Ohio Department of Mental Health and Addiction Services (OhioMHAS)

Community Plan Guidelines SFY 2021 and 2022

Enter Board Name: Belmont, Harrison and Monroe Counties

The following template will help organize the required information needed to complete the SFY 2021-2022 Community Plan. This template has been organized and streamlined to assist in the creation of a forward-looking Community Plan with a focus on identifying community priorities. These community priorities should be identified via a needs assessment process and tracked to determine success in addressing the stated priorities.

Evaluating and Highlighting the Need for Services and Supports

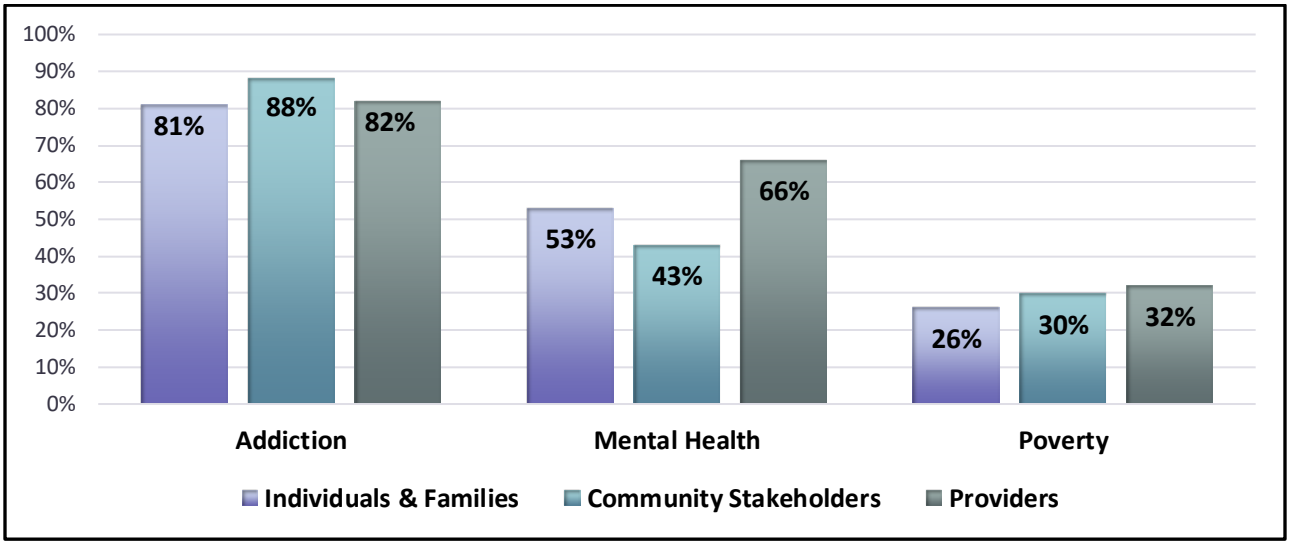
1. Describe the community needs assessment process that led to the identification of the local priorities the Board will address. Describe how the Board engaged local and regional planning and funding bodies, relevant ethnic organizations, providers and people living with or recovering from mental illness and addiction in evaluating needs, evaluating strengths and challenges and setting priorities for treatment and prevention for SFY 2021-2022. [ORC 340.03 (A)(1)(a)].

In preparation for FY 2021 – FY 2022, the MHR Board developed a community needs assessment with the goal of reaching a comprehensive range of participants across all three counties in order to identify themes that would be useful in assessing the effectiveness of our current system and informing our strategic planning efforts for improvements in the future. We tailored the survey to not only capture needs, strengths and weaknesses of the system of care, but also asked questions to capture the degree of integration of ROSC principles. The community needs assessment survey was launched on January 6th, 2020 and responses were collected through January 31st, 2020. The three target populations were individuals and family members, providers, and community stakeholders.

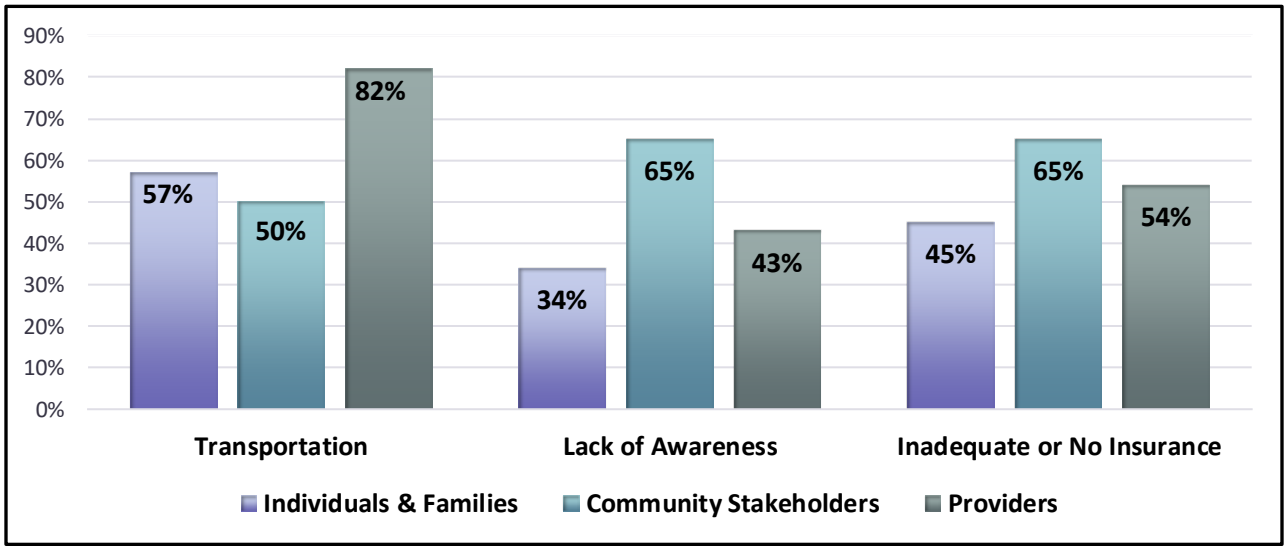
Qualitative and quantitative data was collected by survey, using survey monkey for email distribution, paper format for clients and families, and by link available on the Board's website. ***134*** providers were directly emailed the survey, as well as ***130*** community stakeholders. 600 paper format surveys were sent to the Board's contract providers for distribution to individuals and families receiving services. Provider contract agencies utilized support staff and case managers to assist in assuring there were a variety of opportunities to collect feedback directly from individuals and families in all three counties. In total we had ***383*** surveys returned, with the largest response (**70%**) by individuals and families served by the system. The Board staff shared the results with ***3*** community focus groups, but due to the COVID-19 pandemic, additional planned forums were cancelled. The results were also shared with our Board of Directors and contract provider management staff.

The emerging themes from the survey included the following:

The top 3 pressing issues in the community were addiction, mental health and poverty:



Top 3 barriers to treatment were transportation, lack of awareness and inadequate or no insurance:



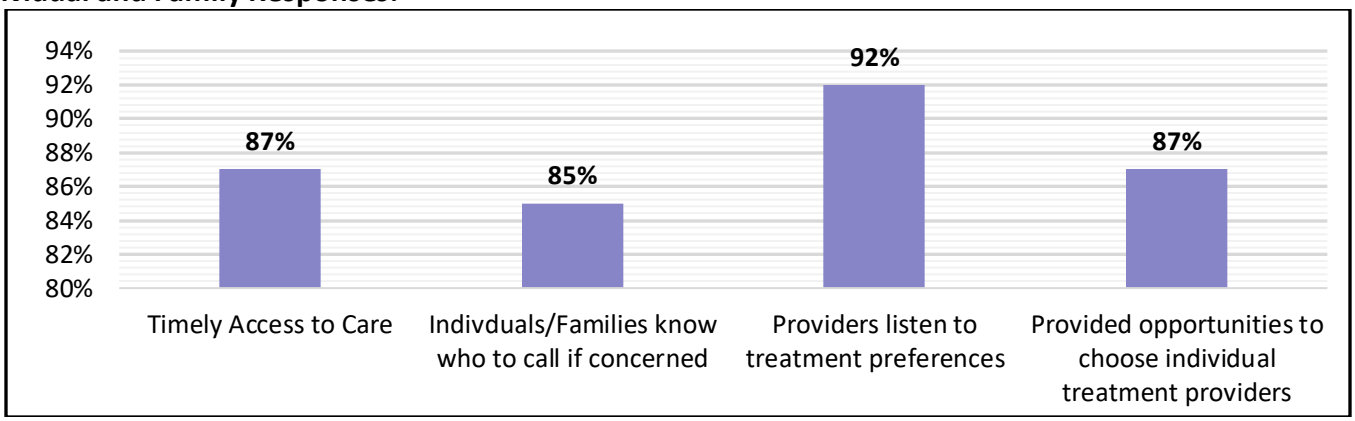
Range and availability of services for mental health and substance use disorders:

All three target audiences surveyed rated the systems range and availability of services excellent to adequate for both mental health and substance abuse services. When we asked for recommendations for service enhancements for mental health responders reported wanting more access to inpatient beds, crisis services, alternative treatments such as yoga, meditation etc., and education and prevention services. For the substance use services, suggested service enhancements included residential treatment, recovery housing, and withdrawal management services. Although the respondents suggested enhancements to residential and recovery housing, it may be more of an issue of awareness of those services, as there are two residential facilities and a recovery house within the Board's area, all of which often operate at a low utilization rate.

