Ohio Department of Mental Health and Addiction Services (OhioMHAS)

Community Plan Guidelines SFY 2019 and 2020

Enter Board Name: Mental Health Recovery Services of Warren & Clinton Counties

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

Environmental Context of the Plan/Current Status

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

Warren and Clinton Counties are in southwest Ohio. Historically, the two were relatively similar in size; however Warren County has become the 10th largest county in Ohio. Warren County has an approximate population of 232,173 and Clinton County's population has remained relatively consistent with a population of approximately 42,057 (US Census Bureau 2018 estimates). The combined total is 274,230. There are no urban centers in either county. The midsize cities of Wilmington, Lebanon, and Mason are the largest. Interstate I-71 transverses both counties and I-75 travels through Warren County as well. At times these two travel arteries become the crossroads for transient crime. There have been several recent situations in which the criminal justice system and mental health system must come together for competency issues and/or NGRI acquitees who are not local residents and are from other counties or states using local resources for services, housing, and hospitalization.

Clinton County has a rural designation and Warren County is now designated as a suburban county. This dichotomy creates some local service delivery issues as all services cannot be duplicated in each county. One common issue is that both still struggle with transportation. Demographically, the counties are similar with Warren County having a greater race diversity. Historically the MHRS catchment area has not seen any funding increases based on the allocation formulation that would be reflective of the population growth Warren & Clinton Counties have experienced over the same time period.

Diversity	Warren	Clinton		Important Demographics	Warren	Clinton
White	85.8%	93.5%		Median Income	$57,652	$49,997
African American	3.7%	2.2%		Persons in Poverty	12.3%	13%
Hispanic	2.8%	1.6%		Without Health Insurance	10.2%	7%
Asian	6.1%	.5%		With a disability	8.7%	11.7%
All others	1.6%	2.2%		Median Gross Rent	$982	$719

According to Ohio Department of Medicaid, in June, 2019, nearly 28,000 Warren and Clinton County residents were enrolled in Medicaid (including Aged, Blind and Disabled (ABD), Covered Families and Children (CFC), Group VIII, and MyCare Ohio populations). The highest percentage of enrollees have selected CareSource as their Managed Care Organization; however all eligible entities have covered lives.

Medicaid Enrollment by Managed Care Organization June, 2019	Clinton County		Warren County		TOTAL	
	Enrolled	Penetration	Enrolled	Penetration	Enrolled	Penetration
BUCKEYE COMMUNITY HEALTH PLAN	509	5.70%	1,330	7.10%	1,839	6.65%
CARESOURCE	5,701	63.82%	12,222	65.28%	17,923	64.81%
MOLINA HEALTHCARE OF OHIO INC	1,334	14.93%	2,162	11.55%	3,496	12.64%
PARAMOUNT ADVANTAGE	479	5.36%	969	5.18%	1,448	5.24%
UNITED HEALTHCARE COMMUNITY PLAN OF OHIO, INC	563	6.30%	1,211	6.47%	1,774	6.41%
AETNA	347	3.88%	827	4.42%	1,174	4.25%
TOTALS	8,933	100.00%	18,721	100.00%	27,654	100.00%
Percentage of County Population enrolled	21%		8%		10%	

Source: https://medicaid.ohio.gov/RESOURCES/Reports-and-Research/Medicaid-Managed-Care-Plan-Enrollment-Reports

By virtue of having multiple Medicaid Managed Care Organizations (MCOs) to bill, providers have reported increased administrative burden. This is particularly apparent in differing denials, billing standards and payment processes across the MCOs. Subsequent to Behavioral Health Re-Design and Medicaid Carve-In, one of our contract agencies has decided to close their outpatient clinic, opting to only continue with prevention services and school based services. Another agency has reported considerable losses in FY19 which could potentially compromise their viability.

Transportation is an overarching barrier in both counties for many who are in in need of services. No public transportation is available except for limited routes. This involves long waits and advanced scheduling which is not possible for many of the clients that need to utilize this services. MHRS does provide van transportation for SPMI clients to attend groups and other services on specific days and at prescheduled times.

An environmental scan shows a stable number of SPMI and SED clients with no anticipated significant increase over the next biennium. MHRS has been able to maintain general mental health outpatient service funding as well as growth in the areas of Recovery Supports, Promotion, and Prevention with local levy monies. About 53% of MHRS funding is from the local levy with the other 47% comprised of state funds, federal funds, and other grant awards.

The incidence of opiate overdose deaths is significantly lower, however there has been a surge in methamphetamine use. Alcohol addiction still retains the number one spot locally with THC use in the top three.

MHRS continues its sponsorship of CIT and ancillary trainings with over 200 officers trained since 2011 and fifty (50) plus dispatchers and other personnel trained.

