual being triggered or traumatized. As such, we make every effort to include only those who wish to have a voice, and to arm them with protective factors that can minimize harm. One way in which we do this is by continually talking with others and by communicating with our contract care providers about how to continue to strengthen the supervision, self-care, and resilience of individuals to ameliorate compassion fatigue.

Another way our Board area has upheld people with lived experience is by supporting the peer and family member workforce. When OhioMHAS began certifying peers, our Board area was an early adopter. We immediately offered to host peer training, continued to do so in the subsequent years, and are committed to continually investing in our peers. We have incentivized our care providers to utilize peer recovery supporters. In FY2019, a Board staff member participated in peer recovery support training. We also recruited an OhioMHAS peer recovery support trainer to join our board by commissioner appointment. Now, the contract provider care network and Board leadership are seeing the benefit and culture change.

As our care providers continue to integrate peers into their workforce, we are committed to helping them create a cultural shift—not only in terms of direct service provision and grassroots advocacy, but also by offering insight about how to organizationally have the right supports and protective factors to affirm peers. This is integral to the success of employing peers, because they are exposed to ongoing risk of recurrence and harm due to having lived experience and by the very nature of their work (e.g., exposure to people in active addiction, risky environments, and hearing traumatic stories over time). The Board recognizes this delicate balance and works to have an ongoing conversation with care providers about how to keep peers healthy and well.

As demonstrated above, MHRB talks informally with our more than twenty care providers throughout the year. We also require all our contracted care providers to submit formal Agency Allocation Requests (AARs) and Strength, Weakness, Opportunity, and Threat (SWOT) analyses annually. These documents provide us with environmental context; offer anecdotal data about the needs, gaps, and disparities in our catchment area; inform us about the current landscape of Behavioral Health (BH) Redesign and its financial impact on service provision; and offer insight into our care providers' relationships with Managed Care Organizations (MCO).

Oftentimes, these reports also are integral in helping our Board to identify common strengths and challenges amongst our care providers. Information from last year's AARs

further highlighted the widespread nature of the supportive housing shortage for people living with mental illness and addiction. This information helped our Board to prioritize our capital plan and provided us with information we needed to seek competitive grants that would help create new levels of care. Through a SFY2019 capital grant, we expanded access to recovery housing beds and in SFY2020 we will secure additional housing for individuals with severe and persistent mental illness. Furthermore, the 21st Century CURES funding allowed us to create the Warm Hand-off program at McKinley Hall in Clark County, which helped fill the need for temporary housing between the time that an individual overdoses and the time they are able to start treatment. Staying in the safe house allows the individual to avoid returning to a place filled with temptation. As in the case of the Warm Hand-off program, AARs helped identify a need and allowed us to draw down grant dollars. With continued SOR funding, our Board was able to contribute our flexible levy dollars to sustain this effective practice. Participating in grant processes like CURES also allow our care provider agencies to learn from one another and to expand effective practices in all different types of settings, including courts, housing, and community outreach.

SWOT analyses submitted annually to MHRB also help us to identify common challenges among our care providers. They have informed our Board about workforce issues and competition with for-profit wages, local transportation barriers, and specific pain points our emergency departments are experiencing because of the opioid epidemic. Note that this list is not exhaustive.

In addition to these annual evaluations, MHRB asks its care providers—as well as community members and leaders—to fill out the Ohio Association of County Behavioral Health Authorities' survey on Recovery-Oriented Systems of Care (ROSC) biannually. This specific data will be further discussed in a later section.

MHRB also collaborates with its local suicide and substance use coalitions to disseminate surveys or to host community forums and educational events with evaluation components. We have collected data to identify community understanding of mental health and substance use disorder, familiarity with local resources, knowledge of how to access care, and perceptions regarding stigma. In partnership with each county's suicide and substance use coalition, MHRB sponsored forums for business and community leaders; prescribers; members of the faith community; families and persons with lived experience; elected officials; and the general public. At the end of these events, we elicit feedback from those in attendance. This data is then used on a regular basis as we build our strategic plans and measure progress.

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.**

All three public health agencies within our catchment area are in the process of completing their 2019 county health improvement process and national accreditation (MHRB assisted in the accreditation survey; one of three has achieved accreditation), to align with the State Health Improvement Process (SHIP). This year, the public health agencies are focusing on priorities identified in the SHIP, such as social determinants of health. Given our Board focus on recovery supports (i.e., employment resources, transportation, and supportive housing), MHRB can bring a level of expertise regarding social determinants in our specific population. We have threaded staff throughout the CHA & CHIP planning committees to contribute behavioral health-specific needs, identify gaps, and to create mutually reinforcing priorities. All MHRB departments apart from finance are heavily integrated in each process. Staff members are represented on CHA steering committees in all three counties, as well as on subcommittees that are more closely examining data and communication aspects. Concomitantly, the same staff are actively participating in each county's current CHIP implementation.

Although some Board areas conduct local surveys annually, MHRB has made a conscious and concerted effort to partner with other organizations to reduce duplication and increase effectiveness. Studies show that survey fatigue is a real phenomenon. To reduce survey fatigue and to increase the chance of our CHA reaching statistically significant samples, we have chosen not to conduct a separate community survey annually.

Our staff have been involved in everything from selecting questions to include on the CHA to identifying necessary data to ranking priorities. This level of involvement allows us to align our plans (i.e., community plan, strategic plan) with the priorities identified in the CHA & CHIP. It also allows us to share information about what we see as emerging needs in behavioral health. To best understand these emergent needs, we leverage data from our care providers—like challenges identified in AARs—as well as available information about the political landscape and relevant policy. We've found that this strategy reduces inefficiency and duplication and truly helps to fill gaps in the community.

It is important to note that while we are heavily involved with the CHA & CHIP processes, our collaboration expands beyond those planning periods and through meaningful implementation of the plans. For example, our coalition structure is modernizing to better address both critical issues of suicide and overdose prevention:

- During the process, two separate coalitions merged keeping a laser focus on both issues. Members are participating in other county-based coalitions to develop complementary strategies and gain feedback from diverse geographical areas.
- Data committees are restructuring to examine suicide and overdose data together. Areas are being identified for cross-training and capacity building for using data-driven approaches to address both issues.

Both examples demonstrate how we are evolving to better support mutual needs of our public health and behavioral health systems and to better facilitate community-based processes to achieve population health outcomes.

Outside of the CHA and CHIP processes, we have collaborated on grant applications and implementation. We also have invested funds, together with the health districts, to both raise the necessary capital to implement strategies and to ensure that successful strategies are sustainable.

In all three counties, we participate in numerous joint endeavors, including: drug death, suicide, and child fatality reviews. Our Board provides claims data to inform the larger committee about potential gaps in our systems or identified mental health or substance use concerns and service utilization. The committees then identify areas for improvement to reduce premature deaths. Moving forward, our Board area will make a concerted effort to gather more information during these reviews about how our care providers can contribute data and improve their processes.

We also collaborate closely with local health districts to share other types of data, including but not limited to epi-center data, syringe change and harm reduction data, and Youth Risk Behavior Survey data to inform our prevention efforts.

Local coroners share statistics regarding suicide and unintentional drug overdose. These statistics are oftentimes granular, including trends in methods, drug type involvement, and impetus. Representatives from the coroners' offices have presented at coalitions to help identify priority populations and inform strategies. Police and fire departments share data about non-fatal overdose runs, suicide attempts, and trending drugs of choice or hot spot neighborhoods. One of our three local hospital systems now is willing to enter a data-sharing relationship with us. Despite collaborative emergency care provided through MHRB funding to contract care providers within these hospital systems, no data sharing was ever before possible.

This type of collaboration is invaluable to our Board because it not only provides local data and context, it also allows us to build relationships and cache with local entities. Our involvement positions us as a thought leader on mental health and addiction. This recognition allows us to better connect systems of care to create healthier, more vibrant communities.

Although we have worked closely with our partners to instill transparency and data-sharing, our number one barrier is the lack of ability to share data. Our systems philosophically agree that data sharing is critical, but logistically, it is difficult to navigate HIPAA compliance, especially regarding hospital data. Through collaboration, we have identified significant data attributes that are not available. We are working collectively to figure out how to solve for those gaps.

