



January 6, 2012

To: Ohio's Mental Health Community

From: Tracy J. Plouck

Subject: Planning for FY13 Community Mental Health Investments

The Ohio Department of Mental Health, in concert with all of our community partners, serves adults with severe and persistent mental illness and youth with serious emotional disturbances (SED) in community settings whenever appropriate, resulting in better clinical outcomes and potentially lesser costs. As a part of this general goal, we want to offer a new funding paradigm that focuses on collaboration and regional leadership. Using a portion of our Fiscal Year 2013 (FY13) non-Medicaid subsidy, we want to incentivize shared planning and service delivery between ADAMH boards in support of high priority service needs to individuals living with mental illness. This philosophy will help us to be as efficient as possible and strengthen our ability to plan for the most impactful use of future resources that may be made available.

Introduction of New Funding Concept

With limited resources, it is imperative for our system to prioritize investments that have the greatest impact for people throughout Ohio who need services. As you may be aware, in FY13 the Department is adopting a new paradigm for the investment of additional non-Medicaid community resources in its General Revenue Fund subsidy line item. Rather than employing a traditional formula-based approach wherein each ADAMH board area receives a small portion of additional state mental health resources, we will be investing additional subsidy resources in collaborative projects that transcend board areas and address "hot spot" concerns. These may vary from region to region in the state. For the purpose of these projects, "hot spots" may be defined as meeting one or more of the following criteria:

- 1) Specialized services for difficult to-serve-populations – high utilizers of service who do not achieve desired clinical outcomes;
- 2) Services for those with the greatest unmet needs – may be defined as highest cost clients; most clinically impaired clients; or a sub-set of clients who need services and a gap in the continuum of care exists;
- 3) Services that divert people from more restrictive and typically higher-cost settings (eg., hospitals, jails/prisons, out-of-home placement for children, nursing facilities, etc.); and
- 4) Incentives to engage clients who are difficult to engage in behavioral health services and likely are costly to other systems.

The Department will work in partnership with the ADAMH boards, advocates, providers and others to develop a “menu” of targeted investment opportunities on a state hospital catchment area basis that will help increase community capacity and relieve pressure from “hot spot” needs. The menu of opportunities may vary by area of the state depending on the specific needs of that area and will be developed by local stakeholders. Each ADAMH board area may partner in one/more investments on its menu. The investment will be ongoing as long as estimated progress is demonstrated. All communities are expected to receive benefit from this strategy, and we are excited about the opportunity that we have to demonstrate our ability to work together in this new way.

The following are some example investments that a collaborative area might propose. Please note that these are for illustrative purposes only, and are intended to familiarize you with the variety of initiatives that might be developed:

- Intake and crisis service augmentation, including the creation of additional crisis beds to benefit people living in multiple board areas;
- Specialized housing for difficult to serve populations;
- Inter-system partnership efforts in support of youth with serious emotional disturbances who are transitioning to adulthood;
- Re-entry initiatives to enable mental health services for individuals leaving prison or jails;
- Services to individuals sentenced to a community setting as a result of sentencing reform;
- Establishment or extension of team-based services to support youth and their families in an effort to minimize the need for out-of-home placement;
- Step-down opportunities for individuals who are long term forensic patients in state hospitals; or
- Innovative strategies to address access challenges related to transportation logistics or general provider capacity.

Available Resources

There is currently \$10.6 million identified within the Department’s FY13 budget to support this initiative. These resources will be allocated regionally based on the most recent available census data. The table below identifies both the base amount that will be available for each collaborative region based on existing appropriations AND an additional planning amount for which the Department would like to receive additional proposals, to be used in the event that additional resources are made available for community mental health in FY13. Note that a map identifying the counties participating in each collaborative region is attached to this memo for your reference.

Regional Collaborative	Current FY13 Resources
Appalachian	\$894,352
Central Ohio/Twin Valley	\$2,128,502
SW Ohio/Summit	\$2,062,636
Northwest	\$1,590,754
NE Ohio/Northcoast	\$2,341,331
East Central/Heartland	\$1,582,425

Collaboratives are encouraged to submit new ideas beyond the amounts indicated in the table. To the extent that a need exists, it would be helpful to provide a second set of concepts – perhaps roughly equal to the amount that is actually available for the collaborative – so that planning could be expedited in the event that other additional funding sources are identified for FY13.

Local Planning is Key

Local control is a key historical concept in Ohio, and the Department will not be overly prescriptive in the definition of local needs and local strategies. A few general parameters have been developed with the assistance of a team of providers, boards and advocacy organizations in order to guide the regional collaborative planning process.

