Ohio Department of Mental Health and Addiction Services (OhioMHAS)

Community Plan Guidelines SFY 2021 and 2022

Enter Board Name: Hancock County Board of Alcohol, Drug Addiction and Mental Health Services

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)].

   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?

      The Board completed a ROSC self-assessment. The Hancock County Board has been involved in a ROSC system transformation effort since 2013. The Board's entire strategic plan is grounded in continuing efforts to implement a ROSC. The Board updated its strategic plan in October 2019. Attached is a summary document of the plan as well as the most recent progress report.

      All efforts of the Board are integrated within this transformation effort and are reflected in the Board's strategic plan. The principles of ROSC guide the work of our Board and the local priorities of our Board exist as a result of the involvement of the community with our system.

   The Board is in a constant state of receiving input/feedback on the system. The Board is engaged with assessment and planning on an ongoing basis via participating in various local Coalitions, Task Forces, and agency specific efforts. The Board collaboratively funds a formal community health assessment every three years with Blanchard Valley Health System, Hancock Public Health and the Community Foundation. The most recent assessment was completed in the fall of 2018 with the Northwest Ohio Hospital Council. As with the prior assessment, the results indicate the highest needs in the community are mental health and addiction.

   The Board engaged local and regional planning and funding bodies in multiple ways. On a local level, the Board Executive Director is a member of the Board of Directors for the Center for Civic Engagement, the local Collective Impact Initiative to address community needs. The Board is comprised of the University of Findlay President; the CEO of the United Way; the CEO of the Community Foundation and a retired business leader. This Board helps to ensure that major

funding to address community needs is using consistent data sources and principles (collective impact). Mental Health and Addiction remain top priorities. In addition, the Board was an active participant with the local Regional Planning Commission on the recently completed Housing Study for our community.

The Board Executive Director and Board staff are deliberate in their involvement with local organizations as a source of ensuring we are current with the needs of the community as well as to continue to build relationships. Across our staff we serve on the following Boards of Directors: The Center for Safe and Healthy Children (a Child Advocacy Center); Welcome to a New Life (adult mentoring for criminal justice-involved individuals); CCE (Center for Civic Engagement); FDA (Findlay Digital Academy); FAHRA (Findlay Area Human Resource Association); and the Chamber Advisory Board.

The Board is also deliberate in our efforts to work with the local Health Department. Hancock Public Health took the lead role in the completion of the health assessment process with the Hospital Council. The resulting Community Health Improvement Plan was completed and shared in the community in October of 2019. The Board is also working collaboratively with the Health Department on Harm Reduction efforts in the community, including the recently implemented BDIP Program (Blood-borne Disease Intervention Program) that includes needle exchange. The Health Department is the recipient of a grant from the Ohio Department of Health which allows them to work closely with our Opiate and Other Addictions Task Force. In addition to serving as the hub for the distribution of Narcan in our community; they also take the lead in coordinating our Overdose Death Review Committee. Each death in the community is reviewed by a multi-disciplinary team in an effort to identify areas for improvement. The Health Department does all the prep work for this review; including contacting the nearest of kin to complete an interview with them. The Health Department is also a recipient of a safety grant; which provides us with the opportunity to work collaboratively on compliance checks. The Health Department has a seat on our Community Partnership, our coalition to address prevention, education and early intervention; and our local Opiate and Other Addictions Task Force.

On a regional level, the Northwest Ohio Collaborative meets regularly to address the needs of our region; discuss any issues related to inpatient care at the state hospital; and resolve state regional funding requirements. We are the project lead on regional withdrawal management services with our local hospital, Blanchard Valley Regional Health System.

Our Board is the recipient of two regional grants: Engage 2.0, a state system of care grant aimed at increasing the availability of MRSS (mobile response and stabilization services); and YT-I, a grant focused on the development of ICT (Integrated Co-occurring Treatment), MAT (Medication Assisted Treatment), and APG (Alternative Peer Group) for youth as well as staff development in motivational interviewing.

In regard to relevant ethnic organizations, our Board took the lead several years ago to establish the Cultural Humility and Health Equity Delegation. Our Board provides backbone support to the Delegation via staff support and participation. This Delegation meets regularly to address the issue of belonging in our community. The membership is robust and diverse and inclusive of the Mayor.

A draft resolution is currently in process of being presented to City Council for adoption related to affirming the city's commitment to a community that embraces diversity, inclusivity, equity and belonging.

At the most recent strategic planning session of the Delegation, held in September, the following priorities were established:

1. Continue to pursue the adoption of the Resolution. The Delegation intends to introduce the Resolution to City Council at the second City Council Meeting in October (10/20/20).
2. Collect qualitative data (stories) from Findlay businesses/corporations that demonstrates the importance of establishing a culture of diversity, inclusivity, equity, and belonging within its enterprise.
3. Develop a one-page business case brief that concisely (and graphically) summarizes the work of the Delegation. This brief will be used to aid in communicating to City Council members the critical need to resolve that Findlay is a Community of Belonging.
4. Seek proposals from potential strategic planning consultants, leading to the development of a Letter of Intent to the Community Foundation for the consideration of grant funding application.

The Board receives regular input from providers and people living with or recovering from mental illness and addiction. Our local recovery support center, FOCUS, is actively involved with our system. Having served over 700 individuals (unduplicated count); they are a natural source for input and feedback. People living with or recovering from mental illness and addiction are active participants in our committees and meetings. Contract agencies are also required to conduct and report on client satisfaction surveys.

Feedback is received through monthly individual meetings held with agency directors; quarterly meetings with agency chairs/directors; agency directors' meetings; monthly program committee meetings of the Board; review of agency quality improvement reports; meetings of the ROSC Leadership Committee; input from the Family Support Group and NAMI; and the ROSC Self-Assessment.

Our Board is also involved on the national level. Our system is the recipient of four large federal grants: a System of Care Grant; a CCBHC grant (awarded directly to Family Resource Center); a COSSAP grant for the implementation of LEAD; a SAMHSA Peer Support grant (awarded directly to FOCUS); and a SAMHSA Suicide Prevention grant (awarded directly to Family Resource Center). All of the federal grant awards include the involvement of Brandeis University as our evaluator and access to multiple outlets for technical assistance. We have been part of multiple learning communities; have attended multiple national meetings; have resources to directly address cultural diversity needs; and through our technical assistance were given access to several one-on-one sessions with national leaders.

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 response to this question can be found on the chart labeled "Board Local System Priorities".

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.