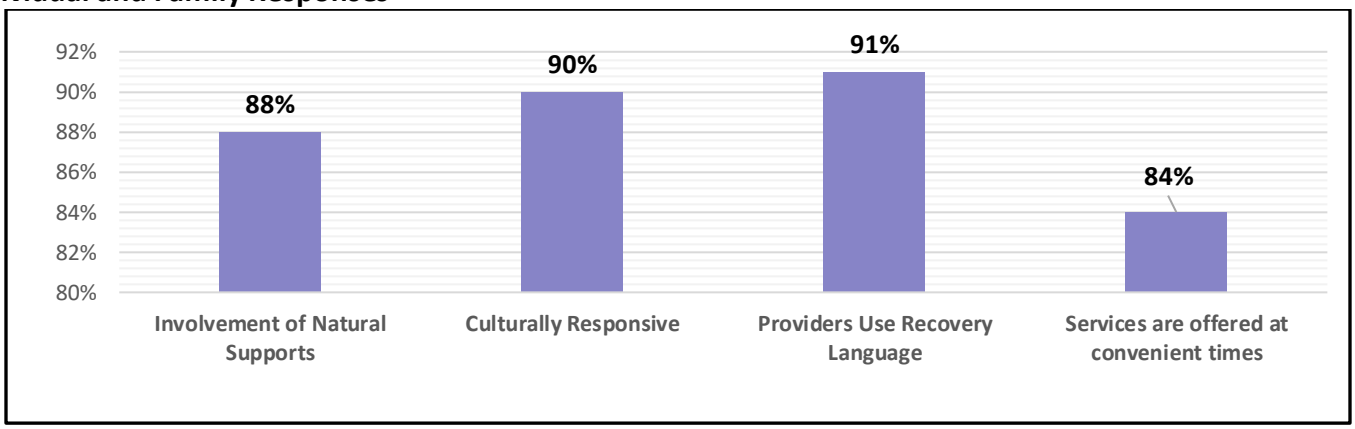
Elements of a Recovery Oriented System of Care:

The three target audiences responded to questions that addressed whether the system was operationalizing the various elements of a recovery-oriented system into the day operations of providing services. Individuals and family members report consistently receiving feedback from providers on their progress towards their goals and ***66%*** feel very confident about the care coordination of services when involved with more than one provider organization. Additional findings are reported in the graphs below.

Individual and Family Responses:



Individual and Family Responses



Community Stakeholders perceive the behavioral health system as fulfilling the no-wrong-door policy for individuals needing services, having a positive presence in the community, and working hard to reduce stigma. ***68%*** of community stakeholders believe that the system has a timely response plan for crisis services. Area stakeholders would like the system to put more efforts into cultivating partnerships to secure employment opportunities, formally acknowledging and celebrating the achievements of people in recovery, and offering recovery supports that include safe sober activities.

Providers were asked a series of questions that focused on the elements of a recovery-oriented environment including the inclusion of peers on various levels, accessibility and flexibility of services, integrated care, system-wide trainings, and offering meaningful recovery support services. ***80%*** of providers report they implement a no-wrong door policy to improve access to treatment and over half of the providers report offering interim services for those on a wait list and flexible hours to meet the needs of individuals who may have other commitments during traditional office hours. ***83%*** of the providers believe there are processes in place that enhance and facilitate integrated care plans across community partners and ***88%*** report routinely assisting individuals with the pursuit of education and employment goals. ***85%*** of service providers feel they are trained regularly in recovery topics and resilience-based trauma informed assessments.

a. If the Board's service and support needs were determined by the Board Recovery Oriented System of Care (ROSC) assessment, how will these identified service and support needs be addressed by the Board?

As the Board moves into fiscal year 2021, we continue our participation in and our committed to the ROSC assessment, in combination with other available data tools to shape and refine our system of care. Our 2018 ROSC survey results were framed by 75 responders. Although this assessment did not produce the volume and diversity of responses we were hoping for, the results were coupled with other data to plan for services and recovery supports needed in our local system of care as noted above in response to question 1.

2. Considering the Board's understanding of local needs and the strengths and challenges of the local system, please identify the Board's unique priorities in the area provided on Page 2. Please be specific about the chosen strategies for adults, children, youth, and families and populations with health equity and diversity needs in your community. OhioMHAS is still interested in any RecoveryOhio priorities Board areas may be addressing. Please address goals and strategies for any gaps in the Ohio Revised Code required service array identified in ORC 340.03(A)(11) and 340.033.
Identify at least one measurement indicator, and subsequent baseline data, that will be used to track progress towards meeting the identified priority(ies).

The MHR Board of Belmont Harrison and Monroe Counties has identified 6 areas of unique priorities to focus on in FY 2021-2022. These areas include prevention services across the lifespan, the criminal justice system, adults with serious and persistent mental illness, children and youth with severe emotional disorders, peer support and recovery services, adults with substance use disorders, and workforce development issues. All six areas in our continuum of care have many strengths but we recognize that we have gaps and challenges that require additional capacity and financial resources. In addition, as we have highlighted on the worksheet, each of these six areas align with the recommendations that were formulated in the RecoveryOhio plan.

3. Describe all environmental factors that influenced the identification of the chosen priorities within the Board area. Factors could include economic, social and demographic factors, transportation, unemployment, uninsured/underinsured population, poverty rates, housing availability, incarceration rates, etc. Note: Regarding current environmental factors, Boards may describe the continuing impact of Behavioral Health Redesign including Medicaid Managed Care carve-in.

Introduction

The Board area covers 1,400 square miles in rural southeastern Ohio, requiring over two hours to travel from the northwest corner of Harrison County to the southern portion of Monroe county. The geographic landmass covers approximately 1397 square miles. The average person per square mile in the State of Ohio is slightly over 282 persons; for this three-county area it is 71 persons per square mile. The area is connected by Interstate 70, making it a beltway for transportation that encourages tourism, industry, as well as drug trafficking. As you read the data below, you will see that each of these three counties may have areas of uniqueness, but by far they are more similar than dissimilar. This allows us to look at our areas as more of a region when planning for services and identifying strategic goals rather than three unique service districts.

Social and Demographic Factors

According to the estimated 2018 United States Census Quick Facts, Belmont County has an estimated population of 67,505, Harrison County 15,174 and Monroe County 13,790. This brings the total population of our service region to 96,511 residents, which in comparison to the 2010 Census count, is a 4.5% decrease in total population over the last eight

years. The area has systematically lost population since the 1950s as graduates and those entering the workforce seek economic opportunities, as well as social and cultural experiences, out of the area. There is very little diversification in age between all the counties. Harrison County has the largest percentage of individuals under 18 years of age; in all three counties over 50% of the residents are represented in the 18 to 64 age categories and over 20% of the residents are 65 or older. Consistent with previous years, our three counties are less racially diverse and slightly more male. For our service district, 538 grandparents in Belmont County are raising their grandchildren, 128 in Harrison, and 66 in Monroe. Additionally, 32% of youth in the custody of the local Children Services agencies are in a kinship placement. Although individuals over the age of 65 represent 20% of our residents in all three counties, in FY 2019 individuals 65 and older represented only 4% of the total adults served by the system. This group was comprised of 72% female, 79% from Belmont County, and the majority served had a diagnosis of Schizophrenia, followed next by Major Depressive Disorder. The most frequently accessed services by this population was Community Residence and Group Community Psychiatric Supportive Treatment.