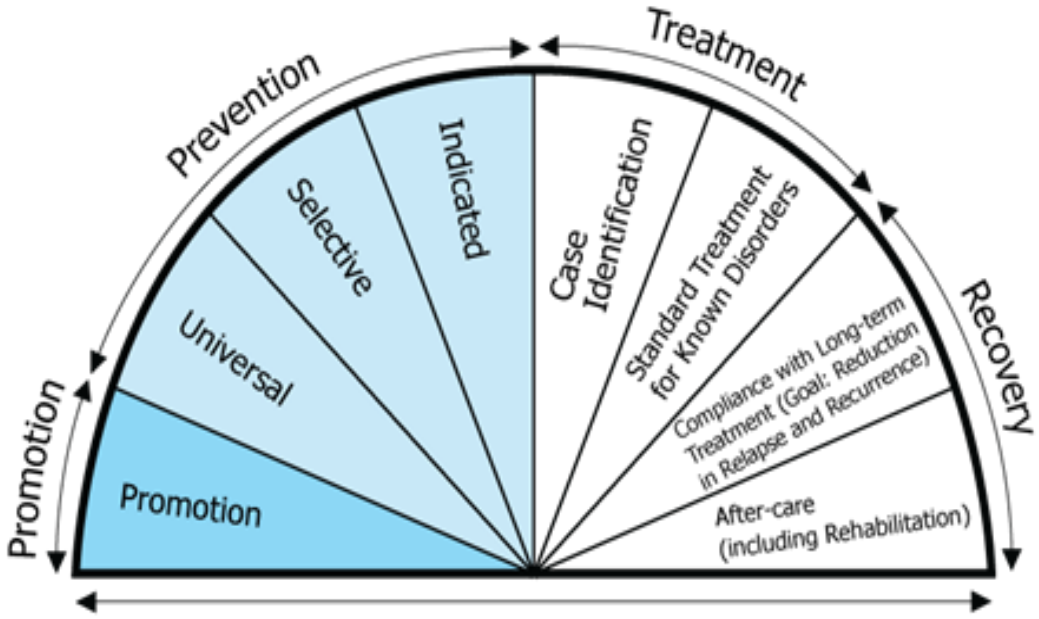
Assessing Needs and Identifying Gaps

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

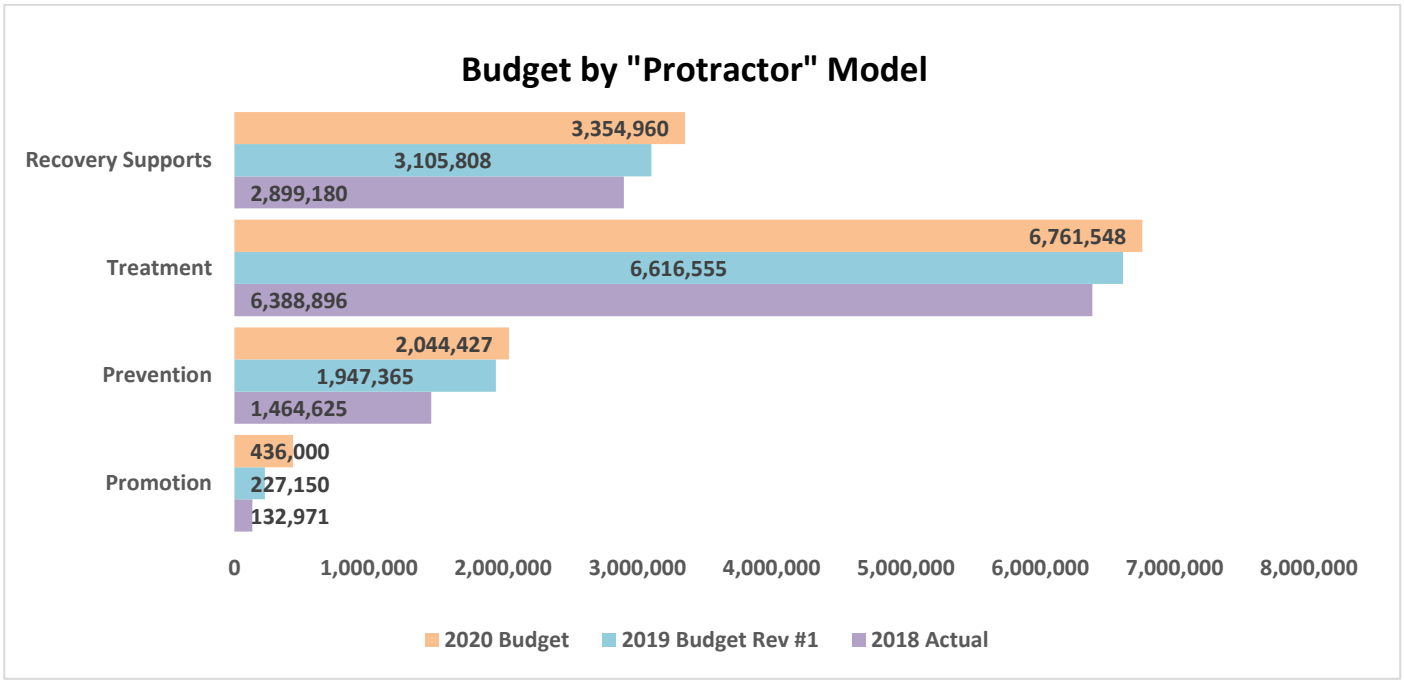
MHRS is dedicated to understanding the needs of our residents and are very engaged in both of our counties. Board staff is consistently involved in various community events, committees, and regularly collaborate with our contract agencies and key stakeholders. MHRS funds peers and NAMI, keeping active engagement with these grass root contacts. Collaborative partners are not limited to: NAMI, the adult and juvenile court systems, schools, law enforcement, Family and Children First Council, Children's Protective Services, Substance Abuse Prevention Community Coalition, Suicide Prevention Coalition, Violence Free Coalition, and Health Departments. Involvement with the community provides guidance with regard to the provision of service delivery and assists in determining funding priorities based the needs of our residents.