   The most significant environmental factor influencing local priorities at this time is the COVID pandemic. As the pandemic has progressed, the importance of getting services to people in need has become more critical than ever. The need for flexibility, creativity both in the delivery of services and on behalf of the workforce has been illuminated on a daily basis. Increased health and safety measures; extensive availability of telehealth; non-traditional ways of reaching out to youth in the absence of on-site school attendance; and consistency in messaging of available resources have been, and continue to be critical. We have worked side by side with the health department to help ensure the safety of the people we serve; especially those in congregate housing settings. The Board has taken the lead on publicizing the availability of services; securing PPE; and providing financial support to ensure the viability of the providers. The pandemic will continue to alter the way we do services and cause us to prioritize services differently. As of the date of this writing, Hancock County has 615 cases; 53 hospitalizations and 9 deaths.

   On the treatment side, our top priority has been to ensure access to medication; stabilization in housing; and the availability of case management. The delivery of telehealth is now common place. In person appointments are reserved for those who require face-to-face services and/or prefer it over telehealth. The recovery support center, FOCUS, has remained open throughout the pandemic. On-line prevention services/supports were developed and continue to be available to youth. The pandemic has limited our accessibility to inmates at the jail and initially limited our available to provide services out in the community. Community based workers are steadily increasing their time out of the office as the availability of PPE and the development of other safety precautions were completed.

The opiate epidemic is still evident in our community but is also following the nationwide trend of decreasing as the use of methamphetamine and cocaine is increasing. The number of overdose deaths dropped by 14% from 2018 to 2019. This follows a reduction of 30% from 2017 to 2018. and it looks promising to drop slightly again in 2020. The rapid increase in the availability of MAT providers and Narcan kits have contributed to this reduction. The epidemic has had a significant impact on multi-system youth. Our county has record numbers of youth in placement. Prior to the epidemic our community averaged 40-50 placements in a year. Currently, there are well over 100 youth in placement. Most of the placements are directly related to substance use and/or mental illness. The system of care grant has provided opportunities for our community to expand wrap-around; peer support; and family peer support. Policy changes aimed at improving the system are being tracked. In depth case reviews have been conducted in order to identify areas of strength and areas in need of improvement.

The Board has been monitoring the impact of the opiate epidemic since 2009 by gathering data from multiple systems within the community. While overdose deaths have decreased, the number of suicides doubled in 2018 and was only reduced by one in 2019. Attached is the most recent composite report.

Immediate access to care continues to be a challenge. This is being addressed through our work to develop a crisis continuum of care. In addition, with the completion of a strategic plan for the Opiate and Other Addictions Task Force, two priority areas were identified: taking services "to" those most in need vs. waiting for them to seek services; and increasing involvement of family and significant others. As a result, increased efforts in harm reduction and outreach are being planned. A community wide conference on Addictions and the Family was held in the spring of 2020.

Moving forward, one challenge is the limited use of the Federal funding to combat the opiate epidemic due to the GPRA requirements. With all of the federal grant awards in our community and the demands for GPRA, it has become too burdensome to individuals receiving services and staff delivering the services to maintain this intense tracking/reporting. We continue to meet with Senator Portman on the need to address this issue.

Another critical environmental factor that influenced priorities is system design. Our local system has been designed for individuals who come thru the front door. Once inside the front door, there are multiple services available. This works well for individuals willing to seek services, however, there are a number of individuals who are not willing to seek services either due to their level of illness and/or barriers such as transportation, fear of judgement/legal consequences, etc. As a result, our Board has been focused on ways to engage individuals in need through outreach and early intervention as well as ways to assist individuals who have a need for temporary 24/7 supervised stabilization services. The inclusion of these approaches will provide a more complete continuum of care that is accessible to all.

One of the greatest challenges our system is facing is the lack of a qualified workforce. Our provider agencies are facing critical shortages that are resulting in vast number of positions left unfilled for many months. One of our provider agencies is participating in a national workforce learning community but they continue to be unable fill many critical positions. Crisis Services is one area

that the workforce shortage has had the greatest impact. This has resulted in our local hospital developing a behavioral health department capable of crisis screening and our inability to fully implement MRSS.

It should be noted that the strengthening of the system could not have been accomplished without the expansion of Medicaid. Should this policy be reversed, the Board would be unable to maintain the system of care as it is currently being developed. The move to Medicaid managed care continues to riddle our system with cash flow challenges. Additional staff have been hired to assist with billing which only increases the expenses. It appears as if Medicaid managed care companies receive the per member per month rate without the burden of the excessive billing requirements placed on an agency. This is especially true for clients who have third party insurance as well as Medicaid. An agency is forced to bill the third party first. While appropriate in theory, this delay in payment of over 90 days is an excessive burden at the agency level. Perhaps the managed care companies should pay 100% of the bill and they collect from 3rd party? As efforts continue with Medicaid managed care it is imperative that access to client level data be available at the Board level. Hancock County is only one of two counties in the state to receive a CCBHC grant. It is hoped that we will be seen as a resource as the state continues to modify and improve Medicaid Managed Care in Ohio.

There are five Board Local System Priorities including: reopening of Tree Line, a previously SUD residential treatment facility into a 24/7 supervised stabilization center; maintaining a robust level of intervention services; expansion of adult outreach and engagement services; the implementation of a mobile health clinic; the creation of a housing plan. Multiple factors as described above influenced the decision to identify them as local priorities.

a. Reopening of Tree Line. Tree Line was our level 3.5 SUD 12 bed residential program. The program was closed in March of 2020 shortly after COVID hit Ohio. Prior to the closing of the facility; the program was negatively impacted by Medicaid residential rates and the fact that Medicaid was unwilling to authorize continuing stays, often notifying the agency after a resident had already been in the facility for more than 30 days. The Agency could not sustain this financial loss in addition to the financial losses associated with the early days of COVID when patients did not come in for appointments and telehealth was not readily available. The need for residential services did not go away. Since that time, the Board has continued to fund residential treatment services for clients in need in out of county placements. We have re-evaluated the need for residential services, seeking input from providers, family members and clients.

   We currently have level 2 recovery housing in our community; however, when residents relapse, there is no local level 3 option for them as a temporary increase in level of care. With the loss of the residential treatment option, we have no local higher level of care. We do have a 5 bed group home that is often used to provide stabilization for individuals struggling with mental illness. The number of beds is inadequate to meet the needs of individuals struggling with mental health and/or addiction. Our goal is to close the group home as a stabilization

service and reopen Tree Line as a stabilization service for mental health and/or addiction. This would provide access to 12 beds with 24/7 supervision and access to medical, mental health and/or addiction services. The concept has been heavily supported throughout our community, especially with the criminal justice system, where 24/7 supervision is often provided at the jail as a default for not having any stabilization services in the community for individuals who do not meet inpatient level of care criteria.

b. Intervention Services – In addition to the existing intervention services which are primarily provided to child serving systems: schools; child welfare and juvenile court, it is anticipated that through the resources of the CCBHC grant, intervention services can be expanded into primary health. This would include mental health and/or addiction screening tools to identify and refer individuals in need to services. One of our Board goals is to get to a population health model, building off of our ROSC Framework and CCBHC award. Dr. Flaherty, our national ROSC consultant, wrote the following to help lay the groundwork for our Board moving forward into population health. Expanding intervention services is just one piece.