Another significant barrier is language. Each system has different terminology, particularly in the arenas of prevention and health promotion. The public health and behavioral health (BH) models of prevention do not neatly line up. For instance, public health entities categorize harm reduction efforts like syringe exchanges as prevention efforts. The BH system, however, conceptualizes prevention as efforts that occur prior to the onset of any substance use disorder or mental illness.

Similarly, public health and BH goals do not always work in tandem. This means that to have effective partnerships, MHRB has to work with public health entities to identify a common agenda, language, metrics, complementary activities, and shared, sustainable funding that can satisfy both systems' mandates. One way MHRB navigates this is by participating in mutually beneficial task forces and coalitions. Oftentimes, this strategy aligns with participation in the CHA or CHIP, as several coalitions and task forces were formed or modified as a result of CHIP strategies.

Perhaps our largest and most challenging barrier to creating meaningful and sustainable change is policy. It is unrealistic to expect that large-scale, measurable outcomes will be seen without addressing policy, securing sustainable funding, and scaling up resources for our respective workforce commensurate with the level of need. Looking forward, we aim to increase joint involvement on policy-related issues with our health departments.

Despite the challenges that our Board faces while integrating public health and BH priorities, our willingness to be at the same table and our ability to be candid with one another is an enormous strength. MHRB has prioritized the building of trusting relationships. This intentional mindset sets the stage for seeking joint funding and sustaining mutually reinforcing implementation strategies, allowing limited resources to go further. It is important to note that despite limited resources available to the public health and behavioral health systems, we have been able to work collaboratively rather than cede to a competitive environment. Securing a growing amount of joint grant dollars to address suicide and overdose is one clear advantage. Finally, each public health department and MHRB are active to strengthen family council efforts, especially those focused on multisystem youth and their families.

While there are many challenges with being a three-county Board, it also comes with advantages. Although each county is unique, we can leverage ideas and learnings from each county and apply them, when applicable, to the larger Board area.

As described in the prior sections, MHRB and our public health partners are committed to continually identifying and working toward common agendas, practicing continuous communication, and improving our data sharing and analytical capabilities. All our health departments recognize that social determinants of health are foundationally important to the overall mental and physical wellness of our communities; meanwhile, MHRB knows that they are key for helping people recover and stay well. As such, social determinants will be a priority for our joint efforts to increase our collective impact.

Consultation and helping our partners with messaging about legislative and policy issues is another way that we can create meaningful change and expand the exposure of our stances on BH issues, which are informed by those that we advocate for and serve. For example, when Clark County Health Commissioner Charlie Patterson was invited to serve as an expert witness for the U.S. House of Representatives' Committee on Oversight and Reform to discuss identification, prevention, and treatment of childhood trauma, MHRB provided support, including individual consultation and sharing of resources.

In addition to supporting our regional partners navigate policy-related issues, MHRB itself aims to be more involved with policy at the local, state, and federal levels. One example is CEO Greta Mayer's testimony related to Governor DeWine's FY2020 budget.

c. **Child service needs resulting from finalized dispute resolution with Family and Children First Council [340.03(A)(1)(c)].**
   Not applicable.

d. **Outpatient service needs of persons currently receiving treatment in State Regional Psychiatric Hospitals [340.03(A)(1)(c)].**
   As gatekeepers of the State Regional Psychiatric Hospitals, Boards have a unique perspective about the outpatient service needs of persons currently receiving treatment in these facilities.

   We know that involvement of families in treatment can yield better outcomes. Yet, because of the regional re-alignment of hospital catchment areas, available hospital beds are not always near where the patients and their families live. Care providers and family members have difficulty participating in the treatment planning needs of patients admitted to Summit Behavioral Healthcare (SBH) due to the distance; for example, Madison County is approximately 72 miles from Summit. Participation in treatment team meetings, transportation, and care coordination needs are costly and time consuming due to the distance. Often the recommendations of the hospital treatment team are not feasible upon discharge due to a disparity in available resources (e.g., public transportation) or recommended level of care at a given point in time in the patient's home community.

Efforts are made by local contract care providers, MHRB, and state hospital staff to coordinate outpatient service needs. For those who are not interested or who are unable to return to their home community, there are additional complex barriers. Transportation alone can be cost prohibitive. Individuals often agree to relocate to leave the hospital, but often don't have the ability or intention to follow through with outpatient treatment.

In many instances, the proper support upon discharge either does not exist or is not available for both civil and forensic populations. This can cause further distress for patients, families, and providers. Efforts to address the barriers continue but gaps in outpatient service needs are complex and require creative partnerships across systems and accessible resources.  A "one size fits all" approach is not feasible due to the diverse and unique needs of those typically requiring the most intensive level of care. Lack of outpatient restoration and robust assisted outpatient commitment programs are additional gaps in care.

MHRB has developed agreements with group homes, residential programs, and supervised settings outside of the immediate region to meet the step-down needs of those leaving institutional settings. While not ideal, these options are necessary to avoid less-desirable plans which often include placement in the less supportive, unsupervised, or unsecure settings like motels or homeless shelters.

The link between safe, stable, and affordable housing and mental illness is clear: individuals who do not have their basic needs met are less likely to have the stability they need to stay well. Our communities need more supervised and supportive housing environments where individuals can stay in long-term recovery. Offering supportive services like stable housing can help prevent crises or recurrence before they occur.

Another gap in services is lack of capacity for individuals with severe co-occurring mental illness and substance use disorders, along with chronic physical health problems. Those with co-occurring illness often have a greater level of acuity and require complex, long-term care. There is a need for more integrated outpatient services to respond to these needs.

Apart from these issues, capacity is a glaring issue. Since de-institutionalization, the number of beds has decreased, despite the growing need for inpatient treatment. Meanwhile, hospital beds are increasingly allocated to forensic patients, leaving little to no room for civil patients. As a result, our care providers stopped requesting state hospital placements on behalf of clients, assuming beds are unavailable. Without a specific number of denied requests, we are unable to accurately identify what volume is needed.

This lack of capacity not only does a disservice to individuals who need help, it also impacts families and other systems. Distressed family members frequently contact

Board staff to advocate for a hospital level of care for their loved one. First responders continually come into contact with individuals who are severely and persistently mentally ill, but they have nowhere to place these individuals when they are in crisis. As a result, these individuals end up interacting with law enforcement and ultimately end up either in jail or return to the community without treatment.

e. **Service and support needs determined by Board Recovery Oriented System of Care (ROSC) assessments.**
In August 2018, MHRB distributed OACBHA's ROSC survey to care providers and community members. Survey results indicated that is it optimal to engage with and deliver care to individuals in their natural environment. For instance, given that we know that 70% of individuals who have substance use disorder are employed—and that addiction can impact work performance—reaching out to businesses is a natural connection opportunity. In conjunction with Working Partners, MHRB developed a strategic plan in fall of 2018 to help employers navigate workplace issues related to mental health and substance use concerns. The plan was built using a data-driven approach from the Drug-free Workplace Community Initiative Employer survey, which was distributed to a statistically significant sample of 1095 businesses and community leaders across Ohio. MHRB is using this robust strategy to engage a population that is inherently hard to reach (adults) and to connect with them in a natural environment (workplace).

MHRB is encouraging our care providers to adopt the same philosophical approach. Moving forward, we will be reviewing claims data monthly to ensure that our care providers are reaching out where people naturally are to help connect them to treatment. We can do this using the place of service information contained in our claims data.

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)].**
The number of capital investments that MHRB has is a unique aspect of our Board. Because of the sheer volume of properties we own, we are able to support regional contract care providers not only fiscally but also by offering them cost-effective space. Hiring a skilled property manager and implementing a preventive maintenance schedule and computer-based maintenance help desk are strategies MHRB employed last fiscal year, which are already garnering results by efficient prioritization of the most critical maintenance requests and fixes. Over time, however, maintaining old buildings and keeping them up to code is cost-prohibitive. Because of this, MHRB developed a robust capital plan to leverage OhioMHAS capital dollars, allowing contract care providers to expand their continuums of care based on their need and capacity. The majority of new capital projects will place the onus of ownership and ongoing maintenance costs on care providers. This allows us to build capacity within our local continuum of care, while being realistic that our budget cannot support ongoing maintenance costs of additional

capital investments without a strategic directional shift. This spring, our Board supported five capital projects across three counties, including a property to house five people living with severe and persistent mental illness (SPMI) in Fairborn, as well as a property for four people with SPMI in Madison County. Three projects received initial approval by OhioMHAS.