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.

Planning for services is based on emphasizing promotion and prevention services and recovery supports. In FY18, MHRS adopted the "Continuum of Care Model" (locally referred to as the "protractor"). This model was developed in 1994 by the Institute of Medicine. The model recognizes the importance of the whole spectrum of interventions within each category for behavioral health care. Historically, behavioral health care systems were founded on the disease model (Medicaid adopted this model for billing purposes) therefore emphasis is upon treatment interventions, whereas, the Protractor model describes the whole spectrum of interventions and depicts "how" MHRS needs to conceptualize our behavioral health care system. The model shows the four categories that make up our system of care and the interaction between them.



MHRS budgeting and contracting reflect the commitment to supporting the model, with increased emphasis on Promotion, Prevention and Recovery supports. Promotion and Prevention are areas with longer term impact and are not measured in immediate outcomes. Recovery supports are measured in the ability to maintain persons in the community that might otherwise require a higher level of care, with increased quality of life and purpose.



In support of the adopted "protractor" depicted above, MHRS has employed various methods in which it obtains planning information.

1. **Transportation as a barrier to treatment has been identified in both counties and MHRS has participated in both county planning commission efforts for identifying gaps and possible solutions to enhance access to treatment services.**
2. **Strategic planning goals brought together key stakeholders in the areas for recovery services and prevention to current services as well as gaps in the continuum.**
3. **MHRS meets with SPMI consumers regularly.**
4. **Convening focus groups as the need is identified.**
5. **Surveys are distributed via survey monkey to obtain valuable information on targeted topics, including the Recovery Oriented System of Care (ROSC).**
6. **A community survey is also done every two years to get a sense of voters' levy support, perception of MHRS' work in the community, and perception of community behavioral health needs.**
7. **Consultants have been engaged to evaluate community perceptions and needs via telephonic means.**
8. **At-Risk Youth Summit hosted by the local United Way and Warren County Foundation which convened nearly 100 community members to identify key issues facing our youth. MHRS staff was involved in the development of the program and served as facilitators for two roundtable discussions. Follow-up/continued discussions are planned for FY20.**
9. **MHRS is an active participant in Criminal Justice Planning Boards for each county to discuss gaps in service and ways to collaborate for those involved in the criminal justice system.**
10. **MHRS has staff sit on both county drug court steering committees and was an integral part of the team for the Mental Health Court pilot program in Warren County.**
11. **Both counties have active partnerships to form the mandated county opiate hubs for planning.**
12. **MHRS is an active participant on a two committees for joint health department/ JFS collaborative.**
13. **MHRS is a founding member of Regional Affiliate Boards (RAB) in which discussions are being held to share resources, create larger provider flexibility for each member's residents, create a shared housing project, save time and money through sharing similar processes in contracting realm as well as look to economies of scale. (HIPAA notification, standardized contracts, joint housing projects)**
14. **MHRS has been an active partner in the development of the Community Health Assessments in both counties. In both counties, mental health and substance use issues were identified as one of the top 3 issues. The new Community Health Assessments will be completed in the next year and MHRS is already planning with the Health Departments to serve a role in those processes.**
15. **MHRS has an active role on the Family and Children's First Councils in both counties. Staff currently serves on the executive committee in Warren County and currently assisted Clinton County in the development of it 3-year shared plan**

a. 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.

<u>Cultivating Relationship with Health Departments & Job & Family Service Agencies</u>:
MHRS is in a unique position covering two counties and their associated separate Health Districts. Over the past few years MHRS staff have collaborated with the health districts on prevention and setting the groundwork to bridge the gap where medical and behavioral health treatment services have not met.

At this time, MHRS is leading a committee with both Health Districts and the Job & Family Services Departments. This group is meeting to look not only at treatment and prevention services but to see how service integration could begin for the point in time clients enter the system, wherever they may be. An array of diagnostic tools are needed (i.e., SBIRT, Gambling, etc.) to assure a complete assessment has been made including physical assessment. One topic of potential integration is SBIRT. Reaching the medical community and finding a way to engage primary care providers will integrate behavioral health screenings into routine medical care. MHRS will continue to promote this idea of this integration and try to explore opportunities for the staff with the health departments to be trained in SBIRT. Each provider will have a direct line for referral should they have a need for care expressed within their offices; currently anyone referred would go through the open access/same day access programs.

In Warren County, the Health District has partnered with one of our local BH service providers, Solutions CCRC, to have some co-located space. This has been in operation for several months and is finding its place within the system providing access to medical care for those individuals seeking behavioral health care.