"In 2012 Hancock County ADAMHS began the transformation of its behavioral health care into a "system" of service based upon best science and practice within the shared values of the community. More than just providing behavioral care, it wanted to design care in which its citizens not only received quality service but became measurably well. At that time Hancock's ADAMHS studied and adopted a Recovery Oriented System of Care (ROSC) which expressed the values subsequently incorporated into a Preamble for Care, Principles and Objectives (on file) for an ever expanding and strengthened system of care. This new system would be more responsive and accessible to the behavioral health needs and resources of the community. The results have added greatly to improved access - and health - of the community as documented monthly by ADAMHS. Overall behavioral care has been expanded in both hospital based and emergency care while community programs have grown continuously to address social and acute needs within the community itself. Peer workers were created, and a Recovery Center expanded. Specialized services for veterans, offenders in jail, Drug Court and criminal justice, housing, pregnant women, addiction and newborns, medical education and workforce development, school-based prevention and intervention, all grew while conducting broad community and family education with an openly inclusive participative model to meet the needs of all. The ROSC In Hancock County has served as an engine and positive gathering place for the entire community.

Inherent in ROSC is while addressing the needs of a community for behavioral and general medical care, the very information gained could be further analyzed to both understand what worked in Hancock County to address illness - and from that what could be further learned about reducing the causes and sources of those illnesses *in the first place*. Community health prevention based not on text or theory but on what was proven to have worked in the community. Finding the root cause of illness became a foundation for community prevention and health.

In conducting ROSC, Hancock's ADAMHS gained a glimpse at both its community's maladies and the root causes of those maladies. While building recovery, Hancock glimpsed the determinants of illness in the community, the prevention of that illness and the foundation for population health.

Population health is the act of incorporating locally derived health determinants into a *health* plan for a community (1). Illness informs health; health prevents illness. Wellness is derived from understanding pathology. Mandatory vaccinations, pollution guidelines, safe and functional sewage and water are common examples of such determinants. While ROSC builds health and recovery from behavioral illness within a distinct population, population health uses that knowledge to strengthen the total health of the entire community by informed prevention of illness and its complications, thereby reducing overall disability and chronicity. While clinicians may focus primarily on treatment interventions, population health targets point where prevention or intervention (social and medical) are most warranted, e.g. school-based education, early family intervention with youth, community health and earlier community education on emerging health concerns. With this greater focus on mental illness and substance use (behavioral care) the general health of *all* in the community can be improved. Population health is a kind of "social vaccine" for behavioral and physical health.

A population health approach offers an augmented but different paradigm than ROSC. ROSC reduces illness and offers a pathway to health, wellness and recovery. Population health designs interventions to prevent risk across *all* populations in the community, e.g. is behavioral care accessible to *all* in the community; what social factors contribute to poor behavioral (and physical) health in the community; what are the social determinants of health for the community? Can they be addressed?

A health system that aims to provide for both the general population and vulnerable groups must provide a spectrum of interventions, from universal prevention to after-care (1, p. 265). Vulnerable populations must be identified while the welfare of the general population becomes fortified. Mental illness is addressed for mental health; acuity of illness is met while mental resilience is fortified (e.g. healthy families, jobs, healthy relationships, opportunities for personal development) and sought.

Population health is an approach to health that aims to improve the health of the entire population and to reduce health inequities among population groups. Unlike approaches to health that focus on the pathology or illness, population health focuses on the health of ordinary people. Population health seeks to reduce the "risk" of people in the community and thereby raise the standard of medicine for all. What makes population health significant is that it focuses on the health of ordinary people through focused medical care, public health interventions, genetics and individual behavior, along with an understanding of how certain social determinants might interact with or impact health, e.g. income, education, employment,

culture. Within the existing ROSC model these determinants are referred to as "recovery capital" of an individual, family and community (2).

Population health is used in many areas of the world, the United States and certain larger urban regions. In all areas it never replaces traditional (more pathology focused) health care but becomes more an overlay or extension to that care to expand health delivery to all populations. In some areas Managed Care has evolved into adding a local population focus. Population health organizations have now developed to help communities design local models of population health (3). These organizations often rely heavily on collected local community health data and analytics technology to inform leaders and shape health delivery systems within a population health approach.

Population health typically benchmarks existing demographic and health data and then seeks to improve selected benchmarks over time. Examples might be longevity, death rates, specific illness prevalence such as lung cancer, opioid dependence/overdose, depression.

In short, a population health focus should improve the health of all citizens. Many examples have proven this, e.g. with diabetes, obesity, heart issues and any population intervention using vaccines (3,4).

At no time should population health replace or by design reduce a community's effort to address illness or disease - and build recovery. The application of a "population health" approach to Hancock via ADAMHS would be a unique "augmentation" of focus, thought and action to the existing ROSC and other health interventions. A comprehensive "population approach" at this time would be too costly and expansive for the resources and systems to support it. Instead, the ADAMHS board, in collaboration with other health, academic and community leaders might gather to assess both basic behavioral health benchmarks (e.g. access to care, attainment of recovery) and then select from that data certain behavioral health points of outcome for further analysis (i.e. population demographics, determinants of success, early prevention strategies, etc.) to both address the illness and assure that access to care is equitable to all - while adding how that knowledge can then strengthen the prevention of the illness and health for all over time within the community."

c. Outreach Services – Outreach services are being increased for adults with the implementation of the LEAD program and the expansion of the QRT to address suicide attempts. The goal of these types of services is to increase the availability of services to ALL residents in the community, not just those willing to come to the front door. This will help to address the health disparities that exist in our community. These programs also provide an opportunity for recovery for some of our counties most disenfranchised citizens. In addition, the goal is to divert them from the criminal justice system. In the event, the individual does connect with the criminal justice system, through the availability of universal screening at the jail, it is our

intent to ensure they are connected to services while in the jail and/or immediately upon discharge.

d. Mobile Health Clinic -The Board is working with the Health Department and the Findlay Rotary Club to establish a mobile health clinic. The Board is committed to having staff available when the clinic is open in order to provide mental health/addiction screening and linkage to treatment. This furthers our goal of primary health integration and population health. We are also working alongside our Health Department to implement a BDIP Program that will include needle exchange and Fentanyl testing strips. The Board is providing financial support and the Health Department is the implementing agency. We experienced multiple delays as a result of COVID, however, the program was recently opened. This program is complimentary to the distribution of Narcan kits, now broadly available throughout the community; and increased access to MAT.

e. Develop a housing strategy outlining capacity needs by level of supervision; and financial and human resources needed to support the strategy.