The nationwide psychiatrist shortage has impacted our Board area, especially as older psychiatrists retire. In the past year, several well-known and reliable psychiatrists from a variety of community-based organizations have retired or relocated. Compounding this issue is the need for prescribers who are confident and comfortable enough to prescribe medication for both mental health and addiction. We have tried to support the workforce by sponsoring DATA2000 trainings, however, there aren't enough prescribers to serve the number of individuals requiring medication management.

Along a similar vein, the complexity of co-occurring issues means fewer prescribers are equipped to provide both mental health medication management and Medication Assisted Treatment (MAT). Although this has improved with our help, it remains a challenge in our area. Several agencies have utilized telehealth, with differing levels of success. Oftentimes, these are gap-filling measures; increasing capacity for psychiatric services is simply cost-prohibitive.

Medicaid Expansion did not benefit traditional mental health providers compared to addiction service providers. Because mental health reimbursements decreased, our mental health agencies are struggling financially and are unable to aggressively expand to provide comprehensive mental health and addiction care that would help alleviate their financial concerns. This is an example where policy limitations are negatively impacting our care providers.

The growing number of families and young children impacted by the opioid epidemic create concern for future generations who now are experiencing increased trauma and Adverse Childhood Experiences (ACEs). To proactively combat this concern, MHRB is building capacity for early childhood mental health services in our communities. Coupled with a comprehensive approach to prevention, this hopefully will provide future generations with the coping skills and the resiliency they need to minimize further risk.

As noted earlier, stable and affordable housing is a critical and foundational aspect to getting and staying well. Yet, it is especially challenging for criminal justice populations with certain felony histories, those with previous eviction histories, women and families, and aging people with SPMI. MHRB invests heavily in housing-related initiatives and is part of the RAB 5 Housing Committee of a Regional Affiliate Boards group, which is working on several collaborative projects that are of common interest. This group uses a regional approach to address housing needs and has explored each of the Board's

unique gaps, populations, strengths, and challenges. The RAB team has been in discussion with OhioMHAS regarding funding opportunities and with The Corporation for Supportive Housing (CSH) to explore sending a regional team to the intensive Supportive Housing Institute. We also participate in the Ohio Region 15 Balance of State Continuum of Care (BoSCoC) needs assessment and planning process.

As noted in prior sections, MHRB has invested in and prioritizes the training, funding, and support of peer recovery supporters and recovery support centers. MHRB leveraged the SOR Peer funding to partner with Ascent powered by Sober Grid, which provides digital access to a supportive community and 24/7 peer support for those recovering from mental illness and addiction. During training, peer supporters are encouraged to set healthy boundaries, however, cravings and triggers often occur outside of normal work hours. Offering Sober Grid to peers, contract care providers, and through recovery support centers provides 24/7 peer support. This new strategy can help prevent relapse for those in early or long-term recovery. It is a way to increase help-seeking and healthy social support for those in active addiction using a low-risk methodology. Importantly, when clients have access to 24/7 peer support, peers are able to have peace of mind and can set healthy boundaries for their self-care. Currently, 50 individuals have utilized digital peer support and an analysis of benefits is underway. Sustainable funding beyond the SOR Peer source has not yet been identified, which is a gap.

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.**
Language is a major gap in crisis work, because there is not a singular definition of crisis. We are actively meeting with contract care providers across the region to assess their current crises practices and to identify their working definition(s) of crisis. To better understand the crisis landscape within our communities, we are expanding our tracking ability within our claims payment system. We hope that tracking this data over time will help us to learn about trigger points for crises in our community, including seasonal trends and environmental changes. Our Board currently is building internal capacity by training front office staff to track crisis calls and to triage those who call MHRB during a crisis.

In anticipation of the additional FY2020 crisis funding, we are identifying what works well and discussing how we can more effectively assess and manage crises services in all three counties. MHRB leadership will continue to lead these discussions to determine with our care providers the best utilization of state and local resources. While the current investment is appreciated, innovative and best practice approaches to stave off crises and to support and stabilize people with serious mental illness or co-occurring disorders often are not sustainably funded. This is a gap in the system statewide.

Assertive Community Treatment requirements for face-to-face service and adequate service billing revenue inhibit the implementation of this evidence-based model. The Governor's Emergency Executive Order is a promising step in the right direction, as the face-to-face requirement for the prescriber team member addresses an aspect of this gap. As previously described, psychiatric and prescriber workforce shortages are threats to the system of care. When policies and funding structures do not uphold best practice programs, the costly consequences are felt by individuals, families, and care providers.

Studies led by The Stepping Up Initiative indicate that a third of Ohio's inmates live with a mental illness—and national statistics suggest that 75% of inmates have a co-occurring substance use disorder. These figures suggest that jails have become proxies for mental health treatment facilities, however, jail staff is not equipped to handle these medical concerns.

In addition to lack of treatment in jails, our jails are well over capacity, leaving less bandwidth for prison guards and corrections staff to tend to the needs of specialized populations. Another concern is that Medicaid is "turned off" while people are incarcerated. In all three counties, MHRB utilizes levy dollars to fund Medicaid eligible services like assessment, crisis, case management, group and individual treatment, and psychiatry to fill this gap.

The Stepping Up Initiative aims to combat these issues in Ohio and nationally. In order to become a Stepping Up Community, County Commissioners must pass a resolution. Last fall, our Clark County Commissioners declared Clark County a Stepping Up Community, which enabled us to host an opioid-specific Sequential Intercept Mapping (SIM) event in Springfield. In preparation for the event, MHRB collected information from our jail, courts, and other system partners. This exercise helped us to identify gaps in the system, like not having evidence-based screening tools at booking or not employing a coordinated response to positive mental health screenings in the Clark County Jail. The SIM event identified gaps and resources across six criminal justice intercepts, and the community identified five priorities for change: specialized dockets; data collection, capacity and access; housing; peer support access across intercepts; and pretrial diversion programs. Workgroups continue to address the goals, objectives, and action steps identified in this process.

Currently, our Board area has only two specialty dockets: drug court and Veterans' Court in Greene County. This is an additional identified need in our communities. MHRB and the behavioral health system are advocating for and leading efforts to expand specialty dockets at juvenile, family, and adult levels.

Finally, our Board area hosts a robust Crisis Intervention Team (CIT) training each fall for law enforcement from all three counties. But training alone is not sufficient. Large scale change requires policy to support the tenets of CIT (e.g. deployment policies,

information sharing, and data collection and analysis). Creating cross-discipline crisis team approaches are challenging without proper sustainable funding.

MHRB has always prioritized funding Family & Children First Council (FCFC) initiatives to pool dollars with other systems partners around multi-system or high-need youth and their families. When not possible through our collaborative decision-making process, MHRB addresses specific needs for services outside of our Board area on a case-by-case basis. For example, we have sent youth out of state and secured special placement when necessary. This helps to fill an all-too-prevalent gap: parents who are faced with relinquishing custody to get their children the care that they need because they cannot otherwise afford it. MHRB tries to safeguard familial structure by paying for care when appropriate and not otherwise available.

The opioid epidemic has forced more strategic collaboration between systems, including child welfare. With potential for joint funding, our agencies are even more focused in unison to address substance use issues through coalitions and task forces. Viewing this issue using the unique lens of how trauma affects mental health and substance use issues later in life has deepened our relationship and made it more effective.

Although our Board is thankful for Governor DeWine's investment in prevention for K-12 students, we would be remiss to not mention that funneling the funds through the Department of Education is a limitation, largely because schools are not held to the same standards as care providers who employ licensed preventionists. This is partially due to the fact that Ohio does not have health education standards, yielding inconsistency in implementation of health and prevention curricula. MHRB promotes evidence-based prevention like PAX Good Behavior Game® and Botvin LifeSkills® Training to maximize positive outcomes. We recognize that in some cases, adaptations should be made to curricula in order to accommodate cultural relevance, however, these changes need to be made in a responsible way that is supported by implementation science and continuous evaluation practices. The Board has made additional investments by engaging in relationship building with our local education systems, by funding prevention planning, and by convening a Prevention Professionals Learning Community (PPLC) to build infrastructure in the community and to increase competence of local preventionists. We provide training, funding, and oversight to deliver evidence-based strategies in partnership with certified prevention agencies— even when their employer is not certified in prevention. Together, these actions support a holistic approach to prevention. This comprehensive strategy demonstrates the value of being a three-county Board; we are able to offer opportunities for cross-training and capacity-building that spans across county lines.