In the news, there has been mention of an outbreak of Hepatitis A. Vaccine is available and the Warren County Health Commissioner, recently reached out to MHRS to see if our providers would be interested in getting staff vaccinated, especially those that conduct drug testing as they would be at higher risk of exposure. Providers have been invited to explore this with their staff, currently most staff insurance plans would cover this expense.

The health districts have also been our local source for naloxone, working not only with law enforcement and EMS, but also looking to create partnerships for community drive naloxone distribution programs within the provider network.

MHRS looks forward to continuing a working and collaborative relationship with the local health districts and with JFS. This will create a stronger, easier to navigate system for our consumers to access behavioral health services and medical care, whether they start out seeking one but needing the other.

Arrangements were made with the Warren County and Clinton County Health Departments to present to the Board of Directors (presentation) information on the working relationship and our initiatives. The MHRS board seemed very receptive to the idea of our systems continuing to find ways to work collaboratively.

It also should be noted that the prevention position for smoking cessation has moved to the Warren County Health District for FY20. MHRS has funded this position for the past several years through one its contracted behavioral health providers. This is the first year this position will be located within the Warren County Health Department.

Also, as mentioned above, MHRS has played an integral role in the development of the Community Health Assessments completed by both health departments. MHRS staff served on several committees in both counties and supported the health departments in the development of the CHAs. Both health departments have indicated that they are in the early planning stages of the next iteration of the CHAs and that they would like MHRS to assist them once again.

The Clinton County Health Department has also taken advantage of the MHRS mini grant funding to fund a couple of initiatives in which behavioral health and physical health are intertwined. First, the health department received funding for part of its diabetes program after realizing that many of the participants were also dealing with symptoms of depression as part of the chronic diagnosis. MHRS also funded a youth physical activity program that included a mindfulness component as well.

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

There have been no disputes filed with either Family & Children First Councils (Warren County or Clinton County) in the past year regarding child service needs.

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

Outpatient services are available within a 14 day time period. The main issue is in the area of accessibility to the state hospital services and in the area of housing once released from the hospital, particularly for those on forensic commitment who are not residents of MHRS' area.

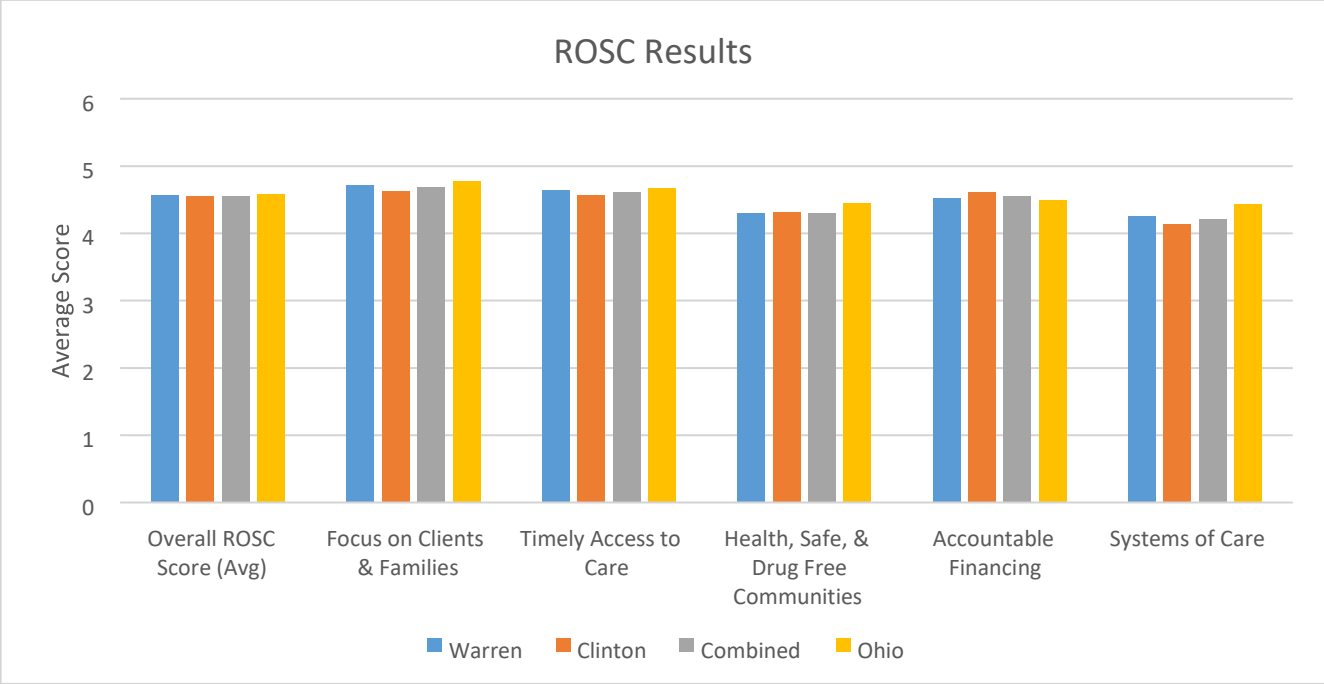
d. Service and support needs determined by Board Recovery Oriented System of Care (ROSC) assessments.