The initiatives identified by a collaborative may be new projects and/or build upon existing programs in circumstances where a demonstrated, continued need exists. In other words, if Board A has a very successful program for SED youth that could be expanded to other boards in that region, one of the potential investment areas could expand SED capacity in Board A and could also be extended to serve youth in partnering board areas. Alternatively, a completely new project could be established that would address a priority service need that is shared across a number of boards, but for which a successful model does not exist in any of the partnering board areas.

The specific number of strategies is left to each collaborative to determine, with the expectation that individuals residing in all board areas have access to a reasonable degree of improvement as a result of participation in this initiative. Note again that this is a paradigm shift in the way that we are framing subsidy funding for community mental health. Individual communities should not expect that they will receive the “exact” value of their jurisdictional per capita share from the overall catchment area amount; some areas may get a little more or less depending on what is prioritized and developed by stakeholders in that catchment area. With that said, however, this is under no circumstances a competition between the individual boards in a catchment area. **The goal is for local boards to engage their providers and local advocates and collaborate with partnering board areas in order to leverage collective resources and recommend meaningful, near-term actionable investments for Ohioans who need services.**

The total amount for each regional collaborative is available for all communities within the area to access through a locally-driven process that emphasizes meaningful stakeholder input, consensus building and meaningful partnership across board areas. It is possible that a specific board area may elect to participate in some – but not all – of the projects identified for that collaborative area of the state, depending on the needs of individuals in that board area. To use an example, if specialized housing for individuals with a history of sex offenses is established as a project, Board A would not participate if there were no persons in need of that type of housing in their board area in FY13. However, it is still a viable project that builds capacity for that general region of the state and could serve as a resource to Board A in the future if an individual in that jurisdiction needed those specialized housing services and there was existing capacity. How Board A negotiates its non-use of this shared resource in FY13 with the other boards and stakeholder partners is left to the locally-led discussions and consensus process. (Please note that the

Department will be offering as a reference some logistical examples of multi-party agreements that could be used as tools for the collaboratives as they develop their detailed plans.)

If a board area chooses not to participate in this initiative generally, that board will not be able to “take” its relative share of the per capita amount and walk away from the shared planning approach. We are seeking to incentivize collaborative planning, economy of scale and shared service provision in this model.

Implementation

The Department currently has worked with a team of advocates, providers and boards to develop the process by which resources will be assigned to specific projects. (A list of participating organizations is attached to this memo for your reference.) The next step is for the regional collaboratives to develop the “menu” of proposals for each region in which an investment would be most impactful. Local engagement is needed within the next few weeks in order to develop strategies that would best address locally articulated “hot spots.” If you are interested in sharing your perspective during this process, please contact your local ADAMH board.

It is our expectation that boards will work with stakeholders including individuals with mental illness, providers, local advocacy organizations and other local partners such as probate judges, re-entry coalitions, family and children first councils, etc. in order to solicit insight and develop ideas, then ultimately to work with adjacent board areas to define specific strategies for use of these limited resources in FY13. This local discussion process can begin immediately with the goal of identifying collaborative-specific projects by mid-February. To the extent that questions arise during your local discussions that would be helpful for the Department to address, please send those to collaborative@mh.ohio.gov. Note, however, that the planning is intended to occur locally within the regional collaborative areas through the leadership of the ADAMH boards.

The Department will host two webinars to provide an overview of the concepts outlined in this memo and respond to any questions raised via the email box. The first will be **Thursday, January 19 at 9 a.m.** To participate in the first webinar, pre-register at <https://www2.gotomeeting.com/register/791729106>. A webinar format was selected instead of a conference call because our webinar capacity is 1,000 people, thus ensuring sufficient access to the session. The second webinar will be a repeat of the first session, to be held **Friday, January 20 at 3:30pm.** To participate in the second webinar, pre-register at <https://www2.gotomeeting.com/register/139069738>.

Regional collaboratives’ proposals are due February 17. The Department is developing a “summary proposal template,” which is expected to be available in advance of the webinars and posted on the Department’s website. It will seek a general overview of the proposal, any data that informed this as a critical need for the region, documentation of stakeholder involvement in the planning process, some basic outcomes that are expected during FY13, effects on other systems (if applicable) and other basic elements.

A more detailed work plan for each initiative must be submitted by April 30.