While we welcome additional funding for K-12 prevention, it is imperative that the behavioral health system consider and invest in prevention across the lifespan. Our Board has invested in this through our work with employed adults and through a one-

time grant for an evidence-based depression program in older adults. The comprehensive need and demand for effective ways to reduce the onset, duration, and severity of mental illness and addiction is untenable. We continue to educate the community and other funders about the broad nature of prevention.

**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).**

The information represented in the table below is intended to reflect that the Board has satisfied the minimum requirements indicated within the inventory template. It does not represent the full breadth of the available facilities, services, and supports available within our Board area. **Double click to open as an Excel document.**

| ESSENTIAL SERVICE CATEGORIES | TREATMENT FOCUS | SERVICE LOCATION | MEDICAID & NON-MEDICAID PAYABLE SERVICES | SERVICE CHOICE INDICATED BY A PROVIDER NAME & ADDRESS IN THIS COLUMN | BOARD CONTRACT (Y/N) |
|---|---|---|---|---|---|
| BOARD: MHRB of Clark, Greene and Madison | | | SFY 2020 CONTINUUM OF CARE: CROSSWALK FROM ESSENTIAL SERVICE CATEGORIES TO INDIVIDUAL SERVICES | | |
| 1 Ambulatory Detox | Opiate Treatment | Must be in Board area Unless Waived per ORC 5119.22t | SUD Withdrawal Management with Extended On Site Monitoring, RN and LPN Services (ASAM LOC 2 WM) | TCN Behavioral Health Services, 452 W. Market, Xenia | Y |
| | | | SUD Withdrawal Management with Extended On Site Monitoring, 23 hour observation per diem (ASAM LOC 2 WM) | TCN Behavioral Health Services, 452 W. Market, Xenia | Y |
| 2 Sub-Acute Detox | Opiate Treatment | May be in another Board area | SUD Clinically Managed Residential Withdrawal Management (ASAM Level 3.2-WM) | Nova House, 732 Beckman, Dayton | |
| 3 Non-Intensive Outpatient Service | Opiate Treatment | Must be in Board area | Adult (age 18 years and older) up to 8 contact hours/week | TCN Behavioral Health Services, 452 W. Market, Xenia | Y |
| | | | Adolescent (age 13 through 17) up to 6 contact hours/week | TCN Behavioral Health Services, 452 W. Market, Xenia | Y |
| 4 Intensive Outpatient Service | Opiate Treatment | Must be in Board area | SUD IOP Adult (age 18 years and older) 9 or more contact hours/week with a minimum of contact 3 days/week | TCN Behavioral Health Services, 452 W. Market, Xenia | Y |
| | | | Adolescent (age 13 through 17) 6 or more contact hours/week with a minimum of contact 3 days/week | TCN Behavioral Health Services, 452 W. Market, Xenia | Y |
| | | | SUD Partial Hospitalization Adult (age 18 years and older) 20 or more contact hours/week with a minimum of contact 3 days/week | TCN Behavioral Health Services, 452 W. Market, Xenia | Y |
| | | | Adolescent (age 13 through 17) 20 or more contact hours/week with a minimum of contact 3 days/week | TCN Behavioral Health Services, 452 W. Market, Xenia | Y |
| 5 Medication-assisted treatment (MAT) | Opiate Treatment | Must be in Board area Unless Waived per ORC 5119.221 | Buprenorphine, Buprenorphine/Naloxone administration | TCN Behavioral Health Services, 452 W. Market, Xenia | Y |
| | | | Injection, naltrexone (Vivitrol) | TCN Behavioral Health Services, 452 W. Market, Xenia | Y |
| | | | Methadone administration | | |
| 6 Peer Mentoring | Opiate Treatment | Must be in Board area | MH Peer Recovery Support (Peer Certification required) [Specialized Recovery Services (SRS 1915(i)) Only] | TCN Behavioral Health Services, 452 W. Market, Xenia | Y |
| | | | BH Peer Recovery Support [No Peer Certification required] [Non-Medicaid Payable Service] | McKinley Hall 2624 Lexington Springfield | Y |
| 7 Residential Treatment | Opiate Treatment | May be in another Board area | Level 4 Recovery Housing | | |
| | | | SUD Clinically Managed Low-Intensity Residential Treatment-Halfway House (ASAM LOC 3.1) | McKinley Hall 2624 Lexington Springfield | Y |
| | | | SUD Clinically Managed Population-Specific High Intensity Residential Treatment (ASAM LOC 3.3) | | |
| | | | SUD Medically Monitored Intensive IP Treatment [Adults] & Medically Monitored High-Intensity IP Services [Adolescent] (ASAM LOCs 3.7) | Womens Recovery Center, 515 Martin, Xenia | Y |
| | | | SUD Medically Monitored Inpatient Withdrawal Management (ASAM LOC 3.5-WM) | | |
| 8 Recovery Housing | Opiate Treatment | Must be in Board area | Level 1 Recovery Housing | | |
| | | | Level 2 Recovery Housing | TCN Behavioral Health Services, 452 W. Market, Xenia | Y |
| | | | Level 2 Recovery Housing (IOP Required) | | |
| | | | Level 3 Recovery Housing (IOP Not Required) | | |
| 9 12 Step Approaches | Opiate Treatment | Must be in Board area | Existence of 12 Step Programs in Board Area | Yes | |