Economic Factors and Trends

The counties of Belmont, Harrison and Monroe are 3 of 26 counties belonging to the Appalachian Partnership for Economic Growth (APEG) in East and Southern Ohio region. In partnership with JobsOhio, APEG works to bring economic growth to the Appalachian area. For more than 100 years the area capitalized on farming, timber, and coal. While farming remains, the area has transitioned from a base of steel mills, coal mines, and other industrial fields to an economic base primarily of oil and gas drilling/fracking.

Belmont County

Belmont County sits in the heart of the Utica and Marcellus Shale industry. Currently the county has 30,000 civilians employed. Most civilians are employed in the private sector of Natural Resources and Mining and the service-providing sectors of Trade, Transportation, and Utilities. The future of Belmont County's economy looks very promising with the decision to develop an ethane cracker plant in Dilles Bottom. The opening of this plant will facilitate a tremendous growth in Belmont County and provide for an estimated 450 new jobs to operate the plant and thousands of more jobs forecasted to come online in other industries such as the plastic industry and gas and oil to support the operations and raw products.

Harrison County

Harrison County sits at the northeast hub of the U.S. petrochemical industry. Harrison County has seen economic growth in the past several years; in April of 2019, the Times Reporter cited Harrison County as being in the top four in economic growth percentages in the United States. Harrison County was noted as one of only two regions to list manufacturing as the fastest growing industry. Harrison County's economy employs over six thousand five hundred civilians. Most civilians are employed in the private sector of Manufacturing and in the service-providing sectors of Trade, Transportation, and Utilities.

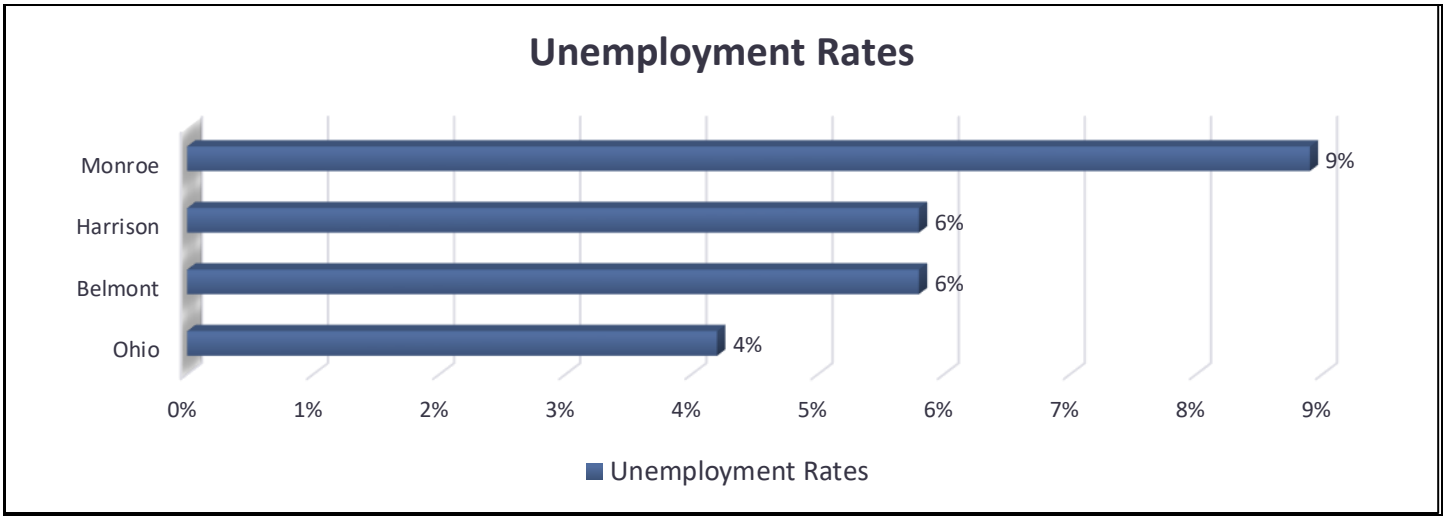
Monroe County

The economy of Monroe County employs approximately five thousand individuals with the largest industry involving Construction in the private sector and Trade, Transportation, and Utilities followed by Education and Healthcare in the service-producing sector. Monroe County, like Belmont, may see growth in their economy with the development of an ethane cracker plant in Dilles Bottom and the need to bring additional manufacturing plants online to support the conversion of the raw products.

Unemployment Rates and Poverty Levels

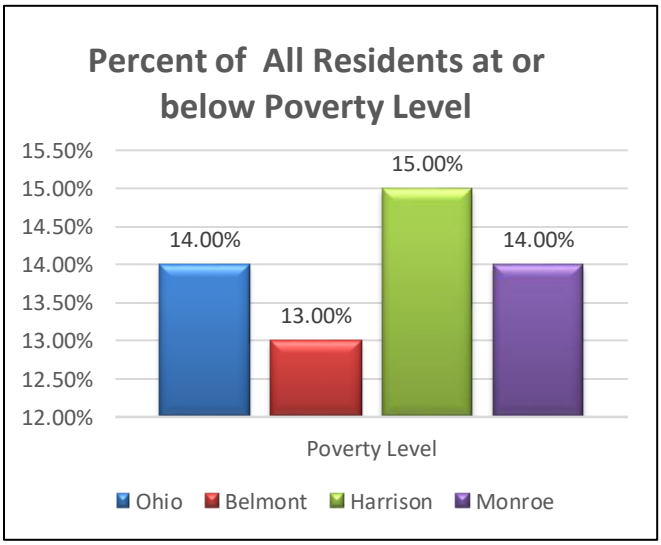
Economic factors and trends of unemployment and poverty in our region are very important to monitor due to the well-established relationship on the impact they have on not just on overall health, but on mental health and addiction as well. From years of research we know that poverty and unemployment are social determinants of health that correlate to increases in stressors and high-risk behaviors that can be seen in or communities in a variety of ways.

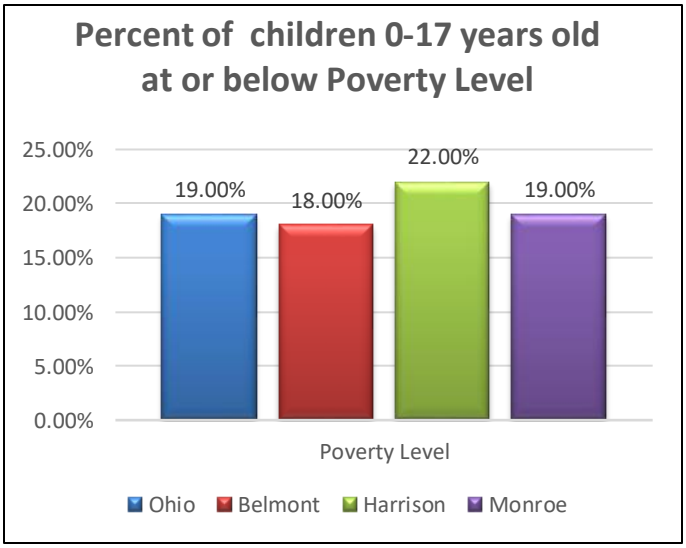
The unemployment rates for our residents as of December 2019 were all above Ohio's rate of 4.2%. These rates also show a slight increase when compared to the previous two reporting years for the same snapshot in time (December). The median household income for our residents is nearly 13% less than the state average.



According to USDA statistics, the percent of all persons living at or below the poverty level and the percent of children ages 0-17 at or below the poverty level are relatively consistent across all three counties, with Harrison County experiencing the largest impact.

Health and Wellness





9% of our region's adults and 6% of our children are uninsured or underinsured, which is slightly higher than the state's average. The University of Wisconsin's Population Health Institute in collaboration with the Robert Wood Johnson Foundation maintains a systems of county rankings in each state on key public health indicators. Below is a table that

reports the 2020 County rankings for Belmont Harrison and Monroe as compared to the rest of Ohio. The term health outcome is defined in this health study as a measurement of length of life and the quality of life. The term health factor is defined as a measurement of four areas to include health behaviors, clinical care, social and economic factors and the physical environment. As you can see by the results, all three counties are closely ranked for health outcomes, but for health factors both Harrison and Monroe are ranked in the bottom 25% of the state.

Counties	Health Factors	Health Outcomes
Belmont	49	46
Harrison	72	51
Monroe	76	43

It is interesting to note that Monroe and Harrison Counties are ranked in the bottom 25% of the state for health factors but surprisingly, rank much higher for health outcomes. According to the data, life expectancy for all three counties is an average of 77 years which is on target with the state's overall life expectancy rating. Looking at specific health factors, our three counties averages for adult obesity, diabetes, and the number of adult smokers, are all above Ohio's average.