   Since the early 1990s, the Hancock County ADAMHS Board has been involved in the purchase and development of housing for people living with mental illness and/or substance use disorders. Today, the Board has accumulated 12 properties currently valued at almost $4.2 million.

   Before 1991 when the first property was acquired on N. Main Street, the Board had led Northwest Ohio in the development of regional housing to assist people who were being discharged from the state hospital.

   Since then, local housing has been greatly increased based on demand as expressed by local service providers. A decision was made by the Board to own the properties due to the fact that there was no private, non-profit housing corporation that was willing to do development for the target population. It's worth noting however, that Hancock County does have a non-profit housing corporation that serves people with developmental disabilities.

   All of the current Board-owned properties, with the exception of the Board's office on Carnahan Avenue, have been purchased or developed through program mortgages using federal funds, such as Federal Home Loan Bank Grants or state capital assistance. In exchange for these funds, Federal Home Loan Grant Program Mortgages require services to be provided for 15 years and state program mortgages require services to be provided for 30 years. All of the properties except for the Board office and FOCUS on Trenton Avenue, are used for housing. The total tenant capacity of the properties is 50, and the tenant occupancy rate from July 1, 2019 -Jan. 31, 2020 was nearly 91 percent. Additionally, four of the properties have on-site supervision provided by a person with lived experience, increasing the total service capacity to 54.

The Board has never had a vision for housing/property ownership in terms of capacity by type of housing as the Board developed housing in response to immediate/urgent needs and funding opportunities. As a result, there is no way to determine when the goal has been reached.

Within the next decade, many of the mortgages will expire, affording the Board an opportunity to determine if they want to retain and/or devolve itself of the properties. A priority for the Board is to complete a housing/property study to help develop a plan that lays out the future vision for housing and property management for the Board.

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

   The Board is an active participant in our local Family and Children First Council. There have been no cases that have gone through the dispute resolution process with our Family First Council.

   The Board is just completing year two of a four-year federal System of Care Grant. The goal of the grant is to integrate the ROSC (Recovery Oriented System of Care) model into services to youth and families. As a result, much intersystem work is being done with all member organizations of Family First Council. One of the first priorities has been to focus on out of home placements. As a result, a thorough review of the current process used has been conducted and areas for improvement have been identified. A learning community approach has been adopted to implement the proposed changes across child serving systems over the next two years of the grant.

   A team comprised of staff from the developmental disabilities system; child welfare; juvenile court; mental health and Family First were able to attend the National Wrap-around Conference in an effort to improve and expand this service in our community. Our local juvenile court Judge attended the National Conference on Children's Mental Health Research. Both of our city and county school superintendents attended the National School and Mental Health Conference. In addition, we have sponsored multiple local trainings, including self-care as a result of COVID. We had a technical assistance visit from FREDLA; and technical assistance related to mortality reviews on youth suicide. During FY'21 we will be bringing Youth Thrive to the community in an effort to focus on protective factors for youth most likely improve outcomes. The goal of involving multiple systems in national opportunities is to identify areas of improvement for our local community.

   Our Juvenile Court is the recipient of a grant with the RFK National Resource Center for Juvenile Justice to receive technical assistance on Dual Status Youth (Youth involved in Juvenile Court and Child Welfare). Our Board has been an invited and active participant in the process to improve the outcome of youth involved in both systems in an effort to prevent out of home placements.

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.

   Hancock County is not a high utilizer of the state hospital. Access to the state regional psychiatric hospital (Toledo), continues to present challenges to our community. This is especially true with

our criminal justice system. The Board funds a hospital liaison position to assist with discharge planning from the state hospital as well as local hospitals. This has been beneficial in ensuring good communication and identification of needs to assist with discharge efforts.

The Board has completely overhauled the prescreening process as a result of changes in the Medicaid Managed Care, the work force shortage, and the need to develop a crisis continuum for our community. Our local system is only responding to prescreens for the state hospital. Since this process was put in place, July 2019, our Board has facilitated a monthly "crisis system" call, inclusive of the Probate Judge; law enforcement; adult protective services; child protective services; treatment agencies; hospital staff, etc. The monthly meetings are used to identify needs, trouble shoot problems and celebrate successes.

Since the meetings have been held, the Board has identified resources for crisis stabilization for youth and adults; identified a mechanism to review cases of frequent users of the emergency room; increased the use of outpatient commitment; expanded the understanding of MRSS and LEAD; reviewed data from the crisis call center, etc. The biggest need identified is 24/7 stabilization services and the financial resources to support their care. This includes the need for Medicaid to establish a stabilization reimbursement rate.

Board Local System Priorities (add as many rows as needed)			
Priorities	Goals	Strategies	Measurement
Meet the needs of adult individuals who need 24/7 supervision.	Create access to 24/7 supervised residential stabilization services.	Reopen Tree Line (previously an SUD residential treatment program) as a residential level of stabilization services.	Measurement indicator: Opening of the facility; numbers served Baseline data: 0 Target: 20
Maintain a robust Intervention Level of Services.	Engage youth and families "at risk"; especially those impacted by the opiate epidemic.	Maintain Intervention Department at Family Resource Center; Conduct outreach and engagement services to priority populations including: early childhood mental health/consultation; wraparound services especially to students having difficulty in school; juvenile court-based liaison to engage and make appropriate referrals; outreach and home-visiting to mothers of infants who have been exposed to substance use via dedicated staff for the child welfare system.	Measurement indicator: Number served for "at risk" population (includes consultations). Baseline data: 184 Target: 200
Take services to adult individuals in need.	Maintain adult outreach and engagement services.	Implementation of the LEAD program and maintenance of QRT services	Measurement indicator: Number of contacts/survivor visits. Baseline data: 52 (QRT only) Target: 100 (QRT & LEAD combined)
Ensure clients receive services	Increase access to services for individuals of all ages.	Work collaboratively with the Health Department to develop a mobile health clinic	Measurement indicator: Number of individuals receiving mental health/addiction services from the mobile clinic Baseline data: 0 Target: 50
Housing Stability for Adult Individuals with Mental Health and/or Addiction Needs	Ensure there is adequate housing available to meet the needs of the population.	Develop a housing strategy outlining capacity needs by level of supervision; and financial and human resources needed to support the strategy	Measurement indicator: Completion of the plan. Baseline data: No plan Target: Plan completed by June 2021

Recovery Ohio Priorities			
Harm Reduction	Provide a continuum of adult harm reduction services in collaboration with the local Health Department.	Maintain availability of NARCAN; fully implement BDIP	Measurement indicator: Distribution of Narcan kits; participation in BDIP Baseline data: 375 (Narcan kits distributed) 0 attendance at BDIP Target: 380 Narcan, 5 BDIPP

Collaboration

6. 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?)

