Ohio Department of Mental Health and Addiction Services (OhioMHAS)

Community Plan Guidelines SFY 2021 and 2022

Due by Friday, June 19, 2020

Enter Board Name: MHDAS Board of Logan & Champaign 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)].

    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 MHDAS Board of Logan and Champaign Counties has participated in a leadership Committee for the Community Health Needs Assessment (CHA) and the Community Health Improvement Plan (CHIP) in both counties for the past 3 processes. In addition to these 3 year processes, the MHDAS Board also uses annual data from Search Institute 40 Developmental Assets: Attitudes and Behavior Surveys, Signs of Suicide screening data for 6th and 9th grade students across all 9 school districts in the two counties and a process driven from the Board to seek feedback on local services, satisfaction with services provide, identified gaps, access to services, etc. from key community partners. The provider agency also does annual client satisfaction surveys and shares the outcomes as part of the information that is used to determine any changes or gaps to address. Both communities have also engaged in a Stepping Up process in the past year that has lent a deeper look into needs related to the criminal justice system and those in a behavioral health crisis in the communities. In addition, we meet quarterly with our primary community service provider agency admin team to review outcomes, as well as with Recovery Zone, the peer operated service organization and Residential Administrators, that manages Board owned housing and a recovery house. Together with ongoing conversations and feedback in community meetings and collaborations we are able to have well rounded picture of the needs of the community related to behavioral health.

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).

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.
    - *Environmental factors influencing MHDAS's priorities are high unemployment rates, limited public transportation options, growing workforce capacity concerns, limited MAT providers, and a continuing battle to address stigma related to mental health and addiction in both communities.*

4. Describe any child service needs resulting from finalized dispute resolution with county Family and Children First Council(s) [340.03(A)(1)(c)].
    - *There have been no cases of dispute resolution through FCFC in either county in the past year.*

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.
    - *Outpatient services for those individuals who experience a psychiatric hospitalization in the state hospital are coordinated through a patient navigator position at the community provider agency, TCN Behavioral Health. They are actively involved in the approval of any state hospital admission for the MHDAS Board and are available to other entities thru a 24/7 Crisis line for those approvals to take place. The patient navigator position at TCN has developed good working relationships with staff at TVBH and is able to coordinate services and many times even transportation back to the community following a TVBH stay. The services needed on an outpatient basis, especially if the person was not a former/active client of TCN would be determined in collaboration with treatment staff at TVBH.*

Board Local System Priorities (add as many rows as needed)			
Priorities	Goals	Strategies	Measurement
Behavioral health needs of students in grades K-12	Increase capacity for screening and identifying needs as early as possible.	1. Implement Handle w/ Care program in 20/21 school year with all 9 school districts 2. Train school staff to use ASQ-SE, DECCA and SBIRT as evidence-based tools for screening social/emotional and behavioral health concerns. 3. Partner with schools to provide clinical care to students in need in the school setting, but also building family engagement/navigator capacity with shared dollars.	1. Measurement indicator: # of schools implementing Handle w/ Care. Baseline data: 2 schools trained, no schools implementing yet Target: all 9 districts, local EMS & law enforcement trained and implementing in all 9 districts. 2. Measurement indicator: # of schools w/ staff trained for ASQ-SE, DECCA and/or SBIRT Baseline data: 5 schools have staff trained to administer ASQ-SE and DECCA at Kindergarten screenings, 1 school is trained and using SBIRT Target: At least 2 additional schools implementing ASQ-SE and DECCA at Kindergarten screening and 2 additional schools implementing SBIRT as a screening tool for at risk students in MS/HS grades. 3. Measurement Indicator: # of days per district that clinical therapist from TCN is in each building. Baseline data: all 9 districts currently have at least 2 days where LISW is in the school. Target: Addition of 1 FTE per county of a case management level position to act as navigator and family engagement coord.