44% of our residents report insufficient sleep hours and 31% report physical inactivity. Both ratings are significantly higher than the state's average. Our service region also reports a higher number of reported poor physical and mental health days, averaging 4.4, which is higher than the state's average of 4.2 days. These health factor ratings would seem to correlate to the reported three leading causes of death in our service region, heart disease, cancer, and respiratory disease.

In looking at this data for future planning, our region has a larger population of older adults, more poverty, more smokers, and health issues predominately caused by personal choice and behaviors. Interventions would call for more behavioral/physical health integration, more prevention activities, and strategies such as more in-home care, a more decentralized system, and more peer and non-traditional services and supports.

Incarceration Rates

Belmont, Harrison, and Monroe Counties' overall crime rate is low in comparison to other counties across Ohio. Harrison and Monroe County have crime rates that show they are very safe to live in compared to other Ohio counties; their crime rates have decreased over the last two years. Belmont County has seen a slight increase in crime rates over the last two years, with most offenses being related to property crime.

Transportation and Availability of Housing

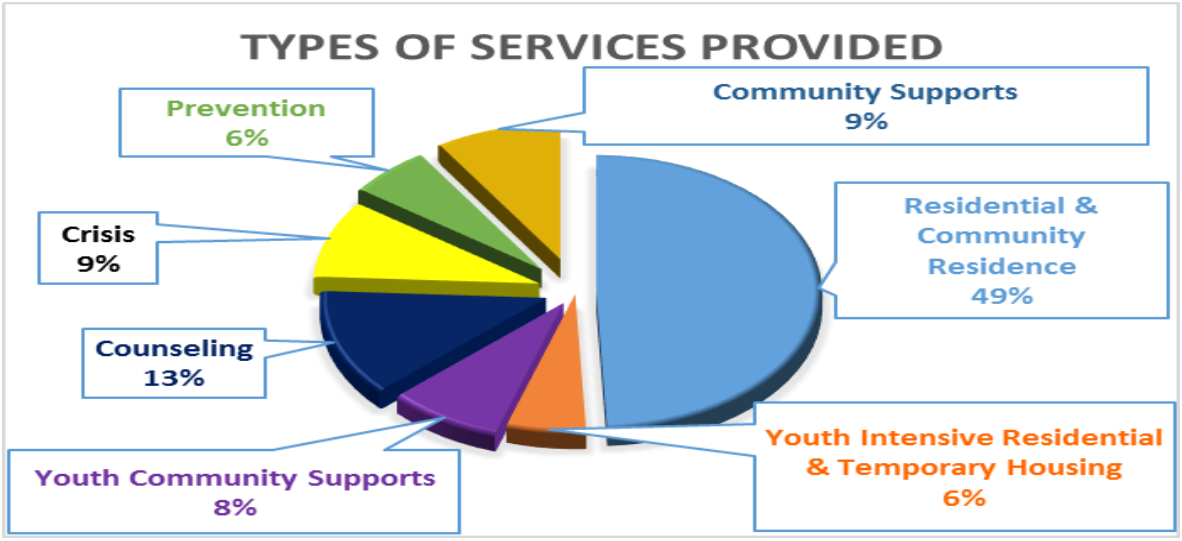
Like most rural areas, availability of safe affordable housing and a viable public transportation system is an ongoing challenge and adds additional burdens on service providers trying to improve access to mental health and addiction services. Since the three county is largely rural, it reasonable to assume that those in the workforce spend more time traveling to and from their place of employment. Harrison and Monroe have a much higher percentage of individuals traveling over 45 minutes to work in comparison to Belmont County residents, with the mean travel time being 40% longer than Ohio's average travel time. This poses a challenge for individuals not only for traveling to work but also for accessing necessary medical and behavioral health services, and this statistic becomes even more troubling considering the number of people who at or below the poverty level in our service district.

Our system continues to be challenged with finding housing placements for individuals who are affected by alcohol and drug addiction, severe and persistent mental illness, and those individuals who are coming from the criminal justice

system. According to the Ohio Balance of State 2019 Point in Time Count (PIT), Belmont County reported 15 households who were homeless, amounting to 21 individuals, 4 of whom were diagnosed with mental illness. Harrison County and Monroe County have no reported incidences of homelessness for the 2019 PIT count. Data on the availability of low-income apartments in all three of our counties looks very different for each area. Belmont County has over 32,000 housing units available, of which 76% are occupied. Of those 32,00 units, only 7% or 2,082 low-income units are available in 34 different apartment communities. Harrison County has over 8,000 housing units available with 76% occupied. Only 3% or 279 of the 8,000 housing units are low income apartments available across 9 apartment communities. Monroe County has 7,500 housing units available of which 76% are occupied. Of those 7,500 units only 1% or 88 units are low- income and are available across 3 apartment properties. All three counties report at least 36% of all individuals paying rent for an apartment are overburden by the cost, which means that rent payments are at or above the median rent rate which we can assume places financial burdens on the individual/family.

Belmont, Harrison and Monroe System and Client Profile

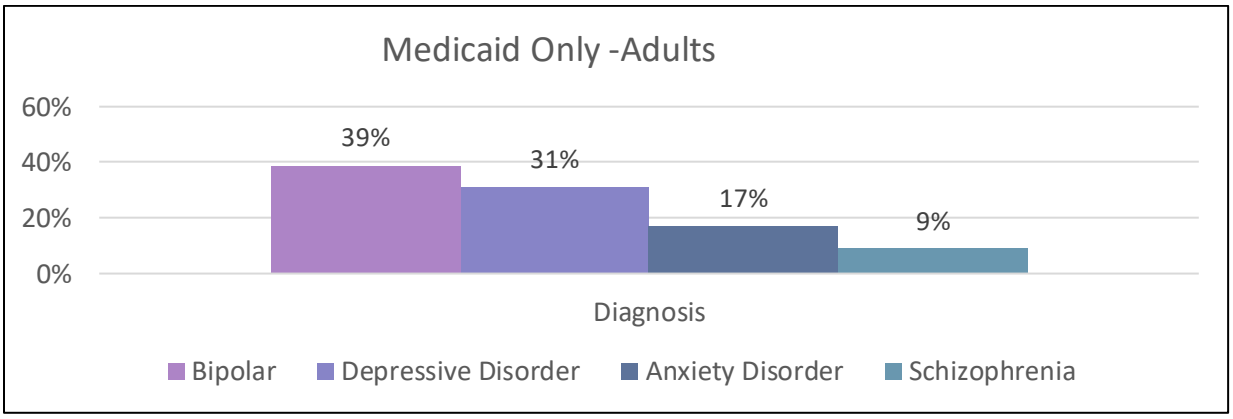
The MHR Board's contracted system of care is comprised of 6 core providers. These include Southeast Health Care, Inc. Crossroads Counseling Inc., Student Services, Tri-County Health Center Inc., The Village Network Inc., and The State of Ohio. In FY 2019 these contracts accounted for the MHR Board's spending of two and half million dollars on direct services to our individuals and families; the types of services supported are represented in the graph below. 49% of board funds were spent on residential and community residence, representing placements in adult care facilities, as well as supportive housing and independent living.