A ROSC assessment was completed by board members, board staff, provider staff as well as consumers and residents of Warren and Clinton Counties. The results were similar to statewide findings; however, MHRS was able to get a good response per capita in comparison to other boards. MHRS participants responded from a spectrum of stakeholders including consumers, provider staff, board members, and board staff.

MHRS provides education at provider staff meetings on the concept of ROSC. Planning includes revisiting the staff meetings and additional training on items that were identified from the survey.

Respondents from the Mental Health & Recovery Services Board Area of Warren & Clinton Counties represent 2.45% of 2018 ROSC participants.

	Warren	Clinton	Combined	Ohio
Number of Participants	44	25	69	2822
Overall ROSC Score (Avg)	4.57	4.55	4.56	4.58
Focus on Clients & Families	4.72	4.62	4.68	4.78
Timely Access to Care	4.64	4.57	4.61	4.68
Health, Safe, & Drug Free Communities	4.31	4.31	4.31	4.45
Accountable Financing	4.52	4.61	4.55	4.49
Systems of Care	4.26	4.14	4.22	4.44



In June of 2019, results were returned to MHRS on the survey with local and statewide summaries. Here is a snapshot on the findings:

1. **Providers use recovery based language and make efforts to include families; prevention strategies are based in science and EBP.**
2. **There is a sufficient array of recovery supports and treatment services throughout the community scoring at 3.9/5.**
3. **Opportunities for improvement is in the area of stigma:**

a. **The community has begun to formally acknowledge and celebrate the achievement of people in recovery**
b. **Partnerships exist with local business for individuals in recovery to reduce stigma and gain employment (3.7/5).**

These findings will continue to direct MHRS' promotion focus on stigma reducing activities.

As indicated earlier in the 2018 community plan update, MHRS has a communication plan set in motion to provide messaging and activities for the community. Focus will be directed to the general community as well as those most closely connected to the public mental health system. Communication will be through traditional media (billboards, print media), social media, podcasting, and email newsletters. MHRS has begun to work with broadcast media as resources allow. Warren and Clinton counties lie between two urban markets (Cincinnati and Dayton), thus creating difficulties in defining where information will contact the most number of our citizens and have the desired impact.

e. 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)].

Currently, there are no gaps in the continuum of care requirements. Since the 2018 plan, MHRS now supports Sojourner LLC in the operation of a men's residential program. This has been a lengthy project, begun in FY16 that has finally come to fruition. There is a reciprocal relationship with Preble County for women's residential services in addition to the contractual relationship with Women's Recovery Center in Greene County.

"Locate and inform" is an area that is a continuing growth opportunity. Currently this service is provided for residents seeking services through the crisis hotline and referral services, care navigators for the Heroin Hope Line, mobile crisis team, and the HOPE team that is a Warren County wide overdose response team.

Additionally, MHRS utilizes children's contract providers and school systems to locate children in need of services. MHRS funds a hospital specialist who outreaches to any MHRS resident who is hospitalized in a private psychiatric facility as notification is received.

f. 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.

1. **There is a continued gap in crisis stabilization, even with the budget allocation for this service. The funding does not significantly impact the need. There is no true crisis stabilization site in the Southwest Ohio area (other than Hamilton County which is not accessible for our consumers). The volume of consumers in need of this service is not large enough to sustain the operating costs for a separate facility.**

2. **The criminal justice population is in need of recovery services once released from jail. This group of persons usually have identified mental health, substance use, or child welfare issues. They have few alternatives for housing and jobs and have often burned their bridges with friends and family.**

3. **There is a gap for sex offenders. There are few available housing options.**

The Regional Affiliate Boards (RAB) are engaged in developing a shared housing project. Its purpose is to focus on ways to house complex clients each board struggles to serve individually. Each RAB board has identified a few clients that need many resources and by combing resources and efforts, there are ways to create a system to meet the needs already mentioned.

Another shared vision is to create recovery housing options when families are involved. An additional area of opportunity is planning for the development of recovery housing for clients using MAT medications that have historically been excluded from existing recovery housing.

Prevention funding continues to be a concern. While it is clear that the Governor has elevated prevention in his new administration, what is not clear is how that funding will come down and be distributed in communities. This is especially true for school-based funding going directly to schools. By bypassing the boards' oversight, it is difficult, if not impossible, to ensure that schools are selecting appropriate, evidence-based prevention approaches.

The other issue with state funding for prevention is "substance specific" funding. While there is no denying that opiates are still a problem in many communities, we are also seeing a shift away from opiates toward methamphetamine and other drugs. Substance specific funding aimed solely at opiates creates a challenge in addressing emerging/shifting priorities in our communities.