   The Board is involved in multiple collaborative efforts. No priorities in this plan can be achieved without collaboration. The success of our system is built on collaborative efforts/initiatives.

Collaborative Organization	Initiative
Blanchard Valley Health System*	MOMS Program; Withdrawal Management; Inpatient Psychiatric Services
Family First Council*	Serving as Governance body to the System of Care Grant
Criminal Justice*	Stepping Up Initiative; on-site to the justice center and the probation department; universal screening at the justice center; establishment of LEAD program; CIT; stabilization services
Rotary/Hancock Public Health	Development of a Mobile Health Clinic
Hancock Public Health	Overdose Reviews; Harm Reduction; Car Seat Safety; Crib Program; Hidden in Plain Sight; Project Dawn
United Way	Participation in their Collective Impact initiative related to the topic areas of housing; substance abuse and mental health.
Drug Court Advisory Committee	Implementation of two adult drug courts.
Juvenile Court	Family Dependency Court; Dual Status Youth Project; on-site behavioral health services
Probate Court*	Implementation of Assisted Outpatient Treatment
University of Findlay	Addictions Minor and annual Trauma Conference
Opiate and Other Addictions Task Force	Medication collection; resource packet; education of the medical community, etc.
Regional Trauma Committee	Planning a training targeting primary care.
Veterans Services	Battle Buddies Program
Child Welfare	Home coaching services
City and County Schools	Prevention, Early Intervention and Treatment Services. Some schools have a signed MOU with the Board
Affordable Housing Alliance	Housing study
Crisis Committee	Implementation of a Crisis Continuum

*Denotes there is a written MOU in place.

In relationship to continuity of care, special emphasis is being placed on "warm hand-offs" at all levels. Individuals and families served by the system are involved at all levels.

Inpatient Hospital Management and Transition Planning

7. 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)
   b. Who will be responsible for this?

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

As previously outlined in the plan, discharge planning with the state and other private hospitals is coordinated through a hospital liaison position funded by the Board and housed with our largest provider, Family Resource Center.

There is an increase in acuity and violence throughout the system. Much of this is due to the increased use of meth and cocaine throughout the community, often needing psychiatric intervention as a result of the psychosis from the drugs. As a result, it is more difficult to get access to inpatient care and/or contain them in the emergency room or jail. Our local Opiate and Other Addictions Task Force is addressing the increased use of meth and cocaine through system education and implementation of the MATRIX model.

Our collaborative worked to develop, and was successful in achieving a more intense, long term inpatient level of care for youth with UTMC. This has assisted with the ability to get access to services for youth with high acuity. For adults, access to the state hospital remains a challenge. Our local justice center is dealing with very high-level mental health and addiction needs.

Our local hospital is continuing to increase the level of acuity they are willing to admit, however they do not do any forced medications.

24/7 supervised housing/stabilization remains a challenge. There are very limited options in the area and any placement comes at great expense. We currently have a federal grant pending that, if awarded, would provide the necessary resources to open a 12-bed stabilization center.

In order to impact the utilization of inpatient services, a full continuum for crisis services will be needed. The vision for such a continuum encompasses prevention through inpatient care. The following gaps/increases in capacity are needed if we are to fully address the need for inpatient care.

a. Prevention/Early Intervention. Prevention and early intervention services exist primarily through our relationships with schools. Prevention and early detection/intervention needs to be expanded into the primary health arena. Our system has the opportunity to do this through the award of a CCBHC grant at our largest mental health agency, Family Resource Center.
b. CIT. We maintain a robust CIT Program. With the new suicide prevention grant we also want to further our efforts related to the Zero Suicide Initiative.
c. Outreach and Engagement. We have developed this for high risk youth through the placement of staff within the juvenile court system; the school systems; and the child welfare system. This works well to identify at risk youth. For adults, we have added QRT. We are in the process of expanding this concept to outreach to individuals who have attempted suicide through the recently awarded suicide prevention grant. We are also in the process of implementing the LEAD Program for

outreach and engagement for those identified by the criminal justice system. We also maintain universal screening for mental health and addiction services at our local jail.

d. 24/7 Hotline. We currently use a national vendor for our hotline, Protocol. This will be maintained.
e. MRSS. While not available 24/7, we have limited access to mobile response and stabilization services for youth/families. As human resources allow, this service would be expanded. We would like to increase the availability of mobile response for adults; however, we are in need of human and capital resources to do so.
f. Day time crisis response is available via a crisis counselor at Family Resource Center. She oversees all crisis programming.
g. Crisis Stabilization Services. The Board has put a contract in place for adult crisis stabilization services via Rescue Crisis Center. We have also worked with Children's Resource Center to have a similar option for youth.
h. 24/7 Stabilization Services. This is the service most critically needed. We need a Medicaid reimbursement rate; funding and human resources in order to implement.
i. Housing. We are currently in the process of conducting a housing study to ensure we have adequate housing options for individuals in need. It should be noted that substance use has increased significantly and continues to challenge housing options/opportunities.
j. Inpatient Care. We maintain an indigent care contract with Blanchard Valley Health System to ensure that payment is not a barrier to admission.
k. Recovery Support Center. FOCUS is our local recovery support center, offering support and services six day a week. In addition, they sponsor an alternative peer group, the LOFT, for youth. Both efforts must continue to be supported if we are to have a positive impact on inpatient care.
l. Community Supports. With the advent of COVID, the number of staff working in the community was dramatically reduced. We are currently in the process of rebuilding a robust community support network including case managers and peer supports that can be out in the community working with those at highest risk.

Continuum of Care Service Inventory

8. 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)].

   Please see attached spreadsheet.

Alignment with Federal and State Priorities

9. 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).

Please see attached table.

Priorities for Hancock County ADAMHS Board				
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)	Ensure access to a full continuum of care; especially MAT.	Implementation of ROSC with a full continuum of care. Expansion of Harm Reduction Efforts.	Quarterly ROSC Implementation Report; including number of MAT slots.	__ 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)	Ensure proper prenatal care and substance use treatment for women and keep the family unit together post-delivery.	Populate apartment complex for pregnant women and children especially women who are opiate dependent and provide "wraparound" services from agencies throughout the community (JFS; Child Welfare; Treatment Agencies; Health Department; Hospital, Metropolitan Housing etc.)	Number of apartments occupied; women served; number of infants delivered; number of mothers/infants maintained as a family unit.	__ 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)	Reduce the number of out of home placements.	Fully implement system of care grant. Support Family Dependency Court.	Number of youth in out of home placements. Quarterly meetings with the County Commissioners.	__ 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.)	Ensure individuals with communicable diseases have access to mental health and substance use services. Identify if other services are needed.	Monitor the increased number of Hepatitis C Cases in the community. Work with the Health Department to determine additional	Ongoing data collection and monitoring of the number of cases.	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):