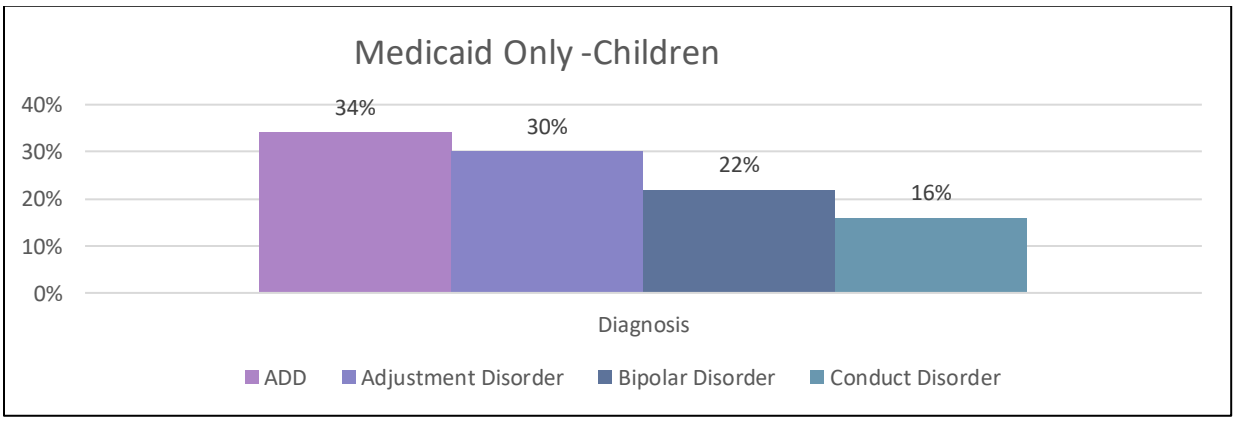


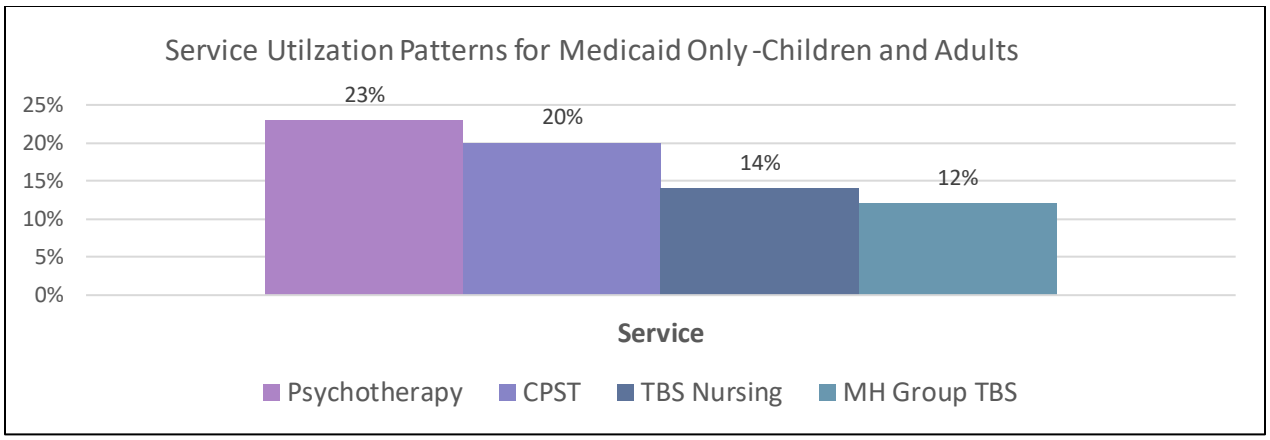
Our local providers continue to see a growing need for services to address complex multi-need individuals and families, often coupled with multigenerational or split generational families (grandparents, /parents/children) all residing together. This includes grandparents raising their grandchildren. In the 2018-2019 Public Children Services Association of Ohio Factbook 14th edition, 728 grandparents were reported to be raising their grandchildren which is a 12% decrease from 2016-2017 but still an area of concern. Our crisis services continue to see many individuals coming into the system due to substance use disorders, particularly methamphetamine, cocaine, and opiate use. Additionally, in FY 20, our community was hit with the closing of three local hospitals that resulted in the loss of nearly 75 beds (both adults and youth) for psychiatric admissions. This decreased capacity has added an extra burden on our crisis response system, local first responders, and emergency room departments, and unfortunately contributes to delays in treatment for the individuals needing care.

The MHR Board is a member of the Partner's Solution administrative services organization which provides a wide variety of reports from claims system for individuals on Medicaid and those who are on the Board's benefit package. These reports provide information on the characteristics of persons receiving services, and the frequency and duration of those services that account for the two and half million dollars spent in FY 19. According to reports from Partners Solutions our behavioral health providers in FY 19 served a total of 4,489 clients, of which 71% were adults and 29% were children under the age of 18 years old. 84% of the clients served were covered by Medicaid and 16% received coverage under the MHR Board benefit plan. As we further drill down into the persons served by payer sources, there is very little diversity in diagnosis for adults and youth and a slight difference in service utilization, which is expected as Community Residence and AOD Room and Board are not Medicaid eligible services.

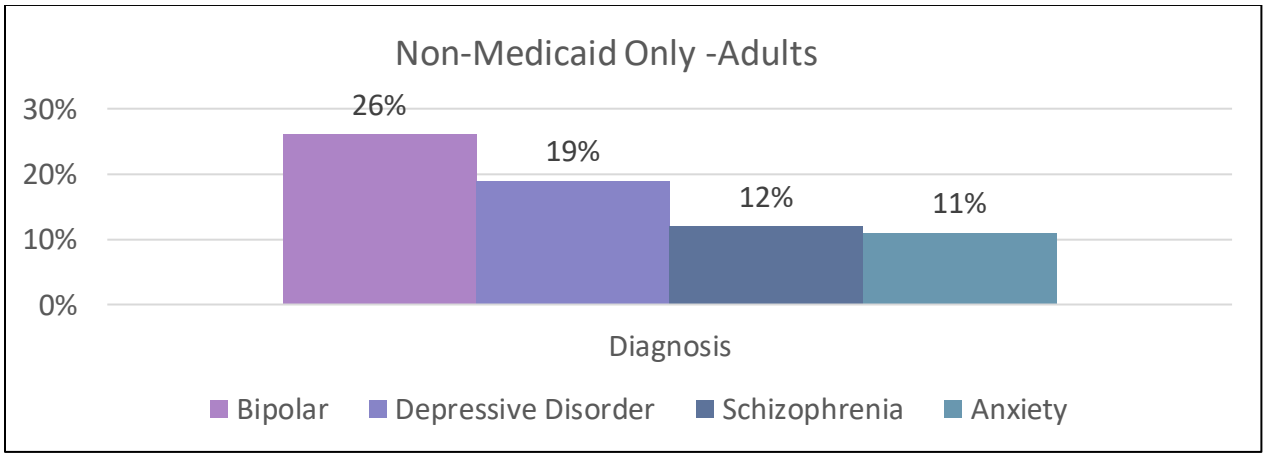
FY19 Medicaid-only clients are represented in the following graphs. 68% of those served were adults, 32% were youth, the majority were females and of Caucasian race. The most common age group served for adults were those between 25 and 54 years of age, representing 47% of the adult population served. The most common age group served for children were those between 14 and 17 years of age, representing 69% of youth receiving care. The following graphs represent the top 4 diagnoses for adults and youth and the service utilization graph shows the primary services accessed by this population.