| ESSENTIAL SERVICE CATEGORIES | TREATMENT FOCUS | SERVICE LOCATION | MEDICAID & NON-MEDICAID PAYABLE SERVICES | SERVICE CHOICE INDICATED BY A PROVIDER NAME & ADDRESS IN THIS COLUMN | BOARD CONTRACT (Y/N) |
|---|---|---|---|---|---|
| BOARD: MHRB of Clark, Greene and Madison | | | ORC 340.032 Mid-Biennial Review (MBR) [Sub.S.B. No. 319, December 2016] | | |
| Prevention & Wellness Management | MH & AOD Treatment Including Opiates | May be in another Board area | SUD Alternatives | | |
| | | | SUD Community Based Process | | |
| | | | SUD Education | Wellspring, 15 E. Pleasant, Springfield | Y |
| | | | SUD Environmental | | |
| | | | SUD Information Dissemination | | |
| | | | SUD Problem Identification and Referral | | |
| | | | MH Alternatives | | |
| | | | MH Community Based Process | | |
| | | | MH Education | Greene County Educational Service Center, 360 E. Enon Rd., Yellow Springs | Y |
| | | | MH Environmental | | |
| | | | MH Information Dissemination | | |
| | | | MH Problem Identification and Referral | | |
| Locate & Inform Persons Needing Services | MH & AOD Treatment Including Opiates | May be in another Board area | BH Referral and Information | TCN Behavioral Health Services, 452 W. Market, Xenia | |
| Recovery Supports, including helping persons in AOD and/or MH services necessary to: | | | | | |
| •meet basic human needs; •care coordination; •obtain assistance with social, personal & living skills; obtain multiple paths to recovery, e.g., 12 step approaches, parent advocacy connection, etc.; • obtain support, assistance, consultation & education for families, friends & persons receiving AOD & MH services & supports; | MH & AOD Treatment Including Opiates | May be in another Board area | SUD Case management | TCN Behavioral Health Services, 452 W. Market, Xenia | Y |
| | | | MH Community Psychiatric Supportive Treatment (CPST) | TCN Behavioral Health Services, 452 W. Market, Xenia | Y |
| • participate in peer programs; | MH & AOD Treatment Including Opiates | May be in another Board area | MH Peer Recovery Support (Peer Certification required) [Specialized Recovery Services (SRS 1915(i)) Only] | | |
| | | | BH Peer Recovery Support [No Peer Certification required] [Non-Medicaid Payable Service] | MHS of Clark & Madison, 474 N Yellow Springs, Springfield | Y |
| | | | MH Consumer Operated Service | | |
| • obtain employment, vocation & educational opportunities; | MH & AOD Treatment Including Opiates | May be in another Board area | BH Individualized Placement and Support-Supported Employment (PS-SE) [Specialized Recovery Services (SRS 1915(i)) Only] | | |
| | | | BH Employment/Vocational [Non-Medicaid Payable Service] | TCN Behavioral Health Services, 452 W. Market, Xenia | Y |
| • obtain housing & support from a wide range of options; | MH & AOD Treatment Including Opiates | May be in another Board area | SUD Housing - Residential Care | | |
| | | | SUD Housing - Permanent | McKinley Hall 2624 Lexington Springfield | Y |
| | | | SUD Time Limited/Temporary | | |
| | | | MH Housing - Residential Care | MHS of Clark & Madison, 474 N Yellow Springs, Springfield | Y |
| | | | MH Housing - Permanent | Housing Solutions of Greene County, 335 E. Market, Xenia | Y |
| | | | MH Time Limited/Temporary | | |
| Assessment Services | MH & Non-Opiate AOD Treatment | May be in another Board area | BH Psychiatric Diagnostic Evaluation (w/o or w/ medical) | MHS of Clark & Madison, 474 N Yellow Springs, Springfield | Y |
| | | | BH Screening, Brief Intervention, Referral to Treatment (SBIRT) | McKinley Hall 2624 Lexington Springfield | Y |
| | | | SUD Assessment | | |
| | | | Psychological Testing | | |
| | | | Developmental Testing | | |
| | | | Neurobehavioral Status Exam | | |
| | | | Neuropsychological Testing | | |
| Residential Services | MH & Non-Opiate AOD Treatment | May be in another Board area | SUD Clinically Managed Low-Intensity Residential Treatment-Halfway House (ASAM LOC 3.1) | | |
| | | | SUD Clinically Managed Population-Specific High Intensity Residential Treatment (ASAM LOC 3.3) | Womens Recovery Center, 515 Martin, Xenia | Y |
| | | | SUD Medically Monitored Intensive IP Treatment [Adult] & Medically Monitored High-Intensity IP Services [Adolescent] (ASAM LOCs 3.7) | | |
| | | | MH Housing - Residential Treatment Room & Board: Type 1 Licensed Facility | MHS of Clark & Madison, 474 N Yellow Springs, Springfield | Y |
| Outpatient services, including: | | | | | |
| • Non-Intensive | MH & Non-Opiate AOD Treatment | May be in another Board area | BH Psychotherapy | TCN Behavioral Health Services, 452 W. Market, Xenia | Y |
| | | | BH Family Psychotherapy | TCN Behavioral Health Services, 452 W. Market, Xenia | Y |
| | | | BH Multiple-Family Group Psychotherapy | | |
| | | | BH Group Psychotherapy | | |
| | | | BH Counseling & Therapy, individual | McKinley Hall 2624 Lexington Springfield | Y |
| | | | SUD Group Counseling | TCN Behavioral Health Services, 452 W. Market, Xenia | Y |
| | | | MH Therapeutic Behavioral Services (TBS) | MHS of Clark & Madison, 474 N Yellow Springs, Springfield | Y |
| | | | MH Psychosocial Rehabilitation (PSR) | TCN Behavioral Health Services, 452 W. Market, Xenia | Y |
| • Intensive Outpatient Services | MH & Non-Opiate AOD Treatment | May be in another Board area | BH Evaluation & Management (E/M) | TCN Behavioral Health Services, 452 W. Market, Xenia | Y |
| | | | SUD Intensive Outpatient Program (IOP) and SUD Partial Hospitalization (PH) group counseling | TCN Behavioral Health Services, 452 W. Market, Xenia | Y |
| | | | BH Electrocardiogram, with at least 12 leads | | |
| | | | SUD RN Services | TCN Behavioral Health Services, 452 W. Market, Xenia | Y |
| | | | SUD LPN Services | TCN Behavioral Health Services, 452 W. Market, Xenia | Y |
| | | | MH LPN Nursing Services | | |
| | | | MH RN Nursing Services | | |
| | | | Urine Drug Screening | TCN Behavioral Health Services, 452 W. Market, Xenia | Y |
| | | | Medication Administered by Medical Personnel (J-Codes) | | |
| | | | Laboratory Services | | |
| | | | Vaccine Administration Code | | |
| | | | Vaccine CPT | | |
| | | | MH Day Treatment | MHS of Clark & Madison, 474 N Yellow Springs, Springfield | Y |
| | | | MH Assertive Community Treatment (ACT) | TCN Behavioral Health Services, 452 W. Market, Xenia | Y |
| | | | MH Intensive Home-based Therapy (IBHT) | | |
| • Withdrawal Management | Non-Opiate AOD Treatment | May be in another Board area | SUD Withdrawal Management with Extended On Site Monitoring, RN and LPN Services (ASAM LOC 2 WM) | | |
| | | | SUD Withdrawal Management with Extended On Site Monitoring, 23 hour observation per diem (ASAM LOC 2 WM) | | |
| | | | SUD Clinically Managed Residential Withdrawal Management (ASAM Level 3.2-WM) | | |
| | | | SUD Clinically Managed High Intensity Residential Treatment (ASAM LOC 3.5-WM) | TCN Behavioral Health Services, 452 W. Market, Xenia | Y |
| | | | SUD Medically Monitored Inpatient Withdrawal Management (ASAM LOC 3.7-WM) | | |
| • Emergency & Crisis | MH & AOD Treatment Including Opiates | May be in another Board area | BH Psychotherapy For Crisis | TCN Behavioral Health Services, 452 W. Market, Xenia | Y |
| | | | BH Counseling & Therapy, individual | MHS of Clark & Madison, 474 N Yellow Springs, Springfield | Y |
| | | | MH Therapeutic Behavioral Services (TBS) (determined by rendering provider, not nursing) | | |
| | | | MH Psychosocial Rehabilitation (PSR) (determined by rendering provider, not nursing) | | |
| | | | BH Hotline | TCN Behavioral Health Services, 452 W. Market, Xenia | Y |
| Inpatient Care | MH & AOD Treatment Including Opiates | May be in another Board area | SUD Acute Hospital Detoxification | Springfield Regional Medical, 100 Medical, Springfield | N |
| | | | MH Private Inpatient psychiatric | MHS of Clark & Madison, 474 N Yellow Springs, Springfield | Y |

| 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.**

**Priorities for treatment:**

MHRB's 2018-2021 Strategic Plan Goal 2 states the MHRB will proactively work with providers and managed care entities to evaluate accessibility for: adults, children/youth, families, and populations with health equity and diversity needs. Objectives of Goal 2 specify that we will:
- Create a program, finance, and information technology work plan to enhance treatment services
- Monitor behavioral health redesign and the transition to managed care

**Priorities for prevention:**

Despite dramatic state funding cuts in fiscal year 2010, our Board continues to invest local levy dollars in prevention. In fiscal year 2019, 44% of MHRB-funded prevention services were funded by local levy dollars. We invested these funds for two reasons. First, we know that there will never be enough treatment dollars available to address the growing demand for services. Second, we know that prevention yields a strong return on investment. According to the National Institute on Drug Abuse, substance abuse costs the United States more than $600 billion dollars annually–but every dollar invested in addiction treatment programs saves between $4 and $7 by reducing crime and criminal justice-related costs.

By investing local dollars, our Board area has greatly expanded its prevention efforts through partnerships with local coalitions, schools, Family and Children First Councils, and Children's Services. These investments not only have increased access to prevention in schools, they also have contributed to building a viable workforce that is equipped to deliver prevention services. Although MHRB continues to invest in prevention, our modest amount of local and state funding to support evidence-based, effective strategies is not enough to address the growing need.

Mental health promotion and prevention across the lifespan can prevent the development of behavioral health problems. It also can identify practices for intervening with varying at-risk populations to reduce the duration or severity for mental health problems throughout life. Knowing the local needs, strengths, and challenges of the local system, MHRB has identified prevention priorities specific to the needs of adults, children and youth, families, and populations with health equity needs.