		services/education that may be necessary. Increase harm reduction efforts.		
MH-BG: Mandatory (for OhioMHAS): Children with Serious Emotional Disturbances (SED)	Ensure SED youth have access to a full continuum of care.	Fully implement the system of care grant. Expand investment in treatment services for youth including: outpatient; home based services; CPST; high fidelity wraparound; access to medication; residential treatment; school and juvenile court-based services.	Number of youth in treatment; by service. Number of youth hospitalized and/or in out of home placement.	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):
MH-BG: Mandatory (for OhioMHAS): Adults with Serious Mental Illness (SMI)	Ensure individuals with severe and persistent mental illness have access to a full continuum of care.	Maintain investment in treatment and recovery support services, including: ACT and IDDT; CPST; access to Medication and outpatient services as well as a continuum of housing supports.	Number of individuals receiving service; inpatient utilization.	__ 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	Ensure individuals in need of housing have access.	Maintain housing. Continue to participate in the local Affordable Housing Alliance to monitor and develop the Continuum of Care.	Continuum of Care. Occupancy rates of Board owned housing.	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):
MH-Treatment: Older Adults				__ No assessed local need __ Lack of funds _x_ 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 individuals involved with the criminal justice system have access to services.	Participate in Stepping-Up Initiative. Maintain Criminal Justice Division (including forensic team; and jail-based services; and reentry services.) Maintain Universal Screening. Implement LEAD Program.	Number of screens completed. Number receiving services. Number of clients diverted in LEAD Program.	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe

Integration of behavioral health and primary care services	Move system to a population/whole health model.	Incorporate whole health principles/language in efforts of the Board. Begin to fund more non-traditional interventions to promote wellness. Target early intervention to those most at risk. Implementation of CCBHC Grant.	Number of screenings conducted for early detection of mental illness and/or addiction. Number participating in non-traditional services. Number of public awareness efforts targeting whole health/population health.	__ 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)	Increase the amount of recovery support services.	Maintain contract with FOCUS for recovery support (youth and adult) and recovery housing services. Increase the number of peer support staff. Submit capital application for additional one-bedroom apartments.	Tracking number of clients receiving peer support services and the hours provided. Number of residents in Board subsidized housing. Number of individuals participating in recovery support center (adults) and LOFT (youth).	__ 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)	Ensure those most in need have access to services.	Work with Cultural Delegation to improve access to services in Hancock County. Monitor Health Disparity Document prepared as part of System of Care Grant.	Number of individuals served in as a reflection of community make up.	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):
Prevention and/or decrease of opiate overdoses and/or deaths	Ensure that no death is in vain.	Review each overdose death in order to identify points of intercept where services are needed and/or could be improved.	Monthly monitoring of overdose deaths. Review of overdose deaths.	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe
Promote Trauma Informed Care approach	Create a trauma informed community.	Participate in regional meetings to continue to advance trauma-informed approaches. Sponsor Annual Trauma Training with University of Findlay Social Work Department.	Community Health Assessment Results. Number of Participants attending training.	__ 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	Ensure a consistent message of wellness throughout the community.	Maintain investment in prevention services with Family Resource Center. Maintain Community Partnership to oversee Prevention/Early Intervention Services.	Number of individuals served and programs offered.	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):
Prevention: Increase access to evidence-based prevention	Invest in programs which are most likely to improve the opportunity for successful outcomes.	Ensure that programs funded are evidence based.	Specific programs funded; numbers served; outcome achieved.	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):
Prevention: Suicide prevention	Reduce the number of suicides.	Participate in Zero Suicide Initiative of State. Monitor the number of deaths monthly. Conduct review for each death. Increase public awareness efforts, follow-up services and warm "hand-offs". Fully Implement the federal suicide prevention grant.	Number of completed suicides.	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):
Prevention: Integrate Problem Gambling Prevention & Screening Strategies in Community and Healthcare Organizations	Ensure that individuals seeking treatment are screened for problem gambling and offered services if needed.	Incorporate screening tool in diagnostic assessment. Maintain staff in treatment agencies skilled in treating gambling disorders Provide recovery support services specifically for individuals with gambling disorders.	Number of clients screened. Number of clients receiving services. Number of staff specially trained. Number attending recovery support services for Gambling Addiction.	__ 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.

No waiver requested.

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

No waiver requested.

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

No waiver requested.

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.)].

Instructions for "SFY 2021 -2022 Community Plan Essential Services Inventory"

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/**

RECOVERY ORIENTED SYSTEM OF CARE (ROSC) FRAMEWORK AND IMPLEMENTATION PLAN Hancock County ADAMHS Board Strategic Plan

Aligning Treatment with a Recovery-Oriented Approach (Services)	Integrated Peer and Other Recovery Supports Mobilizing and Activating the Recovery Community	Performance Improvement and Evaluation	Promotion of Population and Community Health with a Focus on Prevention and Early Intervention	Individualized Services Appropriate to Trauma, Culture, Gender, etc. (Interventions)
EXISTING STRENGTHS				
•Criminal Justice Division Forensic Team Services •Corrections Services •Robust Mental Health Treatment System	•Funded Positions •NAMI •AA-NA-AL Anon Community •SMART Recovery Groups •Celebrate Recovery Groups •Focus on Friends Drop-In Center •You Are Not Alone Support Group	•Dedicated Staff Position at the Board •Database Project	•Community Partnership •Opiate Task Force •Early Intervention Programming in Schools •CIT (Crisis Intervention Training) •Application of the Strategic Prevention Framework	•Existing Evidence Based Practices
ACCOMPLISHED DURING FY'14-FY'17				
•Outreach/Engagement/Recovery Check-ups •Residential Treatment Facility (Tree Line) •Medication Assisted Treatment (Opiate Protocol)	•Transform Focus on Friends into a Peer-led Recovery Support Center •Recovery Homes (two) •Develop Vision for Recovery Guides •Certified Peer Supports; Career Ladder (Delivery Structure; Payment; Supervision; Position Descriptions etc.)	•New Auditing Process •Community Measures for ROSC: Increased Access to Care; Retention in Care; Outcomes	•SBIRT (Screening, Brief Intervention and Referral to Treatment) •Mental Health First Aid	•Trauma Informed Care Learning Community •Mental Health–Substance Abuse Criminal Risk Framework Grant •Implementation of HB43 (Involuntary Outpatient Commitment)
ACCOMPLISHED DURING FY'18 – FY'19				
•Develop of Withdrawal Management Service •Increase the use of Medication Assisted Treatment •Establish Follow-up Care and Warm Handoffs for Individuals who Present with an Overdose in the Emergency Room	•Develop Housing for Pregnant Women with Substance Use Disorders		•Fully Implement CRAFT Groups on an ongoing basis •Apply for Coalition of Excellence Designation from the State Department of Mental Health and Addiction Services	•Establish a Specialty Team for Pregnant Women with Substance Use Disorders
PRIORITIES for FY'20-24				
1. Involvement of peers at all points of the treatment/recovery continuum 2. Development of a crisis continuum that includes "service on demand" 3. Fully implement a criminal justice division at Family Resource Center with focus on engagement and diversion	1. Work with Housing Collective Impact Coalition to advocate for affordable housing for individuals with mental illness and/or substance use disorders 2. Identify ways to incorporate employment as a recovery capital measure and incorporate into contracting	1. Establish a mechanism for ongoing consumer feedback 2. Participate in the Collective Impact Initiative, especially in the focus area of mental health and substance use 3. Monitor implementation of System of Care Grant via national evaluation efforts	1. Conduct a public awareness campaign aimed at involving the community and to promote prevention messages 2. Develop adult prevention services, including a focus on the importance of connection 3. Restructure the delivery of school-based services; create access to universal screening (streamline with System of Care Grant changes) 4. Advance the discussion of a whole health model including the importance of mind/body connection	1. Develop specialized programming for caregiver and children impacted by substance use, mental health and family dysfunction 2. Establish a technology committee to develop and implement a plan to advance the use of technology in board system 3. Fully implement Zero Suicide Initiative for youth and adults 4. Develop a board position statement on acceptance and inclusion to promote community safety 5. Increase the availability of services through the collaborative development of a mobile health clinic and the availability of transportation