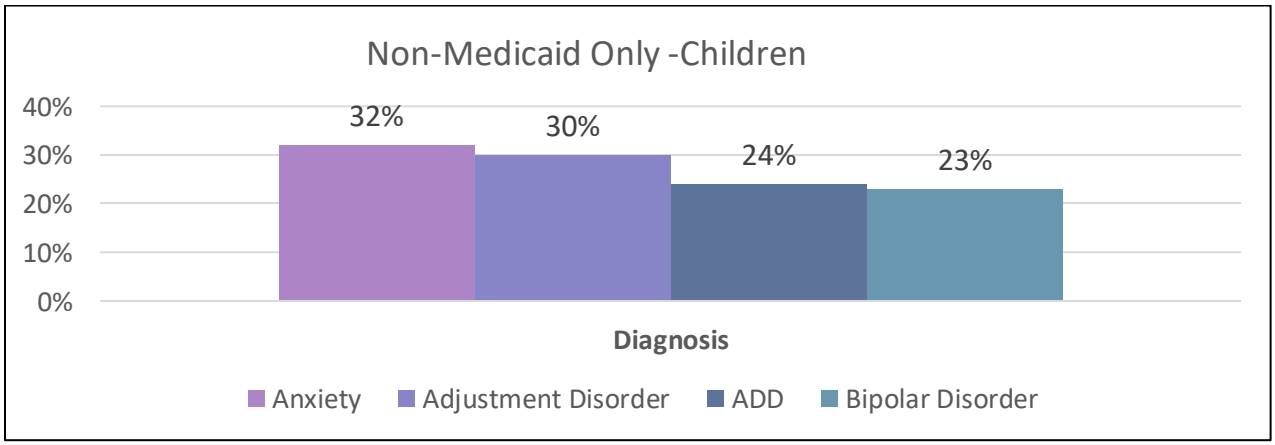


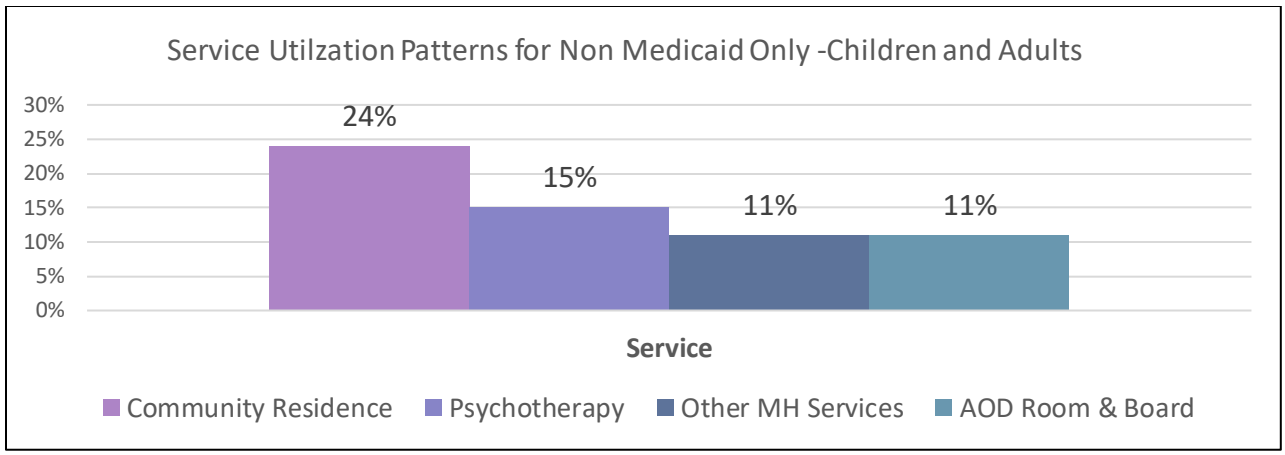




The remaining non-Medicaid clients represent 20% of the total number served in FY19. 88% were adults, 12% were children, the majority were Caucasian, and males/females were evenly represented. Just like in the Medicaid group, the most common non-Medicaid age group served for adults were those between 25 and 54 years of age representing 41% of the adult population served. The most common age group served for children were those between 14 and 17 years of age representing 36% of those receiving care. 54% of the clients in this group pay zero dollars for the services they receive. The following graphs represent the most frequently served diagnosis for adults and youth and the service utilization graph shows the most frequent services accessed by individuals on the Board's benefit plan.







Impact of Behavioral Health Re-Design and Medicaid Managed Care Carve In

As we head into our third year of BH Re-Design, both old and new challenges exist for the system. The Board's funding continues to be utilized as a bridge support until insurance, Medicare, or Medicaid coverage is secured by clients. The Board's funds continue to be utilized for recovery supports and services while the state and local levy funds are applied to support less traditional services and supports or fund new services until the client becomes eligible for Medicaid. As noted by our local needs assessment, providers continue to request guidance and assistance from the Board regarding reimbursement for services provided to individuals with private health care who have such high deductibles and out of pocket limits that they cannot afford to use their insurance. Our local system continues to struggle to find ways of bridging the gap on ability to pay without inadvertently discriminating against other groups. We have made some accommodations for persons who are Title XX eligible but fail to apply for Medicaid, by agreeing to reimburse the providers for the initial assessment and two visits to reduce the financial harm to the providers.

As the Board conducts activities related to planning and system development, the unavailability of or the inability to obtain complete data about the number of people receiving community behavioral health services in the Board area makes it very difficult to assess how well the mental health and addiction needs of the resident population are being met or if there is full utilization of many services.

Lastly, the impact of the COVID-19 pandemic in the Spring of 2020 had a major impact not only financially for providers, but also on every aspect of service delivery. As in other parts of the state, our local service providers had to quickly customize their service delivery system based on available resources to ensure that behavioral health services could remain available, while taking precautions to help slow the spread of the virus. The MHR Board quickly responded by funding technology and equipment upgrades as well as by providing cash payments to contract agencies to assist with projected loss revenues. State and national leaders in behavioral health care have all warned of the coming surge of behavioral health issues because of this unprecedented event. As we move forward over the next two years, providers will be challenged to find resources to provide additional prevention/education services, leverage all types of technology to improve access , work in collaboration with other community organizations to address the increase in unemployment and income disparities for those we serve, and lastly, find ways to support the front-line workforce to ensure capacity to meet the needs of the community.

4. Describe any child service needs resulting from finalized dispute resolution with county Family and Children First Council(s) [340.03(A)(1)(c)].

In FY 20 there was one case that advanced to a dispute level with the Family and Children First Council in Belmont County. A decision was reached and accepted by both parties after the initial meeting.

5. Describe how the future outpatient service needs of persons currently receiving inpatient treatment in State Regional Psychiatric Hospitals [340.03(A)(1)(c)] are identified.

During the 1st quarter of FY 2020, ***47%*** of the admissions to the RPH were jail transfers and ***38%*** were civil admissions. The average length of stay was 6 to 10 days and ***27%*** of these admissions reported using methamphetamines or opiates within the prior year. ***79%*** of the discharges during the 1st quarter of 2020 were made to jails. As part of this process to coordinate outpatient service needs, the MHR Board is involved in a monthly multi-disciplinary team meeting about individuals served by our RPH. The Board maintains close communication with our local pre-screening agency (Southeast, Healthcare Inc.) regarding local individuals who are placed in the RPH. Care Coordination staff employed by Southeast, Healthcare Inc. connect with the hospitalized individual, support the plan for return to the community, and provide follow-up contact after discharge. To assure adequate linkages back to the community, the MHR Board reimburses Southeast Healthcare Inc. for services to any individual who is not a client but is need of services in order to assure a healthy and safe transition back to the community. The forensic population continues to consume the limited state hospital bed stock, which at times limits bed availability for civilian admissions. This can cause long delays for civilian admissions resulting in lengthy emergency room stays, and at times placements that are far from home, away from natural support systems.

While our region has consistently seen an increase in the need for mental health and substance abuse services, we have also seen a reduction in options for psychiatric inpatient care, as over the last year we lost approximately 75 local inpatient beds due to hospital closures. As a result, individuals have been detained in the emergency room department for extended time periods and often sent out of the region for inpatient care, far away from their families and their network of support. Another significant impact on our region continues to be the ability to attract Psychiatrists, Advance Nurse Practitioners, and licensed clinicians to meet the demands of our region. This often leads to our residents having to leave the area to obtain needed services and/or longer wait times for an appointment.

Belmont Harrison and Monroe Board's Local System Priorities (add as many rows as needed)			
Priorities	Goals	Strategies	Measurement
1. Prevention services across the lifespan with efforts focusing on mental health prevention efforts targeting adults and older adults in all three counties. (**RecoveryOhio Priority #4 (25))**	Increase all levels of mental health prevention activities (universal, selective, and indicated) for adults and older adults in Belmont, Harrison, and Monroe Counties.	**A**. Contract for new mental health prevention services for adults in all three counties in FY 21.	**A.** Measurement: # of programs delivered in one year Baseline data: 0 (New Program) Target: 20
2. Criminal Justice System Diversion Programs **(RecoveryOhio Priority #7 (57))**	Increase diversion activities and strengthen engagement and transition services for Mental Health and SUD individuals.	**A**. Provide new funding to support Court Navigators in Belmont County **B.** Contract with provider in Jefferson County to serve Belmont Harrison and Monroe residents who are serving time in the Jefferson County Jail.	**A.** Measurement: # of persons served in one year Baseline data: 0 (New Program) Target: 50 **B.** Measurement: # of persons served in the jail in one year Baseline data: 0 (New Program) Target: 30
3. Services and Supports for Adults with Serious Mental Illness **(RecoveryOhio Priority #6 (36))**	Enhance the array of the crisis services available for adults by continuing to implement the local crisis redesign plan.	**A.** Develop a mobile crisis response team **B.** Purchase crisis stabilization beds from our local regional crisis stabilization program in Jefferson County.	**A.** Measurement indicator: Team Developed Baseline data: 0 (New Program) Target: 1 Mobile Crisis Response Team to serve Belmont, Harrison, and Monroe Counties **B**. Measurement indicator: Baseline data: 0 (New Program) Target: 50 bed days purchased

Board of Belmont Harrison, and Monroe Counties Local System Priorities			
Priorities	**Goals**	Strategies	Measurement
4. Peer Supports for Individuals with Mental Health and Substance Use Disorders. (**RecoveryOhio Priority #6 (48))**	Increase the number of certified peer recovery supporters.	**A**. Contract with a provider to develop peer recovery supports for individuals with mental health and substance use disorders.	**A.** Measurement Indicator: Number of trained certified peer recovery supporters. Baseline Data: 7 Target: 12
5. Adults with Substance Use Disorders **(RecoveryOhio Priority #6 (44))**	Develop 3.7 Withdrawal Management Service in our three-county service district.	**A.** Contract with provider to bring program online in FY 2021.	**A.** Measurement Indicator: Operationalize Withdrawal Management Program. Baseline Data: 0 Beds (New Program) Target: 8 beds
6. Workforce Development **(RecoveryOhio Priority #3 (12))**	Minimize the effect on clients from staff turnover and extended unfilled positions.	**A.** Coordinate networking meeting between local universities and agency directors for recruitment opportunities. **B.** Support and fund workforce incentives offered by providers for retention and recruitment. **C.** Fund and support continuing education opportunities that promote self-care and specialized clinical training for high-risk populations	**A**. Measurement Indicator: # of networking meetings Baseline Data: 0 Target: 2 **B.** Measurement Indicator: Amount of Board resources utilized annually. Baseline: $0 Target: $50,000.00 **C.** Measurement Indicator: # of trainings sponsored Baseline: 1 Target: 3

Collaboration

7. Describe the Board's planned collaborative efforts with other systems, people living with mental illness or addiction, family members, providers, and/or the general public for SFY 2021-2022 that will be needed to implement funded priorities. (Note: Highlight collaborations needed to 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?)