Ability to respond quickly to behavioral health crisis in the community.	Build a response system that can meet with people in the community when a behavioral health crisis arises.	1. Continue working thru CORE, Opiate Task Force and MHDAS to create buy-in from key stakeholders to share in a "mobile response" approach to emerging BH needs. 2. Building a Faith Coalition in each county that will coordinate, and support identified needs to individuals that will help sustain recovery and meet basic needs.	1. Measurement indicator: Presence of a "mobile response" system that able to meet people in the community. Baseline data: There are lots of conversations about the "mobile response" idea but only actual implementation is Logan County's OD Response Team which visits people in the week following an OD encounter with law enforcement. Target: one active "mobile response" team in the Board area. 2. Measurement Indicator: Presence of an active Faith Coalition Baseline data: No Faith Coalition but interest in each county Target: one organized Faith Coalition with targeted strategies in each county.
Increase access to evidence based Prevention services to address needs across the lifespan.	Increase capacity for evidence-based prevention efforts for schools, churches, employers	1. Increase schools/grade levels implementing PAX Good Behavior Game. 2. Increase opportunities and options for training employers in Logan and Champaign Counties 3. Engage w/ Faith Coalition start up to provide training for church members on mental health and addiction, trauma, and ROSC.	1. Measurement indicator: # of school buildings/grade levels implementing PAX Baseline data: Currently 4 schools with 16 classrooms implementing PAX. Target: 2 additional schools implementing PAX in at least one grade level. 2. Measurement indicator: # of trainings to business/employer audiences Baseline data: Currently only opportunity is thru the Chamber of Commerce in collective settings in each county. Target: at least 2 businesses in each county will receive 1 prevention training on QPR, Stress Coping Strategies, MHFA or

			Gatekeeper 3. Measurement indicator: Formal Faith Coalition w/ leadership, goals & strategies Baseline data: 0 formal Faith Coalitions, but interest Target: one Formal Faith Coalition in each county.
Increase access to Peer Support Services in the system.	Support Recovery Zone, Thrive and TCN to develop partnerships and increase capacity for paid peer support positions.	1. Recovery Zone will have peers formally trained as certified peer support specialist and trained supervisors. 2. Certified peer support specialists located at Mary Rutan Hospital ED, local jails and in Recovery Housing through TCN.	1. Measurement indicator: # Certified Peer Support Specialists Baseline data: Currently 6 Certified Peer Support Specialists in two counties Target: at least 2 additional Certified Peer Support Specialists 2. Measurement indicator: # of Peer Support Specialist placed in community settings. Baseline data: no peer support specialists placed outside of Recovery Zone Target: at least 2 peer support positions placed in community locations

Collaboration

6. Describe the Board's 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 the funded priorities including any priorities that are aligned with federal and state 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?)
    - *There are a number of collaborations necessary in order to accomplished the priorities of the MHDAS Board. First and foremost is with the community treatment provider agency, TCN Behavioral Health. We went through a provider change in SFY 20 from Consolidated Care, Inc. which was acquired by TCN in June 2019. We are in the midst of the second year of our relationship and while there were some growing pains in the beginning, we have developed a supportive and collaborative relationship in serving the needs of Logan and Champaign Counties. In addition to TCN, are collaborative relationships with the local Health Districts and hospitals in accomplishing the community needs assessment and resulting strategies for addressing the needs. We will continue to need close relationships with local law enforcement and the court systems as they encounter people with mental illness and addiction. We are fortunate to have two specialty dockets in Logan County and good working relationships with all the court systems. The recent Stepping Up process in both communities has allowed for identifying places where improvements could be made. One significant area is around use of CIT reports from law enforcement to really be able to track the data and understand how earlier interventions may be possible. We are seeing a great increase in the use and the shared value in those reports and will need that continue for establishing the target population of a mobile response team, potential development of community paramedicine teams and coalition prevention strategies.*

      Obviously, we need to continue to work closely with schools. This year and last year have proven to be some of the most challenging that school admin have had to navigate and the behavioral health needs of both students and staff are at the top of concerns for all of us. We want to continue to promote prevention services and develop capacity in school staff for providing screening tools that will better help them determine the best referral and linkage to other services or school-based services.

      Continued collaboration with the Board of DD in both communities is also important as we begin to see a number of significant needs that are difficult and expensive to address in those individuals with dual diagnosis. We hope to grow the relationship and efforts with the faith community in both counties. By helping them to gain understanding of how the church community could really support those in recovery from mental health and addiction we are adding significant community supports that can outlast more formal ones. Business is another entity that we will continue to work to define ways to engage with around access to adults and getting health promotion and prevention messages to them. Helping business understand what to look for and how to address an employee who may be struggling with a mental health or addiction issue will provide better chance for sustained workforce and better sustained recovery for the individual. And lastly, continued relationships with the recovery community and those that can help identify what is working in the system and what is not.