ROSC Implementation 4th Quarter FY'20 Scorecard Report – FINAL August 2020

Current ADAMHS Mission: "To create an environment that brings hope and improves the quality of life for persons affected by mental illness and substance use and promote wellness and recovery."

Strategic Objective: Aligning Treatment with a Recovery-Oriented Approach

Priority 1: Involvement of Peers at All Points of the Treatment/Recovery Continuum

Metric

*** # of clients and (hours) of peer support services provided**

Agency	Q1:	Q2:	Q3:	Q4:
FRC (Adult)	129/977	113/957	100/1096	22/294
FRC (Youth/Family)	45/299	49/54	23/34	38/121
A Renewed Mind	62/198	58/178	92/288	82/206

CH FY 19 Average 116 (1,590)
CH FY 18 Average 100 (873)
CH FY 17 Average 133 (1,131)

Number of Employed Peer Support Specialist FRC Adult= 4
FRC Youth/Family= 4
A Renewed Mind= 2

Focus on Friends Peer Recovery Guide Measures:

	Q1:	Q2:	Q3:	Q4	FY19 Ave:
# of volunteer support hours	1227	1188	692.25	56.5	1152
* # of Recovery Guide hours	1058	1018	643.5	1020	502
* # individuals supported	276	262	127	297	148
# of active RG	11	19	11	7	14
# of new RG trained	0	4	0	0	4
# of total available RG	11	15	18	10	15
* # of RG matches	32	41	58	64	75

Q1	Q2	Q3	Q4

Comments:

All provider agencies now have peer support.

ARM was able to continue their full adult peer support programming through Q4 COVID-19.

FRC increased their youth & family peer support hours after a two-quarter decrease.

NAMI has formed a Client Advocacy Group comprised of agency staff, a board member and family member to assist local peers/families with various needs like court/judicial and housing advocacy.

The volunteer support hours at Focus was impacted by COVID-19. Peer Recovery Guides continued to support their matches and reported numbers similar to Q1 and Q2.

Priority 2: Increase the Use of Medication Assisted Treatment

Metric

Number of Individuals in active Tx for Opiate Dependence out of total number of individuals in Tx for substance use dependence:

Agency	Q1:	Q2:	Q3:	Q4:
FRC (Adult)	295/683(43%)	332/744(45%)	383/829 (46%)	375/1136 (33%)
A Renewed Mind	105/117(90%)	86/107(80%)	115/140 (82%)	90/125 (72%)

Demographics of Individuals in active Tx for Opiate Dependence:

Agency	Q1:	Q2:	Q3:	Q4:
Males	207	216	254	225
Females	193	202	246	240
Age 0-17	0	0	0	0
Age 18-21	9 (2%)	8 (2%)	9 (2%)	5 (1%)

Q1	Q2	Q3	Q4

Comments:

Females outnumbered males for opiate dependence treatment for the first time since 3QFY19.

90% of individuals in active treatment for Opiate Dependence are between 22-45 years old.

Age 22-30	151 (38%)	153 (37%)	189 (38%)	176 (38%)
Age 31-45	206 (52%)	206 (49%)	259 (52%)	242 (52%)
Age 46-60	32 (8%)	28 (7%)	38 (8%)	35 (7%)
Age 61+	2 (<1%)	3 (1%)	3 (1%)	6 (1%)

Number of individuals receiving medication assisted treatment:

Buprenorphine	Q1	Q2	Q3	Q4	FY 19 Ave
FRC (Adult)	46	48	74	89	40
A Renewed Mind	96	85	104	80	97

Naltrexone	Q1	Q2	Q3	Q4	FY 19 Ave
FRC	14	46	44	19*	28
A Renewed Mind	9	1	11	10	7

.

FRC reported a flaw in their EHR for Q1 numbers. Numbers have been corrected.

* FRC is unable to accurately pull the oral vivitrol numbers for Q4.

Priority 3: Develop a Crisis Stabilization/Withdrawal Management Center

Metric	Q1	Q2	Q3	Q4	Comments:

Number of youth and adults utilizing high-end or inpatient care FY20 to Date:

Crisis Stabilization: 1/$8,410.92
Foster Care: 4/$23,627.44
Residential Tx: 2/$3,993.02
Withdrawal (Arrowhead): 0/$0

	Q1	Q2	Q3	Q4	FY 19 Ave.	FY 18 Ave.	FY 17 Ave.
Brookside Utilization Rates	91%	90%	100%	91%	92%	79%	79%
Brookside LOS Average Rates:	47	46	65	41	39	24	25
State Hosp. Days:	84	39	54	52	178	170	73
Orchard Hall:							
Indigent Care:	4/$12,800	1/$2,400	2/$8,800	7/$28,800			
Youth Out of Home Care	60	59	78	39	58	-	-
BVH Medical W/D Mgmt	50/97	50/79	38/88	47/62	64/136		
Youth @UTMC Long-term Days	0	0	0	0	14	-	-

The drop in youth out of home care is due to COVID. Only families are referring for prescreens and it is more common to safety plan vs. refer to inpatient.