We recognize that in order to successfully implement and achieve the Board's priorities for FY 2021-2022, we must build and strengthen collaborative relationships with community behavioral health providers, persons with lived experience, family members, and other essential community stakeholders. It is well understood within our communities that there is a long-standing commitment to service collaboration and cooperation across service systems. This strength will be an essential force in building the partnerships we need to accomplish our local priorities. Although the Board participates in a wide variety of coalitions and collaborations across all three counties, there are several of those partnerships that we are aware need to be more formalized in order to achieve our local service priorities for FY 2021-2022.

1. Prevention services across the lifespan with efforts focusing on mental health prevention efforts targeting adults and older adults in all three counties.

- Increase all levels of mental health prevention activities (universal, selective, and indicated) for adults and older adults in Belmont, Harrison, and Monroe Counties.

Collaborations Needed:

- Facilitate the development of formal relationships with the local senior service organizations to improve access to care.
- Join local service organizations to increase information sharing.
- Enhance existing local partnerships with health departments to promote information sharing and access to care.
- Develop a stronger informal relationship with local media outlets to increase efforts to reduce stigma and promote awareness.
- Develop stronger informal relationships with the faith-based community to increase the awareness of available services and reduce stigma
- Continue to engage in formal relationships with the local school districts to ensure access to care for our youth.

2. Criminal Justice System Diversion Programs

- Increase diversion activities and strengthen engagement and transition services for Mental Health and SUD individuals.

Collaborations Needed:

- Revitalize the local criminal justice linkage committee, with community partners.
- Continue to work on building collaborative partnerships with the local courts and Judges.
- Increase local law enforcement's participation in CIT specific trainings.
- Work with local contract agencies to develop a formal re-entry program/navigator.
- Develop additional formal agreements with MAT providers.

3. Services and Supports for Adults with Serious Mental Illness

- Enhance the array of the crisis services available for adults by continuing to implement the local crisis redesign plan.

Collaborations Needed:

- Improve local relationships with emergency room departments to improve continuity of care and access to care for our residents.

- Formalize a protocol/agreement with local law enforcement and other first-responders that involves crisis workers responding in collaboration with law enforcement officers when responding to behavioral health calls.
- Develop a formal arrangement with private hospitals for access to inpatient beds.
- Collaborate with OHMHAS for technical assistance in developing and implementing a crisis mobile team.

4. Peer Supports for Individuals with Mental Health and Substance Use Disorders.
   - Increase the number of certified peer recovery supporters.

Collaborations Needed:
- Formal arrangement with service provided to implement Peer Recovery Services.
- Collaborate with regional MHR Boards to coordinate and fund a training.
- Establish a formal arrangement with the local NAMI chapter to increase outreach to peers and families.

5. Adults with Substance Use Disorders
   - Develop 3.7 Withdrawal Management Service in our three-county service district.

Collaborations Needed:
- Improve local relationships with emergency room departments to improve continuity of care and access to care for our residents.
- Develop formal agreements with local medical providers to ensure that ancillary services are in place for the program.
- Develop informal arrangements with regional MHR Boards to ensure access to care.
- Enhance relationships with local recovery support groups to share information and improve access to care.

6. Workforce Development
   - Minimize the effect on clients from staff turnover and extended unfilled positions.

Collaborations Needed:
- Enhance relationships between providers and local universities and community colleges.
- Develop formal agreements with trainers to provide continuing education opportunities for self-care, secondary trauma, and best practices.

Inpatient Hospital Management and Transition Planning

8. Describe what partnerships will be needed between the Board and the State Hospital(s), Private Hospital(s) and/or outpatient providers for the identification of needed services and supports.

a. How will the Board coordinate the transition from the hospital to the community? (i.e., discharge planning)

Who will be responsible for this?

As documented in question 5, the Board, RPH, and the provider work closely together to coordinate a care plan for all discharges back to the community. As part of this process to coordinate outpatient service needs, the MHR Board is involved in a monthly multi-disciplinary team meeting to discuss individuals served by our RPH. The Board has an Associate Director who is responsible for overseeing care coordination and reviewing with the provider organization persons who have been identified as high risk and those who have multiple admissions to the RPH. In addition, the Board's Associate Director also reviews all prescreening and maintains close communication with our local pre-screening

agency (Southeast, Healthcare Inc.) regarding local individuals who are placed in the RPH. Care Coordination staff employed by Southeast, Healthcare Inc. connect with the individual while in the hospital, support the plan for return to the community, and provide follow-up contact after discharge.

b. Discuss any planned changes in current utilization that is expected or foreseen.

At the current time, the Board does not see any planned or unforeseen changes in the current RPH utilization rate. However, MHR Board staff understands and is ready to implement the diversion protocols for our residents to another facility should COVID-19 shut down our local admissions to our RPH.

Continuum of Care Service Inventory

9. Complete the attached spreadsheet: Inventory of Facilities, Services and Supports Currently Available to Residents of the Board Area. Instructions are found on Page 10 of the Guidelines.

Continuum of Care definitions found in the Ohio Revised Code [ORC 340.03(A)(1)].

Alignment with Federal and State Priorities

10. The following pages of this template contains a table that provides the specific federal and state priorities for: Mental Health Block Grant (MH-BG), Substance Abuse Prevention and Treatment Block Grant (SAPT-BG), SAMHSA and OhioMHAS treatment and prevention priorities. Please complete the requested information only for those federal and state priorities that are the same as the Board's priorities. 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.

Identify at least one measurement indicator, and subsequent baseline data, that will be used to track progress towards meeting the identified priority(ies).

Priorities for Belmont Harrison and Monroe Counties				
Substance Abuse & Mental Health Block Grant Priorities				
Priorities	Goals	Strategies	Measurement	Reason for not selecting
01 SAPT-BG: Mandatory (for OhioMHAS): Persons who are intravenous/injection drug users (IDU)	Provide a continuum of care for persons who are intravenous/injection drug users. **(RecoveryOhio Priority #6 (44))**	A. Expand and maintain the availability of MAT across all three counties.	A. Measurement: # of persons served annually Baseline data: 262 Target: 300	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):
02 SAPT-BG: Mandatory for boards: Women who are pregnant and have a substance use disorder (NOTE: ORC 5119.17 required priority)	Decrease the number of babies born with neonatal abstinence syndrome.	**A**. Continue to promote and fund the Nurse Care Coordinator Program across all three counties.	**A.** Measurement: # of women served annually Baseline data: 21 Target: 30	__ No assessed local need __ Lack of funds __ Workforce shortage __ Oher (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)	Parents with SUD will choose to enroll in the Family Dependency Treatment Program in lieu of terminating custody. **(RecoveryOhio Priority #7 (58))**	**A**. Continue to promote and fund the Family Dependency Treatment Court Navigator in Harrison County.	**A**. Measurement indicator: # of families who were reunited annually Baseline data: 2 Target: 5	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):
SAPT-BG: Mandatory (for OhioMHAS): Individuals with tuberculosis and other communicable diseases (e.g., AIDS.HIV, Hepatitis C, etc.)				_X_ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):
MH-BG: Mandatory (for OhioMHAS): Children with Serious Emotional Disturbances (SED)	Provide and assure access to an array of core services and supports for children with SED and their families. **(RecoveryOhio Priority #7 (67))** **(RecoveryOhio Priority #6(33))**	**A**. Increase capacity for Intensive Home-Based Treatment for SED children and youth **B**. Maintain the current level of funding for wraparound services, respite care and out of home placements. **C.** Increase capacity to provide Early Childhood Mental Health Intervention	**A**. Measurement: # of families served annually Baseline data: 0 (New Program) Target: 14 **B**. Measurement: 5% of allocated resources Baseline data: 5% Target: 5%	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):