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

Priorities

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

Below is a table that provides federal and state priorities. Please complete the requested information 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 Services of Warren and Clinton 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)	Prioritize services for IVDU seeking services.	Improve current screening for IVDU by moving screen to initial contact and training screeners on appropriate referrals for IVDU.	Continue with open access/ same day access procedures; providers are not reporting any wait lists	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):
SAPT-BG: Mandatory (for boards): Women who are pregnant and have a substance use disorder (NOTE:ORC 5119.17 required priority)	Provider organizations must refer pregnant women to another organization when the program has insufficient capacity to provide services to any such pregnant women who seek the services of the program. Provider organizations shall make interim services available within 48 hours to pregnant women who cannot be admitted because of lack of capacity.	Improve current screening for pregnant SUD females by moving screen to initial contact and training screeners on appropriate referrals for pregnant SUD females.	Continue with open access/ same day access procedures; utilize Heroin Hopeline connections; providers are not reporting any wait lists	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):
SAPT-BG: Mandatory (for boards): Parents with SUDs who have dependent children (NOTE: ORC 340.03 (A)(1)(b) & 340.15 required consultation with County Commissioners and required service priority for children at risk of parental neglect/abuse due to SUDs)	Increase the number of screenings for SUD for pregnant women. Decrease barriers for parents with SUD who have dependent children.	Increase the number of screenings for SUD for pregnant females Provide assessments, prior to leaving the hospital for women whose babies have tested positive. Continue collaborations and providing peer supports to the OhioSTART programs.	Continue capacity building with hospitals to create a warm hand off/ SBIRT expansions	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):
SAPT-BG: Mandatory (for OhioMHAS): Individuals with tuberculosis and other communicable diseases (e.g., AIDS.HIV, Hepatitis C, etc.)	Education regarding STDs, HIV, TB and Hepatitis C shall be provided to all persons seeking services. This information should include how and where to be screened. Additional information may include: 1. counseling and education about	Improve current screening for TB for persons seeking services. Provider organizations are required to link positive screens to appropriate medical services.	Continue to monitor providers reporting; No individuals have been identified with positive screens.	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):

	HIV and TB 2.the risks of needle-sharing 3.the risks of transmission to sexual partners and infants 4. steps that can be taken to ensure that, HIV and TB transmission does not occur 5. referral for HIV or TB treatment services, if necessary.			
MH-BG: Mandatory (for OhioMHAS): Children with Serious Emotional Disturbances (SED)	Manage the demand for services by: 1. Expanding the use of Universal Prevention; continue using Early Intervention Groups. 2. Enhancing Insurance Billing by providers. 3. Promote use of Positive Behavioral Intervention and Supports (PBIS) with schools. 4. Divert youth in crisis from higher levels of care and provide support to youth/families. 5. Strengthen family stability and reduce stress	1. Research and implement evidence-based programs to mitigate risk factors and raise youth resiliency, as well as meet the needs of children when symptoms first begin to emerge. 2. Continue funding for a Benefit Specialist at primary provider agency; role is to assist client's secure insurance coverage and other benefits. 3. Host an annual School Forum for school personnel to promote full array of services from Universal Prevention to Intervention. 4. Continue Mobile Response and Stabilization Services (MRSS) Team. 5. Offer family bonding, therapeutic mentoring and respite options	1. Number of Prevention Services Provided; Type of Prevention Services 2. Analysis of Insurance coverage for active SED clients 3. Registrants for School Forum/Information packet supplied to school personnel 4. Analysis of MRSS outreach to recruit referrals and actual utilization of service. 5. Number of families/youth utilizing service; success in treatment	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):
MH-BG: Mandatory (for OhioMHAS): Adults with Serious Mental Illness (SMI)	Expand housing options, crisis stabilization services, and hospitalization alternatives for SMI clients.	1. Expand housing for all SMI clients, particularly for those who are in need of time to transition into the community from previous settings such as jail or hospital. 2. Partner with Southwest Ohio Collaborative to contract for crisis stabilization services.	1. Additional beds. 2. Contract for crisis stabilization services.	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):

MH-Treatment: Homeless persons and persons with mental illness and/or addiction in need of supportive housing	Provide support for the Homeless Shelters in both counties.	1. Provide funding. 2. Provide vocational services at shelter site. 3. Provide Peer support at shelter site. 4. Provide linkage to housing.	1. Budget allocations. 2. Service agreements for vocational services, peer support, and transitional housing.	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe): discontinued
MH-Treatment: Older Adults	1. Enhance outreach to older adults through the Age-Friendly Clinton County collaborative. 2. Evaluate viability of expanded community-based services to older adults.	1. Share information with cross-systems collaborative members regarding services available. 2. Participation in the Age-Friendly Clinton County Quality of Life and Transportation Committees to further determine need and obstacles in engagement in office-based behavioral health services.	1. Collaborative meeting attendance/ information sharing. 2. Analysis of needs/funding availability/workforce for an older adult project. (NOTE: This expansion continues to be complicated by workforce shortage)	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe)
Additional Priorities Consistent with SAMHSA Strategic Plan and Reported in Block Grant				
Priorities	Goals	Strategies	Measurement	Reason for not selecting
MH/SUD Treatment in Criminal Justice system –in jails, prisons, courts, assisted outpatient treatment	Provide "Seeking Safety" Groups in the jail and outpatient settings to increase continuity in treatment philosophy.	Train providers in seeking safety curriculum. Contract for staff to provide services.	Number of groups delivered in jail setting.	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe)
Integration of behavioral health and primary care services	Development of primary care linkage.	Co-location of mental health provider with pediatric offices.	Contractual agreement with local pediatric providers and the number of contacts made.	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):
Recovery support services for individuals with mental illness or substance use disorders; (e.g. housing, employment, peer support, transportation)	1. Increase number of Certified Peer Supporters. 2. Expand locations of contacts. 3. Increase housing options available to persons in recovery. 4. Improve transportation options.	1. Peer Support: Increased funding to provider and identify locations to be served. 2. Support development of level 1 and 2 housing options for mental health clients. 3. Work with Clinton County transportation committee. 4. Provide transportation and alternative options for clients.	1. Peer Support: Number of peer supporters and sites of contac.t 2. Increased number of housing units available. 3. Clinton County transportation meeting participation. 4. Contract for transportation and gas vouchers.	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):