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.
    - *This answer is similar to question #5 in that TCN Behavioral Health as our primary BH provider agency acts as the local gatekeeper for psychiatric hospitalization if Board dollars are to be accessed for payment. There is a patient navigator position at TCN that contacts the hospitals and makes every effort to engage the client in services back in the community. In terms of partner with the state and private hospitals, again our practice at MHDAS is to have TCN do the contracts or agreements for psychiatric hospitalization, crisis stabilization or withdrawal management. A portion of their allocation is to be used for these services that are not available in our own system to assure that clients are able to access the level of care needed.*
      We are seeing an increase in local crisis evaluations from the ED and need for crisis stabilization type services. There is no anticipation that this will back off for some time.

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)].

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).

Priorities for (enter name of 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 that persons who are IDU have prompt access to treatment services	Coordination with local hospitals/jails to link persons to services.	Measurement indicator: # of IDU assessments and time between that and first appt. Baseline data: IDU clients are prioritized Target: IDY clients seen for assessment within 1 business day	__ 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 that pregnant women with SUD have prompt access to treatment services.	1. Clients are seen within 2 business days of referral. 2. Clients can be referred to MOMS Program where case manager will assist in coordinating treatment services with medical provider. 3. Increase availability of local medical MAT providers.	1. Measurement indicator: # of pregnant women w/ SUD assessed Baseline data: % pregnant women w/ SUD are seen w/in 2 business days. Target: % of pregnant women w/ SUD seen w/ 2 business days 2. Measurement indicator: # of pregnant women referred to MOMS program Baseline data: Currently # of caseload for MOMS program Target: 8-12 women/year. 3. Measurement indicator: # of current MAT providers Baseline data: 16 MAT providers in the two counties Target: Increase MAT providers by 2	__ 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	Parents involved with Children Services and the Family Courts will receive prompt access to treatment and recovery support services	1. Treatment provider will work collaboratively with court and Children's Services staff to coordinate	Measurement indicator: # of clients successfully completing Drug Court or fulfilling Court orders Baseline data: # of Family Court referrals	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):

Commissioners and required service priority for children at risk of parental neglect/abuse due to SUDs)		care and encourage accountability with treatment engagement.	to treatment Target: 70% of Family Treatment Court participants will complete Treatment Court orders for treatment *Copy and paste above for multiple indicators.*	
SAPT-BG: Mandatory (for OhioMHAS): Individuals with tuberculosis and other communicable diseases (e.g., AIDS.HIV, Hepatitis C, etc.)	Linking clients to medical home	Complete health history with all clients; those with identified communicable disease will be referred to PCP.	Measurement indicator: # of clients w/ communicable disease referred to PCP Baseline data: ALL clients are asked about communicable diseases as part of the initial assessment for BH treatment Target: # 100% of clients w/ communicable disease will be referred to PCP.	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):
MH-BG: Mandatory (for OhioMHAS): Children with Serious Emotional Disturbances (SED)	Ensure access to children with SED to needed MH/SUD services	1. Maintain staffing levels to ensure prompt access to services for children with SED. 2. Expand school-based services to improve access to children with SED.	Measurement indicator: Waiting list for children services Baseline data: Avg wait time for children is 7-14 days Target: No more 14 business days wait time for children	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):
MH-BG: Mandatory (for OhioMHAS): Adults with Serious Mental Illness (SMI)	Ensure access to adults with SMI	1. Maintain staffing levels to ensure prompt access to services for adults with SMI	Measurement indicator: Waiting list for adult MH services Baseline data: Avg wait time for Adult MH is Target: No more than day wait time for adults with SMI	__ 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	Continued collaboration with TCN, RA Inc and Homeless shelters to coordinate housing supports.	1. Qtrly meetings w/ treatment provider and Board's housing manager to prioritize and monitor access to permanent supportive housing.	Measurement indicator: # of people waiting more than 60 days for housing Baseline data: RA Inc current wait list # BH referrals waiting over 60 days is 12 Target: Less than 60 days	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):

MH-Treatment: Older Adults			Measurement indicator: Baseline data: Target: *Copy and paste above for multiple indicators.*	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe) Just can't prioritize everything. Working