**Goal 3 of MHRB's 2018-2021 Strategic Plan states that we will lead the community to adopt practices that promote health and prevent mental, emotional, and behavioral health problems.** MHRB has contracted with a prevention expert to help facilitate a prevention strategic plan. Identified priorities include:

**Priority 1: Build prevention infrastructure through development and implementation of a culturally competent framework for integration of prevention into all community systems.**

1. Develop and maintain sustainable prevention funding

2. Infuse culturally competent prevention into all systems, addressing all community members from cradle to grave. This means:
   - Systems and organizations maintain a prevention paradigm and implement prevention interventions internally
   - Child welfare incorporates prevention interventions as a routine element of their work with families and children
   - Law enforcement maintains a "handle with care" approach, responding to situations through a trauma-informed lens
   - Employers incorporate comprehensive drug-free workplace philosophy and practice
   - Hospitals and other health care providers incorporate SBIRT (Screening, Brief Intervention and/or Referral to Treatment) practices and other health promotion and prevention strategies
   - School districts and youth organizations incorporate youth-led prevention, also serving as a foundation for county level youth-led prevention
   - Coalitions develop and maintain the necessary expertise to advocate for and implement prevention interventions

3. Utilize needs assessment and other data collection tools to drive selection and implementation of prevention interventions by community members and prevention professionals

4. Develop the infrastructure of community coalitions to empower and maintain coalition member engagement and activity in planning, implementation, and evaluation of prevention interventions
   - Coalition staff primarily facilitate, support, and provide expertise and guidance to the work of the coalition, while coalition members implement the actual prevention interventions
   - Coalition leaders are trained and equipped with necessary skills to effectively facilitate coalition work

5. Develop and maintain relationships among systems for the purposes of advancing prevention within Clark, Greene, and Madison Counties

**Priority 2: Build the prevention systems, individual prevention professionals, and a community workforce.**

1. Develop and maintain a well-trained, experienced, sustainable prevention professional community in Clark, Greene, and Madison Counties
   - Recognizing the challenges associated with employment of preventionists, individual prevention professionals have myriad career path opportunities within and outside of Clark, Greene, and Madison Counties
   - Prevention Professionals' Learning Community is self-sustaining and provides leadership and guidance for ongoing prevention planning, implementation, and evaluation within Clark, Greene, and Madison Counties
   - Knowledge transfer and skills integration are ensured through training of professionals, coalition leaders, and other stakeholders
2. Develop a community-based, multi-partner fiscal plan to support and sustain prevention
3. Build capacity for and influence funders and other stakeholders to direct resources to evidence-based prevention interventions
4. Ensure all funded prevention providers are certified under OhioMHAS regulation
5. Equip systems and organizations (e.g. schools, CPS, law enforcement) to maintain one or more prevention professionals on their staff
6. Create capacity for communities and community members to "think prevention" and embrace and sustain evidence-based and research-informed prevention interventions delivered with fidelity
7. Maintain at least one Ohio Certified Prevention Specialist or Ohio Certified Prevention Consultant-credentialed staff person at the Mental Health & Recovery Board of Clark, Greene & Madison Counties

**Priority 3: Ensure data collection and measurable outcomes drive all prevention planning, implementation, and evaluation in Clark, Greene, and Madison Counties.**

1. Develop and maintain a data committee for each county
2. Increase data sharing and dissemination among systems and throughout communities
3. Increase systems and community investment in data-driven practice
   - Ensure systems and personnel are trained and equipped in data-driven practice
4. Systemically incorporate evaluation into all prevention planning processes, including funding
5. Collaborate with local universities and colleges on data collection and evaluation
6. Increase and maintain systems and community prioritization of evidence-based and research-informed practice
7. Infuse cultural competence into all prevention planning, implementation, and evaluation
   - Systems and professionals are responsive to health disparities among populations

8. Utilize data to increase prevention services to selective populations
9. Effectively communicate data-driven financial benefit of prevention with messaging to the general population, stakeholders, and systems

**Priorities for supportive services**

A key tenant of MHRB's 2018-2021 Strategic Plan, as identified in Goal 4, is to strengthen existing and leverage new partnerships to expand quality supportive services aligned with ROSC principles. This includes creating a short and long-term supportive services work plan including peer support, housing/facilities, and vocational efforts.

Historically, MHRB has supported development of the peer recovery supporter workforce. Initially, our Board was an early adopter of the approach, sponsoring one of the first OhioMHAS trainings. Since, we have continued to support a peer workforce by offering additional trainings and by helping our care providers embed peer supporters into their agency cultures. Today, we continue to arm those care providers with information and resources to keep their peers well. We recently leveraged SOR dollars to partner with Ascent powered by Sober Grid, an app to support those in recovery and help offer reprieve for our peer workforce.

Recognizing the importance of safe and affordable housing as a foundational component of helping people get and stay well, MHRB allocates funding and resources to several housing efforts. Our efforts address specific populations that oftentimes face barriers to finding housing, including criminal justice populations with certain felony histories, those with previous history of eviction, single-mothers and families, and aging people with severe and persistent mental illness. We work with several entities, including public health districts, other Boards as part of the Regional Affiliate Boards (RAB) group, and the Ohio Region 15 Balance of State Continuum of Care (BoSCoc) to address housing challenges from a regional perspective. We also have a robust capital plan, which allows us to help our contract care providers expand their continuums of care based on their individual readiness. This spring, MHRB submitted five capital projects, spanning all three counties, for consideration to OhioMHAS. Our Board will continue to submit proposals as additional needs are identified.

**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 & Recovery Board of Clark, Greene & Madison Counties | | | | |
|---|---|---|---|---|
| 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) | Increase the availability and timeliness of quality treatment and recovery services across the continuum of care for residents who have IV substance use problems (IDU), while also addressing the social determinants of health that help the care have a better chance of being successful | Expand care provider relationships and increase the timeliness of data exchanges to more accurately measure gaps in care. This will help us to be more equipped to fund the proper gaps, and to reduce the time individuals wait for treatment services and recovery supports (e.g., employment support, recovery and permanent supportive housing, certified peers, recovery centers).<br><br>Support the development process for specialized dockets (Fairborn Municipal Court Drug Court/addiction treatment program (ATP); new certified drug courts) with a focus on increasing the number of treatment and recovery resources (increase supports and funding to address barriers) for families and individuals. | • # of new provider relationships established<br>• # of new established data exchanges<br>• Consistency of data received (Data Quality Measure)<br><br><br>• Collect qualitative data (phenomenological and narrative) related to the special docket development process to inform changes in strategy<br>• Track the increase of new treatment and recovery resources because of specialized dockets<br>• Track the volume of families and individuals using the incremental resources | __ No assessed local need<br>__ Lack of funds<br>__ Workforce shortage<br>__ Other (describe): |

| | | Expand the continuum of care (with existing and new providers) through increased allocations and contracts to address crisis stabilization and withdrawal management services | • Volume of crisis stabilization and withdrawal management services leveraged by providers<br><br>• Monitor allocation usage | |
| | | Increase access to medication assisted treatment (MAT) within care provider agency services and expanding access within the neighborhood location (harm reduction, GROW, Project DAWN), jails/court assessment and linkage, primary physician care prescribers (DATA2000, forums), quick response team/safe housing. | • Track MAT volume trends, and the associated place of service detail<br>• Monitor allocation usage | |
| **SAPT-BG:** Mandatory (for boards): Women who are pregnant and have a substance use disorder (NOTE:ORC 5119.17 required priority) | Pregnant women will have access to gender-specific treatment across the three-county region | Continue to provide gender-specific treatment for women who are pregnant and have a substance use disorder<br><br>Re-evaluate the scalability of the current structure to increase regional capacity. As referenced in section 2, do providers have the resilience to manage the ebb and flow of community need? | • Evaluate the utilization of available services<br><br>• Define potential population volumes<br>• Track volume trends over time in order to look for patterns in the ebb and flow in community needs (seasonal, etc.) | __ No assessed local need<br>__ Lack of funds<br>__ Workforce shortage<br>__ Other (describe): |
| **SAPT-BG:** Mandatory (for boards): Parents with SUDs who have dependent children | Increase the juvenile, family treatment, and adult drug courts' ability to | Increase access to special placements, parent education, high-fidelity wrap- | • Track funding usage | __ No assessed local need<br>__ Lack of funds |