Emergency Services Response for NOPH & UTMC
Number hospitalized/Number of Screens

Agency	Q1:	Q2:	Q3:	Q4:
FRC (adult)	5/10	3/3	5/6	6/6
FRC (youth)	0/0	0/0	0/0	0/0

Number of MRSS responses:	Q1:	Q2:	Q3:	Q4:
	7	13	10	3

MRSS available during agency open hours. Additional hours will be added as staff are added.

Priority 4: Establish Follow-Up Care and Warm Hand-Offs for Individuals Who Present with an Overdose in the Emergency Room

Metric	Q1	Q2	Q3	Q4	Comments:
Quick Response Team Measures					FY18 was reported on 3 quarters only.
					FRC reports the QRT Program has seen a dramatic increase in overdose reports, sometimes being the same individual overdosing multiple times. Also, many reports coming from the same household with a parent and their adult child overdosing.

	Q1:	Q2:	Q3:	Q4:	Ave/qtr FY19	Ave/qtr FY18
Reported Overdoses	35	24	26	47	28	27
Total Survivor Visits	11	10	13	18	15	13
Survivors in Recovery	11	3	4	7	7	9

Priority 4: Monitored Outcomes.

Metric	Q1	Q2	Q3	Q4	Comments:

calendar year metrics:	**2016**	**2017**	**2018**	**2019**	**2020**
*** ER Visits Related to Overdose	159	297	248	235	113
*** ER Admissions Related to Overdose	80	92	79	103	34
*** Confirmed Overdose Deaths	15	30	21	15	4/4p

Recovery Check- Ups

Number of individuals maintaining recovery (through self-report) 90 days after completion of treatment:

	Q1	Q2	Q3	Q4	Total
FRC	-	* 5/5 (100%)	46/140 (33%)	11/26 (42%)	
ARM	5/8 (62%)	4/6 (66%)	4/8 (50%)	12/14 (85%)	25/36 (69%)

FRC reached 26 of 86 discharged clients for the recovery check-ups.

Tree Line Residential Treatment

Residents will complete their recommended LOS.

	Q1	Q2	Q3	Q4
Discharges	20	19	*16	n/a
Met goal & (%)	3 (9%)	7 (23%)	6 (29%)	n/a
Left AMA	17 (50%)	12 (39%)	5 (24%)	n/a

Tree Line remained closed 4Q.

FY 19 Total = 92 discharges with 46% meeting goals

FY 18 Total = 83 discharges with 79% meeting goals

FY 17 Total= 81 discharges with 73% meeting goals

Monitor occupancy and Length of Stay (in days) rates

	Q1	Q2	Q3	Q4	FY19	FY18	FY17
Tree Line Occupancy Rates	56%	63%	66%	n/a	80%	83%	83%
LOS Average Rates (days)	18	23	30	n/a	31	37	54

90 days after discharge, residents will have engaged in at least three clinical, case management, or peer support visits.

	Q1	Q2	Q3	Q4
# discharged	20	19	*16	n/a
# with 3+ contacts	6	7	15	n/a

FY 19= 92 discharged with an average of 70% with 3+ contacts
FY 18= 83 discharged with an average of 27% with 3+ contacts
FY 17= 62 discharged with an average of 60% with 3+ contacts

Number of clients requiring inpatient care or emergency services within 30 days of discharge from Tree Line

Q1	Q2	Q3	Q4
3	3	2	n/a

Strategic Objective: Integrated Peer and Other Recovery Supports Mobilizing and Activating the Recovery Community

Priority 1: Work with Housing Collective Impact Coalition to Advocate for Affordable Housing for Individuals with Mental Illness and/or Substance Use Disorders

Metric	Q1	Q2	Q3	Q4	Comments:
Recovery Homes Occupancy (4 to date) Number of Clients Served FY 20 = 20 % occupancy for male home FY20 = 86.6% % occupancy for female home FY 20 = 73.7% % occupancy for MOM's home FY 20=10.2% Number of Clients Served FY 20=20 FY 19= 26 FY 18= 17 FY 17= 22 Average Length of Stay					

	YTD FY20	FY19	Opening to Date
Men's Recovery	381	146	167
Women's Recovery	128	204	136
MOM's Recovery	20	NA	20

Priority 2: Work with Employment Collective Impact Coalition to Advocate for Employment Opportunities for Individuals with Mental Illness and/or Substance Use Disorders

Metric	Q1	Q2	Q3	Q4	Comments:
Participation with Chamber Advisory Board **Participation in Raise the Bar Initiative**					Raise the Bar has a new director and became actively engaged with ROSC Leadership. Zach Thomas continues to serve as a member of the Chamber Advisory Board and the discussion continues regarding the Drug-Free Workplace Community Initiative. The Chamber has also agreed to serve as a partner in the SAMHSA Suicide Prevention Grant with FRC, by assisting in the promotion of suicide prevention resources throughout the business community if awarded.

Priority 3: Develop Housing for Pregnant Women with Substance Use Disorders

Metric	Q1	Q2	Q3	Q4	Comments:
Housing Units for Pregnant Women with Substance Use Disorders					The project is complete and has begun serving clients and the first baby was born and brought home.

Number of WRAPs Completed through Focus Trainings: Calendar year metrics: 2018 2019 2020 3 4 7					No WRAP Workshops were completed this quarter due to COVID-19. These workshops were not approved to be facilitated remotely during this period. The LEAD Program is moving forward and referrals are being made by law enforcement.
Strategic Objective: Fiscal, Policy and Regulatory Alignment					
Priority 1: Monitor the Implementation of BH Redesign and Managed Care					
Metric	**Q1**	**Q2**	**Q3**	**Q4**	**Comments:**
Successful billing as of July 1, 2018					FY20 claims are successfully being billed.
Priority 2: Incorporate Quality Measures and Service Evaluation Results into Contracting and Link to Funding					
Metric	**Q1**	**Q2**	**Q3**	**Q4**	**Comments:**
Progress on 13th payment measures (met, partial progress, not met) Q1 Q2 Q3 Q4 FY19 ARM partial partial partial partial partial FRC met partial partial partial partial Focus partial partial partial partial partial NAMI met partial partial partial partial					Agencies received their full allocations, including 13th payment, in April to assist with COVID-19 related financial setbacks.
Priority 3: Monitored Outcomes					
Metric	**Q1**	**Q2**	**Q3**	**Q4**	**Comments:**
Ohio Wait List					Wait list continues to be received and reviewed.
Major Incidents Reported to State Department					Agencies reported there were no major incidents to report to the state.

ROSC Measures Imbedded In Report: * Increase Access to Care; ** Retention in Care; *** Outcomes

Yellow: progress is being made
Green: progress is according to timeline and/or task is completed
Red: There are critical issues that need to be brought to the attention of the Board for discussion

Glossary of Abbreviations:
CME: Continuing Medical Education MBR: Mid-biennial Review ROSC: Recovery Oriented System of Care