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	Use data from Stepping Up activities to improve and coordinate access to treatment resources.	1. Standardize evidence-based pre-trial and jail assessments.	Measurement indicator: # of inmates receiving BH assessments and treatment services while incarcerated Baseline data: 1 FTE shared between the 2 counties to begin engagement in tx for inmates in Logan Co Jail, Tri-Co Jail and WCCCF Target: Increase capacity to provide more assessments/tx in each location	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe
Integration of behavioral health and primary care services	Increase collaboration with local FQHC entity (CHWPLC) and other medical providers.	1. Monitoring access to care and unmet needs	Measurement indicator: # of clients w/ identified PCP Baseline data: all clients are asked about having a PCP as part of assessments Target: increase the clients who are linked to a PCP if they do not have one at time of assessment	__ 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 access to certified peer support specialists in community settings	1. Training for peer support specialist to be certified. 2. Explore coordination with Faith Coalition for transportation and other recovery supports 3. Continue contract w/ RTC Industries for supported employment services	1. Measurement indicator: # of certified Peer support specialists Baseline data: 7 certifed peer support specialist Target: At least 2 peer support specialists to be placed in community settings. 2. Measurement indicator: # of transports offered by peer suppters/ faith coalition members Baseline data: Not currently being tracked as no faith coalition exists Target: Have active faith coalition in each county and coord w/ Rec. Zone	__ 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)	Want to address this as part of our SFY22 Strategic Planning	1. Review local data to see if there are significant health disparities for any subgroup and build plans to address as part of Board's SFY22 Strategic plan	Measurement indicator: Goal on SFY22 Strategic plan Baseline data: Target:	__ No assessed local need __ Lack of funds __ Workforce shortage _X_ Other (describe):
Prevention and/or decrease of opiate overdoses and/or deaths	Decrease # of opiate OD deaths in Logan & Champaign Counties	1. Increase access to Naloxone 2. Increase access to MAT locally	1. Measurement indicator: # of sites disbursing naloxone in each county Baseline data: Logan & Champaign Health District training and disbursement #'s Target: Increase # of sites trained and given Naloxone 2. Measurement indicator: # of providers in each county providing MAT Baseline data: 15 in Logan Co and 8 in Champaign Target: Increase # MAT providers by 2 in each county	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe

Promote Trauma Informed Care approach	Increase # of organizations trained in Trauma 101 and/or Trauma Informed Care principles.	1. Provide/ Host Trauma training to community agencies/organizations 2. Maintain staffing credentialed in EMDR	1. Measurement indicator: # of Trauma trainings provided/hosted Baseline data: 3 Trauma trainings in SFY20 Target: @ least 3 Trauma trainings in each county in SFY21 and SFY22 2. Measurement indicator: # of EMDR or other trauma certified clinical providers Baseline: 3 MH Therapists Target: Additional 2 MH Therapists trained/certified in trauma evidence based tx methods.	__ 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	Addressed in Board Priorities on Pg. 4		Measurement indicator: Baseline data: Target: *Copy and paste above for multiple indicators.*	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):
Prevention: Increase access to evidence-based prevention	Addressed in Board Priorities on Pg. 4		Measurement indicator: Baseline data: Target: *Copy and paste above for multiple indicators.*	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):

Recovery Ohio and Prevention: Suicide prevention	Continue to follow Zero Suicides recommendations for implementation of Pathways to Care	1. Expansion of use of PHQ-9 in medical and BH settings 2. Use of caring contacts following psychiatric hospitalization on client engagement 3. QPR Trainings	1. Measurement indicator: # of sites using PHQ-9 for suicide screening Baseline data: Standard practice in BH agencies, 2 medical practices Target: Increase in # of sites using PHQ-9 for suicide screening 2. Measurement indicator: % of psychiatric inpatient clients receive caring contacts afterwards Baseline: implemented this practice at the provider in the past year for all psychiatric hospitalizations Target: Caring contact sent to all psychiatric hospital discharges arranged by the agency within 1 wk of discharge	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):
Prevention: Integrate Problem Gambling Prevention & Screening Strategies in Community and Healthcare Organizations			Measurement indicator: Baseline data: Target: *Copy and paste above for multiple indicators.*	X__ 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 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 ADAMH Board.

_____

ADAMH Board Name (Please print or type)

_____ _____

ADAMH Board Executive Director Date

_____ _____

ADAMH 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**. The 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/**