| | | | | |
|---|---|---|---|---|
| (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) | connect this population to Board-funded services in prevention early childhood mental health consultation, Strengthening Families), treatment, and recovery supports | around, and respite care by enhancing funding through Family & Children First Council partnerships (DD, juvenile court, children's services, job & family services, care providers).<br><br>Partner with courts and local Job & Family Services departments to obtain more funding to support the volume of need in our community | • Track funding usage | __ Workforce shortage<br>__ Other (describe): |
| **SAPT-BG:** Mandatory (for OhioMHAS): Individuals with tuberculosis and other communicable diseases (e.g., AIDS.HIV, Hepatitis C, etc.) | Due to the rising incidences and correlation between communicable disease and mental illness/addiction, we are improving our partnership with local public health and contract care providers to promote awareness and eliminate spread of disease to our populations | Partner on Community Health Assessments and Community Health Improvement Plans with the public health districts in Clark, Greene and Madison Counties<br><br>Collaborate with local health districts and contract providers on harm-reduction projects (e.g. needle exchange projects are active in Clark and Greene).<br><br>Annual contract SUD provider agency reporting of TB MOE: Residents with Tuberculosis and other communicable diseases in the MHRB 3-county region will have access to appropriate healthcare | • Review public health data for information related to communicable disease and access to care, needle exchange data | __ No assessed local need<br>__ Lack of funds<br>__ Workforce shortage<br>__ Other (describe): |
| **MH-BG:** Mandatory (for OhioMHAS): Children with Serious Emotional Disturbances (SED) | Increase school, Job & Family Services, Family & Children First Council, juvenile, family treatment, adult drug courts' ability to respond to and | Monitor the volume of children being connected to these services to ensure that the appropriate level of funding | • Service Level Monitoring | __ No assessed local need<br>__ Lack of funds<br>__ Workforce shortage<br>__ Other (describe): |

| | | | | |
|---|---|---|---|---|
| | connect children with SED and their families to Board-funded services in prevention (early childhood mental health consultation, variety of prevention), treatment, and recovery supports, keeping in mind the least restrictive environments and ensuring entry into continuum of care | needed to support it is maintained and is increased if needed<br><br>Increase awareness of access related to special placements, parent education, high-fidelity wrap-around, and respite care by enhancing funding through Family & Children First Council partnerships (DD, juvenile court, children's services, Job & Family Services, care providers)<br><br>Participate in Inter-agency Review Committee (IRC) across three counties in partnership with FCFC's.<br>• Pooled funding agreements to support IHBT, residential access, and coordinator salary<br>• Co-located therapist to address the SED needs of Springfield City Schools<br>• IRC participation<br>• Monitor multi-system youth allocation | | |
| **MH-BG:** Mandatory (for OhioMHAS): Adults with Serious Mental Illness (SMI) | To leverage and integrate trauma-sensitive and Recovery-Oriented System of Care principles in order to better serve individuals with SMI and their families within our Board area | Sponsor certified peer support training<br><br>Support NAMI drop-in centers for individuals with SMI in two counties, NAMI panels at regional CIT trainings<br><br>Evaluate and increase capacity of housing support for adults with SMI | • Number of people with lived experience trained locally and obtained certification<br>• # of staff members trained and certified as peer supporters<br>• Assessment of capacity/# of beds<br>• Service Level Monitoring | __ No assessed local need<br>__ Lack of funds<br>__ Workforce shortage<br>__ Other (describe): |

| | | Address transportation barrier (e.g. funded a van for NAMI)<br><br>Support transitional youth group (NAMI)<br><br>Increase supported employment<br><br>MHRB staff trained and certified as peer supporters | | |
|---|---|---|---|---|
| **MH-Treatment:** Homeless persons and persons with mental illness and/or addiction in need of supportive housing | Provide consistent funding to support the existing and growth of permanent supportive housing solutions for those with mental illness, including co-occurring addiction<br><br>Work toward developing a resilient approach for safe, transitional, and recovery housing so that we can sustain a robust structure that can survive the ebb and flow of demand | Participate in the RAB 5 Regional Plan, CSH Supportive Housing Intensive Housing Institute<br><br>Housing Solutions, funding partner in capital plan<br><br>BOSCOC Region 15<br><br>Collaborative meetings to address the needs of individuals in housing policy | • Service Level Monitoring<br>• Track volume increase of available housing with our Board area | __ No assessed local need<br>__ Lack of funds<br>__ Workforce shortage<br>__ Other (describe): |
| **MH-Treatment:** Older Adults | Leverage and integrate trauma-sensitive and Recovery-Oriented System of Care principles in order to better serve seniors and their families within our Board area | Conduct QPR training<br><br>Provide substance use training (e.g. Clark County I-TEAM)<br><br>Collaborate with Dementia Friendly Communities Advisory Committee in Yellow Springs | • Volume of QPR trainings<br>• Volume of substance abuse trainings | __ No assessed local need<br>__ Lack of funds<br>__ Workforce shortage<br>__ Other (describe) |

| | | Collaborate with health districts in our Board area to obtain better data regarding this population | | |
|---|---|---|---|---|

| **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 | To identify, educate, and influence a trauma-sensitive, Recovery-Oriented System of Care that connects the criminal justice and behavioral health systems to help minimize criminal justice involvement for persons with mental illness and/or substance use disorders<br><br>Activating and reactivating a trauma-sensitive, recovery-oriented system for individuals and their families who are involved with the criminal justice systems | Adopt Stepping Up by commissioner resolution in Clark, Greene and Madison Counties<br><br>Opioid-specific Sequential Intercept Mapping in Clark County<br><br>Criminal Justice Behavioral Health Linkage project<br><br>Facilitate annual regional CIT trainings<br><br>Participate on Criminal Justice Council<br><br>Support, fund, and monitor jail-based services (e.g. Greene Leaf)<br><br>Advocate for and support development of specialized dockets<br><br>Increase Assisted Outpatient Treatment | • Adoption rate of Stepping Up across Clark, Greene and Madison Counties<br>• Opioid use reporting<br><br>• Collect qualitative data (phenomenological and narrative) related to the special docket development process to inform changes in strategy | __ No assessed local need<br>__ Lack of funds<br>__ Workforce shortage<br>__ Other (describe |
| Integration of behavioral health and primary care services | MHRB will continue efforts to work collaboratively with local health districts, hospitals, providers, and persons with mental and substance use | Participate in local Community Health Assessments and Community Health Improvement Plan processes across all three counties | • Number of DATA2000 prescribers trained, and trainings hosted | __ No assessed local need<br>__ Lack of funds<br>__ Workforce shortage<br>__ Other (describe): |

| | disorders to create integrated healthcare approaches and the systematic coordination of general and behavioral healthcare | Educate about and encourage evidence-based practices<br><br>Collaborate with FQHC's across three counties to identify needs, address gaps, and improve access to public behavioral health resources<br><br>Support and enhance prescriber best practices | | |
|---|---|---|---|---|
| Recovery support services for individuals with mental illness or substance use disorders; (e.g. housing, employment, peer support, transportation) | In order to break the cycle of individuals coming in and out of receiving episodes of clinical or supportive care, we are focusing on the foundational strategies to address the social determinants of health (i.e. housing, poverty, trauma, transportation, access to care, employment, incarceration, literacy, sense of community, hope, education, income) | Increase training access for peer support; assess housing, vocational, funding needs<br><br>Strategically partner with system leadership to find better ways to align our combined focus on social determinants<br><br>Create more awareness of re-entry pathways back into the system whenever a recurrence or new episode of mental illness/addiction happens that might be brought on by unexpected trauma (e.g. community violence, job loss, tornado) | • Number of peer support certification trainings hosted<br>• # of system partners with whom we collaborate on social determinant strategies | __ No assessed local need<br>__ Lack of funds<br>__ Workforce shortage<br>__ Other (describe): |
| Promote health equity and reduce disparities across populations (e.g. racial, ethnic & linguistic minorities, LGBT) | Promote health equity and increase awareness and knowledge to reduce disparities across all populations (e.g. linguistic minorities, LGBTQ, disability, racial, ethnic and economic) | Contract and funding practices to support agencies serving disparate populations<br><br>Engage diverse populations to determine to provide feedback re: | • Volume of contract care providers with cultural competency training/plan<br><br>• Number of focus groups and interviews from individuals | __ No assessed local need<br>__ Lack of funds<br>__ Workforce shortage<br>__ Other (describe): |

| | | access and capacity problems through focus groups, surveys, agency provider data, and forums<br><br>Host events that promote health equity and reduce disparities across populations (e.g. Minority Health Listening Tour for Governor's Committee)<br><br>Obtain funding to support the uninsured/underinsured<br><br>Promoting diverse board member representation<br><br>Communication strategies developed from stakeholder feedback (e.g. preferred language)<br><br>Diversity and Cultural Competency Training for staff<br><br>Use ROSC Survey findings to prioritize and plan | • Number of community forums hosted or sponsored, perception data<br>• Percent of MHRB budget from local levy funding for uninsured and underinsured<br>• Review diverse board member representation on 18-member board | |
|---|---|---|---|---|
| Prevention and/or decrease of opiate overdoses and/or deaths | Opiate-addicted people will have access to SUD services and supports necessary to prevent overdose or death by accidental overdose | Support substance abuse coalition strategies in each of the three Board region counties using strategic planning processes and best practices | • Completion rate on assigned tasks from coalition strategies | __ No assessed local need<br>__ Lack of funds<br>__ Workforce shortage<br>__ Other (describe |
| Promote Trauma Informed Care approach | Trauma-informed approaches will be preferred, supported, and integrated across providers and systems | Trauma Steering Committee | • Volume of educational opportunities completed | __ No assessed local need<br>__ Lack of funds<br>__ Workforce shortage<br>__ Other (describe |