Promote health equity and reduce disparities across populations (e.g. racial, ethnic & linguistic minorities, LGBT)				_X No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):
Prevention and/or decrease of opiate overdoses and/or deaths	Increase awareness and availability of naloxone.	1. Offer trainings. 2. Provide materials and resources. 3. Promote partnerships with local health departments and first responders.	1. Continue working with providers for this service. 2. Increase financial support to Sherriff, HD and local EMS/ first responders to provide grants to pay for naloxone. 3. Explore QRT/ HRT to also create linkage to care using the above named entities and work toward community naloxone distribution programming.	__ No assessed local need __ Lack of funds __ Workforce shortage _x_ Other (describe): Continued, refer to Current Status item #2.
Promote Trauma Informed Care approach	Continue Trauma Informed Care Learning Collaborative with cross-systems member organizations.	1. Offer trainings. 2. Offer expert consultation. 3. Provide materials and resources. 4. Promote/support implementation of Handle with Care Program in Schools.	1. Number of trainings offered/Number of registrants. 2. Number of organizations requesting/being provided expert consultation. 3. Number of emails sent to members with materials/resources. 4. Number of Learning Collaborative meetings. 5. Educational efforts to schools/first responders on Handle With Care; Number of schools choosing to implement program.	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe
Prevention Priorities				
Priorities	Goals	Strategies	Measurement	Reason for not selecting
Prevention: Ensure prevention services are available across the lifespan	1.Working with community partners to identify and map current prevention services. 2. Identify current gaps in services. 3. Develop comprehensive community plan to address gaps.	1. Community/service mapping. 2. Building collaborative partnerships. 3. Coalition development and support. 4. Needs assessment. 5. Training and TA.	Increased number of prevention services provided across the lifespan	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):

Prevention: Increase access to evidence-based prevention	Continue to provide a broad array of evidence-based prevention programming in both counties.	1. Offer trainings on evidence-based prevention programs. 2. Work with schools to develop comprehensive, evidence-based prevention plans. 3. Provide materials, resources, and funding.	Increased number of evidenced-based prevention programs. ALTERNATIVELY Increase the number of people exposed to evidenced-based prevention initiatives.	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):
Prevention: Suicide prevention	1. Promote awareness that suicide is a public health and social ecological problem that is preventable. 2. Develop and implement community prevention programs. 3. Develop and implement strategies to reduce the stigma associated with being a consumer of mental health, substance abuse, and suicide prevention services. 4. Implement training for recognition of at-risk behavior and delivery of effective treatment.	1. Gather and analyze local suicide death data; Disseminate results to community partners and the public. 2. Based upon data, pinpoint high-risk populations and create outreach and prevention messaging and materials. 3. Incorporate representatives from multiple sectors in coalition operations 4. Promote stigma reduction. 5. Work with schools to implement suicide prevention best practices.	1. Number of gatekeeper trainings held. 2. Suicide Prevention Coalition Meeting minutes. 3. Number of community partners working with Suicide Prevention Coalition.	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):
Prevention: Integrate Problem Gambling Prevention & Screening Strategies in Community and Healthcare Organizations	Screen 100% of individuals who are seeking services at contract organizations.	Provider organizations will integrate an approved screening instrument for problem gambling into the intake process.	Providers continue to screen all individuals seeking services	__ No assessed local need __ Lack of funds __ Workforce shortage _x_ Other (describe): continued

Board Local System Priorities (add as many rows as needed)			
Priorities	Goals	Strategies	Measurement
Dually Diagnosed clients with behavioral health/developmental disabilities (BH/DD)	Enhance services to clients with BH/DD to ensure access and quality/quantity necessary.	1. Fund and implement a BH/DD care manager position to work cross-systems. 2. Continue to evaluate gaps in service and determine/fund solutions as financially possible.	1. Service Agreement to contract for BH/DD Care Manager; Employment of BH/DD care manager; number of clients served. 2. Number of cross-systems committee meetings; minutes from meetings

Collaboration

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?)

MHRS is dedicated to understanding the needs of our residents and are very engaged in both of our counties. Board staff is consistently involved in various community events, and committees. MHRS regularly collaborates with our contract agencies and key stakeholders. MHRS funds peer supports and NAMI, keeping active engagement with these grass root organizations.