Timeline

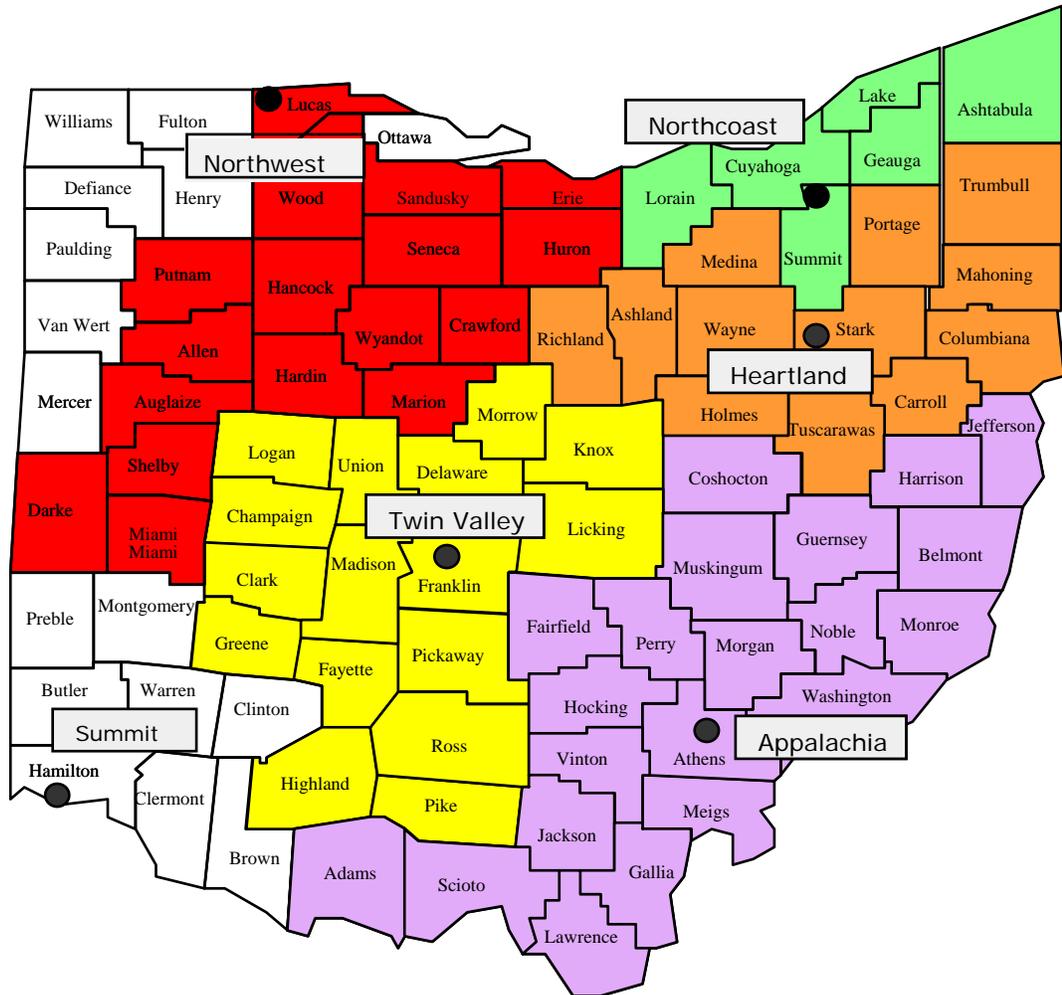
January 6, 2012	DMH issues this announcement letter; local discussions begin
January 18	Behavioral Health Leadership Group, where this initiative will be featured as a core agenda item on Wednesday, January 18 th at 1pm – 4pm, ODMH, 30 E. Broad Street, 8 th Floor.
January 19, 9 am	Webinar in which DMH provides overview of general concept, fields questions posed by the field to date, and receives a limited amount of follow-up questions during the session. Pre-register at https://www2.gotomeeting.com/register/791729106 .
January 20, 3:30 pm	Repeat of webinar from 1/19 Pre-register at https://www2.gotomeeting.com/register/139069738
February 17	General concept documents submitted to DMH by regional collaboratives
April 30	Detailed work plans submitted to DMH by regional collaboratives
July 1	Appropriation is available for use

Attachment A = Map of Department of Mental Health Regions

Attachment B = List of Organizations on Logistics Team

Attachment C = Webinar Information

Map of DMH Regions



Organizations Represented on the Logistics Team

ADAMHS Board of Cuyahoga County

Clermont County MH & R Board

Columbiana County Mental Health & Recovery Services Board

Hancock County ADAMHS Board

Medina County ADAMH Board

Mental Health Advocacy Coalition

MHRS Board of Richland County

MHRS Board of Stark County

Muskingum Area ADAMH Board

National Alliance Mentally Ill

Ohio Department of Mental Health

Ohio Empowerment Coalition

Ohio Federation for Children's Mental Health

The Ohio Council of Behavioral Health & Family Services Providers

Wood County ADAMHS Board

Webinar Information

January 19th Webinar

Pre-register

<https://www2.gotomeeting.com/register/791729106>

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