		D. Promote and offer trainings to support best practices in diagnosis and treatment for those with SED.	**C**. Measurement: # of centers/agencies receiving intervention services annually. Baseline Data: 15 Target: 25 **D**. Measurement: # of annual trainings Baseline: 1 Target: 2	
MH-BG: Mandatory (for OhioMHAS): Adults with Serious Mental Illness (SMI)	Provide an array of services for adults with SMI that offer opportunities to access services and recovery supports to meet their individual recovery needs to live successfully in their community. **(RecoveryOhio Priority#1(3))** **(RecoveryOhio Priority #6 (49))** (**RecoveryOhio Priority #6 (48))**	**A**. Promote and offer trainings to support best practices in diagnosis and treatment planning for those with SMI. **B**. Continue to provide funding for employment services. **C.** Increase the number of certified peers supports in the three-county area.	**A.** Measurement: # of trainings in a year Baseline data: 0 Target: 2 **B**. Measurement: # of persons served annually Baseline data: 54 Target: 64 **C.** Measurement: # of certified peer supporters across all three counties Baseline data: 7 Target: 10	__ 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 opportunities for individuals who are homeless, and person who are diagnosed with mental illness and/ or addiction to access to supportive housing options. **(RecoveryOhio Priority#6(47))**	**A.** Continue the MHB Board Community Housing Assistance Program **B.** Continue to provide funding for RCF placements.	**A.** Measurement: # of persons served by the program in a year Baseline data: 25 Target: 35 **B**. Measurement: # of persons served in a year Baseline Data: 42 Target: 48	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):
MH-Treatment: Older Adults	Increase the number of older adults receiving services in the local behavioral health system. **(RecoveryOhio Priority#7(70))**	**A.** Fund opportunities to use media outlets and capitalize on free social networks, and websites to educate seniors on locally available mental health and substance abuse services.	**A**. Measurement: # of awareness campaigns in one year Baseline data: 0 Target: 4 **B**. Measurement: % of individuals 65 and older who received services annually Baseline Data: 5% Target: 7%	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe)

Additional Priorities Consistent with SAMHSA Strategic Plan and Reported in Block Grant				
Priorities	Goals	Strategies	Measurement	Reason for not selecting
MH/SUD Treatment in Criminal Justice system –in jails, prisons, courts, assisted outpatient treatment	Ensure adequate and appropriate behavioral health services are available to meet the needs of individuals in the criminal justice system and provide opportunities for diversion from the jails. **(RecoveryOhio Priority #7 (57))**	**A.** Continue and expand funding for services provided in the local jails. **B.** Provide new funding to support Court Navigators in Belmont County	**A**. Measurement: # of persons served in the jails annually. Baseline data: 100 Target: 175 **B.** Measurement: # of persons served by court navigators in a year. Baseline data: 0 (new Program) Target: 50	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe)
Integration of behavioral health and primary care services	Support the local community integrated care models.	**A.** Maintain local partnerships and develop new partnerships with primary care organizations and hospitals. (Barnesville Professional Association, Ohio Hills, SE FQHC)	**A**. Measurement: # of collaborative partnerships. Baseline data: 1 Target: 3	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):
Recovery support services for individuals with mental illness or substance use disorders; (e.g. housing, employment, peer support, transportation)	Improve outcomes for individuals with mental health or substance use disorders through improved access to recovery support services. **(RecoveryOhio Priority #6 (48))** **(RecoveryOhio Priority#6(47))**	**A**. Increase access to peer support recovery services through contract agency agreements. **B**. Continue to invest in recovery housing options	**A.** Measurement: # of contracts for peer support services Baseline data: 1 Target: 3 B. Measurement: # of contracts in place to support recovery housing Baseline data: 1 Target: 2	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):
Promote health equity and reduce disparities across populations (e.g. racial, ethnic & linguistic minorities, LGBT)	Encourage access to services for racial and ethnic minorities and LGBTQ populations	**A**. Contract and collaborate with provider network to advance culturally and linguistically appropriate trainings and development activities.	**A**. Measurement: # of annual trainings Baseline data: 1 Target: 2	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):
Prevention and/or decrease of opiate overdoses and/or deaths	Decrease the number of overdoses and/or deaths through the number of program options available. **(RecoveryOhio Priority#4 (22))** **(RecoveryOhio Priority #6 (44))**	**A.** Participate in local county substance abuse prevention coalitions. **B**. Collaborate and contract with a local service provider to develop local detox beds.	**A**. Measurement: % of coalition meetings attended by Board staff in a year Baseline data: 75% Target: 95% **B**. Measurement: # of detox beds available in the three-county area. Baseline data: 0 Target: 6	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe)

Promote Trauma Informed Care approach	Increase awareness of Trauma Informed Care **(RecoveryOhio Priority #1 (4))** **(RecoveryOhio Priority#4 (22))**	**A**. Participate in the local and regional Trauma Informed Care Collaboratives	**A**. Measurement indicator: % of coalition meetings attended by Board staff in a year Baseline data: 25% Target: 75%	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe

OhioMHAS Prevention Priorities				
Priorities	Goals	Strategies	Measurement	Reason for not selecting
Prevention: Ensure prevention services are available across the lifespan	Promote a healthier community through providing prevention services to address all the needs of residents in all three counties. (**RecoveryOhio Priority #4 (25))**	**A**. Contract for new mental health prevention services for adults in all three counties in FY 21.	**A**. Measurement indicator: # of programs delivered in one year Baseline data: 0 (New Program) Target: 20	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):
Prevention: Increase access to evidence-based prevention	Maintain certified prevention programming and staff within our system. **RecoveryOhio Priority #4 (23))**	**A.** Contract for EBPs prevention services for children and youth, including school based.	**A.** Measurement: # of schools in the district where EBPs activities are offered. Baseline data: 29 Target: 32 **B**. Measurement # of public schools utilizing prevention services in the three-county area Baseline: 100% Target: 100%	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):
Recovery Ohio and Prevention: Suicide prevention	Increase awareness that suicide is a public health problem in order to reduce stigma and increase individuals' ability to seek help.	**A**. Invest in gatekeeper trainings to community groups and key stakeholders. **B**. Fund and support local coalition activities to bring about public awareness.	**A.** Measurement: # of persons trained in a year. Baseline data: 0 Target: 100 **B.** Measurement: # activities funded for suicide coalitions in one year Baseline data: 2 Target: 4	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):
Prevention: Integrate Problem Gambling Prevention & Screening Strategies in Community and Healthcare Organizations	Continue to ensure that persons seeking or being referred to substance abuse treatment are screened for problem gambling.			__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):

Community Plan Appendix 1: Alcohol & Other Drugs Waivers

A. Waiver Request for Ambulatory Detoxification or Medication-Assisted Treatment

ORC 340.033 allows for a process to request a time-limited waiver under section 5119.221 for the Revised Code for ambulatory detoxification and medication-assisted treatment. As stated in ORC 5119.221, the director may provide a time-limited waiver if both of the following apply:

- The board seeking the waiver has made reasonable efforts to make ambulatory detoxification and medication-assisted treatment available within the borders of the board's service district;
- Ambulatory detoxification and medication-assisted treatment can be made available through a contract with one or more providers located not more than thirty (30) miles from your board's service area.

To complete your waiver request for review, please include below, a brief overview of your board's "reasonable efforts" to provide ambulatory detoxification or medication-assisted treatment and attach a copy of the contract(s) with the identified provider(s) that has agreed to provide this service to your area. This information will be forwarded to the director as part of the waiver review and approval process.

B. 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

C. 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 2021-2022

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

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

_____

ADAMHS Board Name (Please print or type)

_____ _____

ADAMHS Board Executive Director Date

_____ _____

ADAMHS Board Chair Date

[Signatures must be original or if not signed by designated individual, then documentation of authority to do so must be included (Board minutes, letter of authority, etc.)].

Attached is the SFY 2021-2022 Community Plan Essential Services Inventory**. Each Board’s completed SFY 2019-2020 form will be sent in separate email should the board want to use it to update information.**

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

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

Instructions for the Essential Services Inventory

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

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

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

Additional Sources of CoC Information

1. **SAMHSA Treatment Locator** **https://www.findtreatment.gov/**