| | | Education on Eye-Movement Desensitization and Reprocessing (EMDR)  Trauma-Informed policing | | |
|---|---|---|---|---|
| **Prevention Priorities** | | | | |
| Priorities | Goals | Strategies | Measurement | Reason for not selecting |
| **Prevention:** Ensure prevention services are available across the lifespan | Ensure prevention services are available across the lifespan | List out the population density of each population along the lifespan continuum and overlay the prevention service penetrations by population. Adjust service availability accordingly. | • Track that all populations have services at the level of their population density | __ No assessed local need<br>__ Lack of funds<br>__ Workforce shortage<br>__ Other (describe): |
| **Prevention:** Suicide prevention | | State-level Suicide Committee participation, MHRB CEO  Involvement on OACBHA Committee to Address Suicide, with MHRB CEO serving as chair of committee  Adopt a leadership role in the suicide Prevention Coalitions in all 3 counties  OSPF grants: Greene QPR Gatekeeper trainings, Clark Campaign for first responders, LOSS team materials | • # of QPR trainings<br>• Completion rate of tasks related to coalitions | __ No assessed local need<br>__ Lack of funds<br>__ Workforce shortage<br>__ Other (describe): |

| 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?)**

Utilizing an overarching ROSC framework, three significant MHRB efforts have accelerated the growth of the recovery community for both mental illness and addiction. MHRB recruited participants, provided oversight logistics, and sponsored OhioMHAS peer certification to increase the workforce. We have promoted employment of peers by providing and sustaining increased funding to care providers and drop-in/recovery support centers throughout the region. Second, MHRB staff involve people living with mental illness or addiction and their families in decision-making and leadership roles for educational events to address community-wide stigma. Third, MHRB developed and hosted a year-long Champions training Academy with 12 care provider leaders, some of whom represented a diverse group of individuals and families with lived experience. Day-long learning sessions were provided once a month by a variety of system leaders from each county from different geographical areas. The purpose was to build a cohesive leadership team and to equip our partners with effective communication and advocacy tools to promote an integrated, local system of care. Feedback and discussion were solicited at each learning session to more clearly define the MHRB role and relationship with care providers to better serve the community. MHRB has planned, funded, and nurtured leadership positions of people with lived experience within the recovery community, while simultaneously assisting care providers in employing peers.

Over the past year and for SFY 2020, the Board has experienced remarkable change in leadership and workforce. There were several planned staff retirements, each of whom had more than 30 years of service and expertise. Seasoned, committed board members were term-limited, and have been cycling from the Board. New onboarding processes and orientation for three new staff/board members have been instituted to expedite engagement and learning. Board meetings, bylaws, policies, and practices are modernizing our structure and clarifying our shared understanding of key priorities. This allows for more efficient use and deployment of limited resources (e.g., time, human, fiscal) across the three counties. A staff leadership and team-building learning series has rounded out these internal strategies to strengthen our workforce and knowledge base. These coordinated efforts are designed to better equip MHRB to pivot and respond effectively to the dynamic behavioral health environment now and in the future.

MHRB is formalizing relationships through memorandums of understandings (MOUs) and policy (e.g., criminal justice initiatives, hospital collaboration/funding, first responder

pathways to trauma care). New communication techniques and best practice strategies have been developed and implemented to grow drug-free workplaces and workforces. Most recently, we've expanded our collaborative efforts to include higher education institutions, which has garnered competitive funding to support behavioral health workforce development. For the first time, MHRB has identified and begun working with additional care providers to expand service delivery and access to new levels of prevention, treatment, and supportive care. These efforts are made to strengthen access to and responsiveness of care providers to the systems where people with mental illness and addiction are naturally found. MHRB's role is to identify and connect people and families to the resources needed within a full continuum of care.

The above examples are of illustrative nature only and do not fully represent all our valued relationships across important sectors of the community. For example, MHRB will continue to build relationships with cultural, ethnic, and faith-based groups in rural, suburban, and urban areas across the region to address health equity concerns and to improve engagement to effective resources.

| 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.**

Unfortunately, state hospital beds largely have been at capacity with forensic clients for the duration of SFY2019-2020, making little availability for civil admissions. MHRB routinely communicates and collaborates with state hospital staff, with clients who receive civil (one admission in SFY2019; discharged in July 2019) or forensic levels of care (11 -15 admissions in SFY2019 through July 2019), and their county-based providers. MHRB receives feedback from family members who express frustration with lack of access to civil state hospital care for their loved ones. To mitigate client and family member concerns, MHRB engages care provider discharge planning at the earliest opportunity to ease both civil and forensic transition to community-based treatment and housing. Despite the lack of access and minimal admission/discharge movement, MHRB staff convene state hospital staff and care provider staff in monthly conference calls to plan for successful community reintegration. For forensic cases, MHRB gather our contract forensic monitor and care provider staff on a quarterly basis.

To facilitate access to the appropriate level of care for individuals with mental illness and addiction, MHRB leads team meetings with care providers, individuals, and families (when appropriate). MHRB has utilized contract care providers in neighboring counties whenever the recommended level of care is not available in our region. MHRB advocates for both inpatient levels of care when necessary and for the least restrictive levels of community-based outpatient care. This approach matches our organizational philosophy of protecting client rights and empowering individuals and their families. As previously mentioned, increased capacity for supervised, supportive, and transitional housing are needed.

MHRB accesses civil inpatient hospital care through two contract providers. One is a stand-alone, inpatient unit within a community behavioral health provider in the region; the other is a community-based provider whose psychiatric staff contracts with a hospital-based inpatient unit near our region. Despite designated MHRB funding for crisis services and formalized pathways to access inpatient levels of care, both inpatient units are often at capacity. Whenever possible, care providers locate beds outside of the region and plan for clients to return to their home communities when appropriate to receive continuity of care.

Hospital levels of care for youth are very difficult to find. We have a significant youth population in crisis on a regular basis, with inadequate inpatient services available across the state. During the final quarter of SFY2019, Dayton Children's Hospital opened an inpatient unit. Unfortunately, Kettering Behavioral Medical Center closed their unit, resulting in a zero-net gain for youth bed capacity in our area.

An unexpected issue surfaced when MHRB located an available bed for a youth, but no transportation services were available. Law enforcement, ambulance, and private transportation all were unwilling to transport our youth across the state during threat of inclement weather. This is absolutely unacceptable—to have a payor source and available hospital level of care for a suicidal youth—yet no willing, safe transportation option to make sure the youth gets the care needed. Since this time, MHRB, Madison County Board of Developmental Disabilities (DD), Madison County Juvenile Court, Madison County Department of Job and Family Services, and the Madison-County based care provider have formalized an agreement to transport such youth utilizing on-call DD trained drivers and vans to reduce the likelihood of this scenario happening again.

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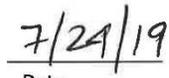
The undersigned are duly authorized representatives of the ADAMHS/ADAS/CMHS Board.

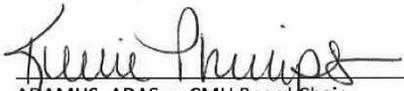Mental Health & Recovery Board of Clark, Greene & Madison Counties
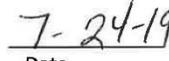ADAMHS, ADAS or CMH Board Name     (Please print or type)

_____          7/24/19
ADAMHS, ADAS or CMH Board Executive Director          Date
Dr. Greta Mayer

_____          7-24-19
ADAMHS, ADAS or CMH Board Chair          Date
Kellie Phillips

[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.)].

Instructions for Table 1, "SFY 2019 -20 Community Plan Essential Services Inventory"

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. <u>However, at a minimum, at least one entity must be identified for each essential service category identified in Column A of the form</u>.

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/**