Collaborative partners but are not limited to:
NAMI, the adult and juvenile court systems, schools, law enforcement, Family and Children First Council, Children's Protective Services, Substance Abuse Prevention Coalition, Suicide Prevention Coalition, and Health Departments. Involvement with the community provides guidance with regard to the provision of service delivery and assists in determining funding priorities based on the needs of our residents.

From a communications perspective, MHRS drew attention to opiate alternatives through a collaborative marketing campaign, partnering with the Warren and Clinton County Health Districts. This 2018 project involved billboards highlighting one alternative to using opiates for pain management (e.g., exercise, yoga, or physical therapy), as well as tear-off pads placed in local doctors' offices. The goal was to encourage discussion with physicians about opiate alternatives, and was based on research noting that most opiate addictions had begun with a prescription. Other collaborations of this nature are possible in the future.

Thanks to the Engage 2.0 grant, MHRS was able to work collaboratively with three other boards in Southwest Ohio (Preble, Butler and Clermont) to implement a Mobile Response and Stabilization Service. One provider is being used by three boards, including MHRS. The grant functions also included robust information sharing, not only across board areas but also to the community partners and the public in general. Integral to this endeavor is a connection to families impacted by behavioral health issues. Thus, focus groups have been convened with families with lived experience. Additionally, this grant enabled public awareness campaigns regarding youth suicide prevention and hotline number publicity. We are also currently collaborating on rolling out the Handle With Care (HWC) Program to schools. This HWC collaboration within Warren County consists of the JFS director, Children's Services Director, Lebanon Police Department, Educational Service Center and MHRS.

The Ohio START Program was piloted in both our counties in the past two years with demonstrated success. MHRS was involved with the start-up, particularly involving the required Peer component.

MHRS has worked collaboratively with both county Board of Developmental Disabilities. A needs assessment/gap analysis was conducted and a cross-systems training was held. For FY20, a service agreement has been entered into by all parties to co-fund a behavioral health/developmental disabilities care manager to work across the systems to ensure access to services and to provide

specialized consultation. This follows a successful collaboration and joint funding of a supported education counselor at a local community college by MHRS and Warren County Board of Developmental Disabilities.

Clinton County has been named an Age-Friendly Community (Under the AARP Network of Age-Friendly States and Communities) and conducted a comprehensive needs assessment. Several issues related to behavioral health were identified. As a result, MHRS staff members serve on two sub-committees:

(1) Quality of Life.
(2)Transportation.

MHRS hosted a LGBTQ Cultural Competency training in April, 2019, to fulfill one of the reports recommendations.

Since the last community plan, recovery housing has continued to expand. One provider has increased beds (Clean Acres Women's recovery home from 6 to 8 beds), and an additional recovery home opened for men in 2018 in Warren County. As indicated above, a provider has recently opened a residential treatment center for men.

The Substance Abuse Prevention Coalition of Warren County was awarded a Strategic Prevention Framework – Partnerships for Success (SPF-PFS) Grant through OMHAS. The coalition has been able to leverage its work on this grant to bring a number of new and non-traditional partners to the table to assist in its work in preventing substance youth among youth in Warren County. The coalition was also able to implement the "Talk, They Hear You" Campaign from SAMHSA through radio advertisements, billboards, and movie theaters.

The board was also able to secure a Community Collective Impact Model for Change (CCiM4C) grant through OMHAS to work collaboratively across systems to address the opiate problem in Clinton County. The grant led to some assistance in building and maintaining a prevention coalition in Clinton County, along with addressing naloxone distribution and education.

Inpatient Hospital Management

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.

Finding beds at the state hospital in our area, Summit Behavioral (SBH), remains difficult due to the facility being at capacity. Our local court system has numerous individuals in line to be seen for restoration and competency. This puts a burden on beds being open for civil commitments and those incarcerated needing emergency care.

There have been relatively no civil admissions to Summit, only those coming from jail. In addition, when a forensically monitored client who is on conditional release, has a revocation for behavioral or public safety reasons, the local RPH has no beds. Acquitees must be held in jail until a bed is available. The jails are reluctant to admit acquitees who are decompensating.

Due to Medicaid expansion, there are numerous local facilities our crisis and outpatient staff have been able to coordinate emergency admissions for most adult civil patients. As part of the Southwest Hospital Collaborative, MHRS set up a relationship for Beckett Springs Hospital to take individuals for crisis stabilization through OhioMHAS' crisis allocations; however the shared funding process was difficult. Residents were not always able access the service. We will be managing our own portion of those funds beginning FY20.

There continues to be a shortage of child/adolescent psychiatric beds. MHRS contract providers have experienced wait times of more than 72 hours in order to access a bed. Oftentimes the child is sent to other parts of the state. This is not conducive to keeping the family engaged in the child's treatment and maintaining engagement with local providers for discharge planning.

Community Plan Appendix 1: Alcohol & Other Drugs Waivers

A. Waiver Request for Inpatient Hospital Rehabilitation Services - NA

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